



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface Central

on 01/17/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Cheri Pettitt, Executive Director, Arnette House

Toni Liebhart, Senior Counselor, Youth and Family Alternatives (RAP House)

Rachel Greene, Clinical Director, Capital City Youth Services

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 14 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 12 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

5 Youth 6 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Central provides both residential and non-residential programs. This program site is located in Gainesville, Florida. The CDS Central program provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS Central agency primarily provides CINS/FINS services in Alachua, Gilchrest and Levy Counties. CDS Central also operates sister Residential and Non-Residential programs in Lake City and Palatka, Florida respectively. All three CINS/FINS program locations report to the agency’s Chief Executive Officer and Chief Operations Officer that are located in the headquarters office in Gainesville, Florida.

Since the last annual program review:

The Residential Supervisor and the House Manager were both out on leave for the same twelve week time frame. These two critical positions missing for this extended period of time put a hardship on the shelter but staff pulled together to continue to provide the services needed each day.

The House Manager resigned after that twelve week leave and that position is still vacant. A skilled Youth Care Worker is fulfilling many of the responsibilities of this position until it is filled.

The agency is in the beginning stages of building a new shelter facility. They are currently requesting to enter into a land agreement with the state and are reaching out to secure funding for the actual facility. The desire is to eventually have a campus setting which will house all of the CDS offices on one site.

In August, the shelter had a sewage leak from a break in an old septic tank. The primary repairs were completed just before hurricane Irma coming through. They are awaiting the completion of some cosmetic finishing touches to allow the participants to use the on-site recreational area. Until then they have been primarily using a local park in the neighborhood for outdoor recreation.

The agency is proud of the continued longevity of staff. They have four staff with fourteen or more years. This year one staff member will reach twenty years and another staff member will reach twenty-five years.

Standard 1: Management Accountability

Overview

Narrative

The daily operations of CDS Central Residential and Non-Residential programs are overseen by a Regional Coordinator. The Regional Coordinator position is the highest ranking position for the agency at this location. The agency also has Residential and Non-Residential counselors, Residential Direct Care and Non-Residential staff members. The agency has a Centralized Human Resources and fiscal departments that are responsible for all personnel and financial matters respectively. All CDS Residential Shelters and Non-Residential Programs have implemented uniform operating protocols for all three service locations in their respective service areas. Other uniform program and operations protocol for all three locations include training and professional development exercises.

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

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

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency uses policy P-1025 to address background screening requirements. The policy titled Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns was last reviewed in November 2016.

Background screenings will be processed and housed in the Care Provider Background Screening Clearinghouse online portal. Screening results will be displayed on the Clearinghouse website within three to seven days from when DJJ BSU receives the packet and fingerprint data. No offer of employment or volunteer/internship may be made prior to receipt of DJJ clearance. Five-year re-screens should be conducted on employees, calculated from the "Retained Prints Expiration Date" posted on the Clearinghouse site.

There were a total of ten staff hired since the last review. All ten staff received a background screening prior to their hire date. There were four staff eligible for a five-year screening to be conducted. Three screenings were completed prior to the staff's initial date of hire as required. The remaining screening was completed three months after the staffs' initial hire date.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit on January 4, 2018.

Exception:

One five year re-screening was completed three months late.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for the provision of an abuse free environment which includes a code of conduct for staff, duty to report to Florida Abuse Hotline, an accessible and responsive grievance process for youth, and requirement for management to take immediate action to address of abuse, intimidation, use of profanity and/or excessive use of force.

The procedure to implement the provision of an abuse free environment policy is outlined in policy and procedures for rule violations, behavioral expectations for staff, standards of conduct for participants, Florida abuse reporting, and complaint/grievance process for participants.

The program has a code of conduct that is explained in depth in the employee handbook which is signed by the employee acknowledging they have read and understand the contents. Employee's job descriptions also address the program's code of conduct and the employee signs acknowledging that they are aware of what is expected of them.

The parent/guardian orientation packet and the orientation checklist explains the program's grievance procedures, each are signed by the client and/or parent/guardian. The program has grievance forms and a locked box to submit the forms easily accessible in the boys and girls area of the shelter. Four grievance forms were reviewed and of the four, one was resolved within the 72 hour timeframe. Three of the four were resolved in 6, 8, and 9 days following the issue of the grievance. Two of the grievances were for profanity and disrespect by staff toward clients, and one was for staff calling a client a liar. When the staff addresses the issues in the client's grievances, the clients are given points if they handle the process in an appropriate manner.

The program has the Florida Abuse Hotline phone number and information posted at numerous locations within the shelter. The program keeps an Abuse Hotline log as required.

Eight training files were reviewed and of the eight all but one had training on Abuse Free Environment.

Six youth were surveyed and all six stated that they know about the Hotline, where to find the number, and that they are allowed to call. They all say they have never been or seen anyone denied a call. They also state that the adults in the program treat them respectfully and they feel safe.

Five staff members completed surveys and all five had been trained on Abuse reporting and stated that they had never seen a co-worker deny a child a call to the hotline. They also reported that they have not heard a co-worker threaten or intimidate a client.

Exception:

Three out of four grievances were not resolved within the 72 hour time frame.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy to address Incident Reporting. The intent of this policy is to ensure reporting of incidents is consistent with the requirements of state agencies and that incidents are properly documented in required time frames.

The agency has a comprehensive policy and procedure to address incident reporting with specific procedures for all participants and procedures for DJJ participants.

There were twelve CCC incident reports reviewed. Of the twelve reports, nine CCC calls were documented in the logbook and three were not. All follow up documentation was provided where necessary. Of the

twelve reports three were documented as "failure to report" by the CCC, meaning they were reported outside the two hour time frame. All three of these incidents were addressed at the next staff meeting and retraining was completed on CCC reporting time frames. Internal Unusual Event reports were reviewed and all incidents that required call in to CCC were called in.

The program has the CCC Hotline number posted.

Exceptions:

Three CCC incident reports were not documented in the program logbook.

Of the twelve CCC reports, three were documented as "failure to report" by the CCC.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Training Plan in place that is effective from July 1, 2017 – June 30, 2018.

The plan states that the Program/Regional Coordinator at the program will maintain training files that include documentation of training and certifications on each employee. A position-specific annual training plan, which indicates completed training as well as projected training topics for the remainder of the year, is also maintained in each employees training file. The training outlined in the plan meets the requirements outlined in the Florida Network's CINS/FINS Policy and Procedure Manual.

There were five staff training files reviewed for training completed during the first 120 days of employment. One staff was missing CINS/FINS Core Training, another staff received the CINS/FINS Core training late and not within the first 120 days. All other trainings in all five training files were completed as required.

There were four staff training files reviewed for training requirements during the first year of employment. All four staff documented more than the required 80 hours of training. Two staff did not complete PREA training during the first year of employment. All other trainings in all four trainings files were completed as required.

There were three staff training files reviewed for in-service training requirements. All three staff documented more than the required forty hours of training for the year. However, one documented a lapse in CPR and first aid certification from 2/11/2017 until 1/18/2018.

Exceptions:

One staff was missing CINS/FINS Core training in the first 120 days. One staff received CINS/FINS Core training outside the 120 requirement.

Two staff did not complete PREA training during the first year of employment.

One staff had a lapse in CPR and first aid from 2/11/2017 until 1/18/2018.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency maintains a quality assurance program to objectively and systematically monitor and evaluate the quality and utilization of services. CDS formally and routinely collects and analyzes data for the purpose of quality improvement.

CDS has a written plan that was developed in accordance with DJJ Quality Assurance Standards. The Quality Assurance policy and procedures addresses the minimum guidelines for the agency including: participant care and services standards, participant charts and maintenance procedures, staff development policies and procedures, facility safety and maintenance standards, peer review and utilization procedures, and incident reporting policies and procedures.

In 2013, the program developed a comprehensive five year Risk Management Plan which assists the program in risk management and quality improvement. The agency incorporates their Continuous Quality Improvement Committee and subcommittees into their Quarterly Executive Management Meetings and Quarterly CINS/FINS meetings (program level). The meeting minutes clearly include peer record review, safety/risk management, program outcomes, and consumer satisfaction surveys. Documentation for all of these areas of evaluation was reviewed. The program analyzes a wealth of data to determine quality improvement.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory Limited Failed

Rating Narrative

The program has a policy that outlines responsibilities and expectations for driving practices and care and security of vehicles. The policy also outlines procedures to avoid situations that put youth or staff in danger of real or perceived harm or allegations of inappropriate conduct by either staff or youth.

The procedure to avoid alleged impropriety is to have a third party present when transporting a participant. The third party may be an approved volunteer, intern, agency staff, or other participant. If a third party is not available the participant and the drivers individual situations are evaluated and the program supervisor gives consent prior to the transportation.

The program keeps a weekly log of approved single transport clients and drivers. Transportation logs and approved single transport logs were reviewed and verified with logbooks. Of twenty-one single transports reviewed over a six month period all but three were approved and documented.

There is a log of vehicle maintenance, registration, and procedures. In addition, there are logs of actual vehicle usage which do include parties transported, driver, and all information outlined in the policy. One log is specifically for trips to schools. The other log is to document use of vehicles for outings. Both are set up in similar manner.

Exception:

Three single client transports were not documented as being approved.

1.07 Outreach Services

Satisfactory Limited Failed

Rating Narrative

The program has policies that address the roles and responsibilities of their staff to ensure the implementation of the Department of Juvenile Justice objectives through participation in local and circuit level meetings. They also have a policy addressing targeted outreach to at-risk youth. Outreach services are designed to increase public awareness of: a) the needs of troubled youth at risk of running away, being habitually truant, or being beyond the control of their parents/guardians and b) the services for this population available through CDS.

CDS staff assigned by the CEO/COO attends local DJJ board and council meetings. The assigned

representatives will advocate for the effective use of CINS/FINS services. The program maintains appropriate service linkages by coordinating with local agencies and schools.

Documentation of participation in Circuit Board Meetings shows that program representatives not only participate in meetings but volunteer for special committee work. Printed outreach materials and cooperative service agreements were reviewed. It appears that the program has long standing and strong relationships with community partners.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Non-Residential Counseling Program provides services for youth and their families primarily in Alachua, Gilchrest, and Levy Counties. The program receives calls for services from parents, guardians, system partners, and the general community. The non-residential component for CDS Central consists of five Non-Residential Counselors; three of which are Master's level Counselors, one holds a Ph.D., and one is a Bachelor's level counselor. All Family Action Staff members and residential counseling staff members have access to the agency's Non-Residential Regional Coordinator, who is a Licensed Mental Health Counselor (LMHC).

The screening determines eligible youth and family whom are referred to the respective residential or non-residential program to start the intake process. If the program is full at the time of referral, the agency will make a referral for the family to another appropriate community agency, according to the youth's zip code.

The program has the capability to offer both case management and substance abuse prevention education on an as needed basis. The agency conducts Case 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.

Both the Residential Supervisor and residential and non-residential CDS Central counseling staff are engaged in partnerships with local school systems regarding the options available for status offenders and the overall petitions process and displayed a high level of knowledge and insight regarding their involvement in the community in this area.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The agency's policy and procedures were last updated in November 2014.

The provider's procedure requires the trained staff to complete the intake screening process upon receiving the referral within 24 hours, but no later than seven calendar days. The provider's procedures also state that upon completion of the intake screening, the intake/assessment process needs to be initiated within seven days along with necessary assessments.

A total of ten files were reviewed including five Non-Residential files and five Residential files. Out of the five Non-Residential files, two were open and three were closed. Out of the five Residential files, three were open and two were closed.

Ten of the ten files completed the eligibility screening within seven calendar days of referral. Ten of the ten files indicated that youth and parents/guardians received the following in writing from provider: available service options, rights and responsibilities of youth and parents/guardians, and a parent/guardian brochure. All files indicated that youth and parents/guardians have access to possible actions occurring through involvement with CINS/FINS services and grievance procedures. Provider meets the standards by giving parents/guardians the necessary paperwork at time of Screening and Intake.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy in place was last updated in November 2014.

The provider's procedure requires a Bachelor's or Master's level staff member to initiate or attempt the Needs Assessment within 72 hours of admission. The Needs Assessment is to be completed within two to three face-to-face contacts following the initial intake. The provider requires the counselor/case manager to sign and date the Needs Assessment form corresponding to the date of completion. The supervisor is then required to review and sign the completed document.

A total of five Non-Residential files (two open and three closed) and five Residential files (three open and two closed) were reviewed. Five of five Non-Residential files were not applicable for the Needs Assessment being initiated within 72 hours of admission due to cases being Non-residential. In five of the five Residential files, the needs assessment was initiated within 72 hours of admission. Ten of the ten files indicated that the Needs Assessment was completed within two to three face-to-face contacts after the initial intake or updated, the Needs Assessments were conducted by a Bachelor's or Master's level staff member, the Needs Assessment includes a supervisor review signature upon completion. Seven of the ten files indicated that youth were not identified as an elevated risk of suicide as a result of the Needs Assessment and were not applicable for the assessment of suicide risk (conducted under the direct supervision of a licensed mental health professional) due to no suicide risks established during the Needs Assessment. The remaining three files indicated that youth were identified as an elevated risk of suicide as a result of the Needs Assessment. These files had completed assessment of suicide risk which was conducted by a licensed mental health professional.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy in place was last updated in November 2014.

The provider's procedure requires an Individual Plan to be developed with the youth and family within seven working days, following completion of the assessment. The provider outlines all the requirements for each Individual Plan that needs to be included, which corresponds to the requirements outlined in the CQI Indicator. The Case/Service Plan includes the following: individualized and prioritized need(s) and goal(s) identified by the Psychosocial Assessment, service type, frequency, location, person(s) responsible, target date(s) for completion, actual completion date(s), signature of youth, parent/guardian, counselor and supervisor, date the plan was initiated, and reviewed for progress/revised by counselor and parent (if available) every thirty days for the first three months and every six months after.

A total of five Non-Residential files (two open and three closed) and five Residential files (three open and two closed) were reviewed.

Ten of the ten files had the Case/Service Plan developed within seven working days of psychosocial assessment, the individualized and prioritized need(s) and goal(s) identified by the psychosocial assessment, the service type, frequency, and location for the Case/Service Plan. Of these ten files, all ten had the person(s) responsible and the target date(s) for completion. All ten files had youth, parent/guardian, counselor, and supervisor signatures, the date the plan was initiated, and were reviewed for progress/revised by counselor and parent every thirty days for the first three months and every six months after if applicable. Five of the five open files were not applicable for actual completion dates due to cases currently being open. Five of the five closed files had the actual completion dates.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy in place was last updated July 2014.

The provider's procedure requires the assigned counselor/case manager/residential counselor to be responsible for providing the individual and family counseling based on the Individual Plan. The counselor/case managers are responsible for following the youth's case and to ensure youth/family receive the necessary services and/or referrals needed based on their Individual Plan. The process includes the following: establish referral needs and coordinate referrals based on the ongoing assessment of the youth/family problems and needs identified in the Individual Plan, coordinate Individual Plan implementations, monitoring youth's/family's progress in services and providing support for the families, monitoring out-of-home placement, if necessary, making referrals to the case staffing committee, as needed to address the problems and needs of the youth/family, recommending and pursuing judicial intervention in cases as appropriate, accompanying youth and parent/guardian to court hearings and related appointments (if applicable), make referrals to additional services, if needed, continued case monitoring and review of court orders and case termination with a follow-up.

A total of five Non-Residential files (two open and three closed) and five Residential files (three open and two closed) were reviewed. Ten out of the ten files had a Counselor/Case Manager assigned, established referral needs, coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in services, and provided support for families. Five of five files (Non-Residential) were not applicable for monitoring out-of-home placement. Ten out of the ten files referred youth/family for additional services when appropriate and provided case monitoring and reviews court orders. Ten out of the ten files were not applicable for staff accompanying youth and parent/guardian to court hearings and related appointments. Ten of the ten files were not applicable for referring to case staffing to address problems and needs of the youth/family. Five of the five closed files provided case termination notes.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy in place was last in updated July 2014.

The agency procedure requires counselor/case managers to be responsible for documenting all contacts in progress notes and maintaining them in the participant's file which includes regular contact with the youth and family as well as any outside service providers that may be applicable. Counselor/case manager is to ensure continuity of care along with monitor delivery of services.

Residential counselors are to give individual counseling based on the Individual Plan, group counseling sessions based on established group process procedures; which are to be conducted a minimum of five days per week focusing on clear and relevant topics (informational/developmental/educational). Group sessions are to have a clear leader or facilitator and be at least thirty minutes in length. Group sessions should be an opportunity for youth to engage. Non-residential counselors provide services through a therapeutic community based service designed to provide the intervention necessary to: stabilize the family in the event of a crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services and prevent the involvement of families in the delinquency and dependency systems.

A total of five Non-Residential files (two open and three closed) and five Residential files (three open and two closed) were reviewed.

Ten of the ten files had youth's presenting problems addressed in the psychosocial assessment, had youth's presenting problems addressed in the initial case/service plan, youth's presenting problems addressed in the case/service plan reviews, case notes maintained for all counseling services provided, and documented youth's progress. Ten of the ten files had an on-going internal process that ensures clinical reviews of case records and staff performance, youth and families receive counseling services in accordance with the case/service plan, program provides individual/family counseling. Five of five files (Non-Residential) are not applicable for group counseling due to not being in shelter care. Five of five files (Non-Residential) are not applicable for group counseling dates due to not being in shelter care. Five of five files (Non-Residential) were not applicable for group counseling sessions consisting for at least thirty minutes, clear leader or facilitator, clear and relevant topic or opportunity for youth engagement due to not being in shelter care for group counseling sessions. Five of the five files (Residential) indicated that group counseling sessions were provided at least five days a week, if not more and the counseling sessions consisted of the following: length of at least thirty minutes, clear leader or facilitator, clear and relevant topic (informational/developmental/educational), and opportunity for youth engagement.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy in place was last updated in February 2008.

The agency's procedure states that a Case Staffing Committee meeting is to be held to review cases determined in need of services or treatment if: the family or youth is not in agreement with the services or treatment offered, the family or youth will not participate in the services or treatment selected, the counselor/case manager needs assistance in developing an appropriate Individual Plan, the parent or guardian, or any member of the committee requests that a Case Staffing Committee meeting be arranged (If requested by a parent, a Case Staffing Committee meeting must be held within seven days, excluding weekends and holidays, of written request). The counselor/case manager is responsible for implementing and monitoring the Plan of Services. A copy is required to be sent to the parent/guardian within seven days of the meeting to provide a written report outlining reasons for or against a petition being filed and the recommendations. The Case Staffing Committee must include, but not limited to, the following: a representative from the Department of Juvenile Justice or designee in accordance with the CINS/FINS Operations Manual, a representative of the CINS/FINS provider and a representative of the youth's school district.

A total of five Non-Residential files (two open and three closed) and five Residential files (three open and two closed) were reviewed.

Ten of the ten files were not applicable for Case Staffing. Provider did not have any cases that went to case staffing/petition within the past six months.

Reviewer reviewed two most recent files that were applicable for Case Staffing. The two files were from June 2017.

Two of two files the case staffing was initiated by the Counselor. Two of the two files were not applicable for staffing being held within seven days due to parent/guardian not initiating the staffing. Two of two files indicated the family was notified of staffing no less than five working days prior to the staffing and indicated local school district representative was present at staffing as well as DJJ rep. or CINS/FINS provider was present at staffing. Two of two files indicated that attendance officer also attended the staffing as well as a mental health representative. Two of two files indicated others requested by

youth/family was not applicable due to youth/family not requesting others at staffing. Two of two files indicated as a result of the case staffing committee meeting, the youth and family were provided a new or revised plan for services and a written report was provided to the parent/guardian within seven days of the case staffing meeting, outlining recommendations and reasons behind the recommendations. Two of two files indicated the program works with the circuit court for judicial intervention for the youth/family and the Case Manager/Counselor completes a review summary prior to the court hearing.

The program has an established case staffing committee and regular communication with committee members. The program has an internal procedure for the case staffing process, including a schedule for committee meetings as well as notifying committee members when no case staffing will be held.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy in place was last updated in September 2015.

The provider's procedure requires that an official record shall be maintained for each youth receiving services upon Intake. Case records are to be kept in a neat, orderly manner. All records are to be marked as "confidential" and stored in a secure room or locked in a file cabinet that is marked "confidential." When in transport, all records are to be locked in an opaque container marked "confidential."

A total of five Non-Residential files (two open and three closed) and five Residential files (three open and two closed) were reviewed. Of those files, all were marked "confidential." The provider has locks and "confidential" tags for transporting files. The provider uses locked cabinets in controlled rooms. Files were neat, well kept, and easy to guide through.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS Central youth shelter is located in Gainesville, Florida in Alachua County. The CDS Central facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and families for twenty beds. The agency serves both CINS/FINS and DCF program participants.

The shelter is comprised of a detached building that is a one level landscape or ranch style design. The shelter has both a front and side entrance. The building is designed with equally sized dorms and day rooms for female and male residential clients. Each residential section of the shelter can accommodate up to ten to twelve residents. The female and male sides of the facility are equipped with a large dorm, bathrooms, and a dayroom. The facility includes a kitchen and dining area, Youth Care Work station, staff offices, a smaller meeting room, multipurpose recreation, and an instruction/class room. Youth that are not in school spend a majority of their free time in the dayroom either engaged in planned life skills activities, playing video games, watching television, or completing homework assignments on the computers. Youth attend local area schools if they are not on suspension, expulsion, or suffering from an illness.

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

The program staff for the Residential staff includes a Regional Coordinator; a Residential Supervisor; one Senior Youth Care Worker; twenty-one full-time, part-time and PRN Youth Care Workers; one administrative staff person; and one Registered Nurse. Two Residential Counselors are assigned to provide counseling and case management services to the residential program. The Youth Care Workers are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision, and general assistance.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure in place which outlines the fire plan, leisure and education activities program as well as a plan for participation in faith based activities. In addition, youth and their parent/guardian are provided with an orientation packet which outlines expectations for providing a safe, clean and neat program in addition to providing information on structured daily programming.

The Program/Regional Coordinator is responsible for oversight of emergency disaster plans and drills which are to be conducted annually on each shift. A fire drill log will be completed following each drill.

A tour of the facility was provided and the facility was found to be in good repair, free of any insect infestation/debris and was clean. It is important to note that the COO did state the facility was old and they are in the process of acquiring a new site. However all areas were clean and functional. Staff provided reviewer with access to two agency vans which were found to be locked and held all mandatory safety equipment. In addition two personal staff vehicles were also found to be locked.

A copy of the DCF child care license was found on display in multiple places throughout the facility. Upon inspection, both the male and female youth rooms/bathrooms were found to be well kept and without visible graffiti (except on chalkboard where graffiti is permitted).

A review of fire inspection reports indicate that the facility is in compliance with the local fire marshall. In addition documentation was found corroborating that staff complete one mock emergency drill per shift each quarter.

A youth schedule was provided for review which outlined education, recreation, counseling and social

skills activities youth are involved in during their stay. Five open youth files and the log book corroborated participation in these activities. The youth schedule was also found to be posted publicly in multiple locations.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place outlining admission/intake and participant orientation which is provided within twenty-four hours of intake.

At intake each youth is provided a detailed orientation by program staff informing the youth (but not limited) to the following:

Key staff and their roles

Program dress code

List of prohibited contraband

Grievance procedures

Tour/Physical layout of the facility

Dress code

Access to medical & mental health procedure

Review of program rules

Disciplinary action

Five open residential youth files were reviewed for this indicator. Of the five files reviewed it appeared the program orientation was included as a part of the intake process with a handbook and guidelines provided by the intake staff. The program provides a detailed orientation to each youth entering the facility upon the youth completing the intake process. Each file contained necessary documentation indicating that program orientation was completed by program staff with each youth. Each youth and staff member signed off on the program orientation as well as the youth's parent/guardian.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place outlining room assignments which is titled "Sleeping Arrangements".

During the intake process, each youth is assigned a room or bed based on the information provided by the youth, parent or guardian, and outside related sources that may have knowledge of the youth's history. Several factors are taken into consideration when assigning a youth to a room including:

suicide risk

physical characteristics

mental or physical disability

gang affiliation

aggressive/violent behavior.

Five open files were reviewed and two residential staff were interviewed to address this indicator. All evidence reviewed corroborated that staff make bed assignments based on the above mentioned information provided by the youth, their parent/guardian and outside sources when appropriate. It is important to note that in this facility there are dorm style rooms, one for males and one for females, equipped with multiple bunk beds. However staff thoroughly articulated how bed assignments are made and what factors are taken into account to determine if a youth is placed on a top vs. bottom bunk and where in the room they would be placed (close to the door vs. the back of the room). Youth who are placed on sight and sound during sleeping hours sleep in the living room to allow for line of sight supervision by a staff member.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place which outlines that "a permanent, bound program logbook" will be used to record daily events in the program. The policy provides guidelines for its use and dictates that logbooks will be retained for a period of three years.

The policy of the program states that it is the responsibility of the shift leader to ensure that appropriate documentation occurs on each shift. It also states that the program Log Book shall document, but is not limited to, the following:

- All incidents when physical intervention used
- Intakes and Dispositions of youth
- The staff on duty
- That the security of the building has been checked
- All incidents including when youth leave and return to the general population
- Any current deficiencies in the program.

A review of the program log by the incoming shift leader and staff of the previous three shifts in order to be familiar with activity on prior shifts, unusual occurrences or problems.

A signature title and date shall be documented accordingly.

Weekly review by the Program Manager, Supervisor or designee with corrections, recommendations, directives or followup.

Any other pertinent information (i.e. schedule contacts, visits, meetings).

Logbooks from a period of four months (October 12-January 17) were reviewed for this indicator. It appears that the staff understand and utilize the logbook for its primary function which is to document routine daily activities and events. All chronological entries were properly documented with the time and accompanied by a staff signature. All entries were made without white out or erasures.

Exceptions:

A supervisor regularly reviewed the logbook however staff reviews of the logbook were inconsistent. There were many issues with proper voiding of errors as most errors were noted by scribbling through or darkly marking through the error with no "void" noted or initials documented.

In addition, it would be helpful if youth were referred to consistently throughout the log book. For instance, referring to youth by their first name or first initial, last name consistently instead of switching back and forth.

Last, the "shift leader summary" section often included information regarding incidents such as fights without a time attached that were not captured in the chronological record.

3.05 Behavior Management Strategies

Satisfactory Limited Failed

Rating Narrative

CDS Central has a policy in place which outlines the major facets of the behavior management system. In addition there are several additional policies ("rule violations", "participant/staff interactions and interventions", "seclusion, restraint and aggression control") which serve to enhance understanding of staff conduct and responsibilities.

Upon intake, each youth is provided with an orientation handbook which outlines the programs behavior management system. The program utilizes a token economy called FACE (facilitating activity and communication effectively) which is explained to the youth at intake. The system is comprised of three different phases and youth are able to move through the phases, acquiring privileges, based on compliance with program rules and through demonstrating mastery of target skills.

Five open residential youth files and eight training files were reviewed as well as one direct care staff interviewed and one youth interviewed to assess this indicator. Of the five residential youth files reviewed, all were found to have confirmation from the youth, in the form of their signature, that they were provided with information and instructions regarding the FACE system for behavior management at their intake.

The eight training files all included documentation to support that staff were trained in the theory and practice of the behavior management system. The staff who was interviewed articulated the policy regarding the behavior management system and gave clear examples of its utilization. She provided examples which included how staff use points and incentives to encourage participation, use of appropriate consequences or negative points for negative behavior as well as supervisory conversations providing feedback on staff use of the FACE system. The youth interviewed articulated her understanding of FACE system including distribution of points and examples of positive behavior. She also reported being fully informed of the workings of the system at intake and during her first day at the program.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place outlining their staffing supervision ratio it specifies that the minimum ratio is one staff to six youth during awake hours and one staff to twelve youth during sleeping hours. In addition it dictates that one male and one female staff must be scheduled at all times. They also have additional policies titled "Bed time supervision and bed checks" and "participant supervision" which supplements the general policy. In addition, residential shelter maintains a video surveillance system that operates twenty-four hours per day, seven days per week.

The Regional Coordinator is responsible for scheduling and assuring all coverage requirements are in accordance with the standard. There are clear procedures for staff calling out sick or being unable to attend their shift. There is also a clear procedure for bed checks including that bed checks are required to be gender specific and occur every fifteen minutes. The bed checks are completed electronically with a wand and a printable report by each shift. The reports are kept in a binder which was reviewed by this

reviewer to ensure accuracy of reporting process.

Staff schedules, the program log book, and surveillance footage was reviewed to assess this indicator. The staff schedule was found to be located in a place visible to staff. In addition it provided documentation that the necessary staffing ratio was maintained at all times and that a male and female staff were assigned to each shift. Video surveillance and bed check logs were provided to demonstrate that staff observe youth and document this observation every fifteen minutes. This reviewer observed surveillance for 11/11/17 from 3:30am-4:40am, 10/21/17 from 3:30am-4:30am, and 12/4/17 from 1:30am-2:30am. Based on this surveillance, bed checks were found to be conducted appropriately.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for each special population they serve including staff secure, domestic violence respite, and probation respite. The agency does not serve DMST youth and therefore does not have a policy regarding this program. There are policies in place for enhanced supervision, in-depth orientations, assessments and service planning, as well as enhanced parental involvement and collaborative aftercare.

Procedures are in place for all special population categories served through CDS including contacting Florida Network as appropriate. Length of stay is noted for each population in procedure as well as policy statements. Procedures denote required time frames to include NetMIS entries and other documentation. There are also clear procedures regarding in depth orientation and assessment, service planning, enhanced supervision and security, parental involvement and collaborative aftercare.

Five closed residential files were reviewed to satisfy this indicator; four DV files and one staff secure. The program did not serve any probation respite youth for the review period. The four DV files reviewed all included evidence of being screened by detention and had a pending DV charge. None of the stays exceeded twenty-one days and all services provided were consistent with all other CINS/FINS program requirements. Two of the DV files had a case plan which reflected goals focusing on aggression management and family coping skills. Two files did not have a case plan but had a stay of three days or less, indicating there was not enough time to develop a case plan. For the one staff secure file reviewed there was evidence to support proper intake occurring after a court order. The logbook was reviewed to determine if a specific staff was assigned during each shift to monitor the youth. For the majority of shifts a specific staff was assigned. However there were twenty-four shifts in which a specific staff person was not identified in the log book or in the youth's file.

There were no probation respite or DMST youth served during the review period.

Exception:

There were twenty-four shifts in which a specific staff person was not identified in the log book or in the youth's file for the Staff Secure youth.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy to maintain a video surveillance system that operated twenty-four hours a day,

seven days a week. The existence of video surveillance for security purposes is posted at the shelter entrance. The policy states that the system will be accessible to only trained and designated staff. Supervisory reviews of the video system will occur bi-weekly. Cameras will have the ability to record date, time and location with facial recognition. Cameras will have back up capabilities in case of a power outage.

The agency's procedure for video surveillance is to place cameras only in public areas (none in bathrooms or sleeping areas) and be openly visible. The cameras will be placed both inside and outside of the shelter. Video recordings will be available for at least thirty days unless there is a special request or investigation and then recordings will be kept longer.

The agency has a posted notice of video surveillance at access doors to the building. There are fifteen cameras in use with the availability of one more on the system. All cameras are visible and none are in private areas such as sleeping quarters and bathrooms. The system can capture and retain video images with facial recognition. The surveillance system is capable of storing video for up to ninety days.

There is no specific list of designated personnel who can access the cameras because only two supervisory staff has access. If a third party requests to review the video one of the two supervisors who have access to the system will copy the video to the computer or a jump drive.

Exceptions:

Bi-weekly supervisory reviews of the video surveillance system began in October 2017.

The program has no backup for the system in the event of a power outage.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS Central program has specific policies and procedures related to the admission, screening, interviewing, client inventory, and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will conduct a full intake interview with the youth and parent/guardian. An initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available, and staff's assessment of the youth's ability to function effectively within program rules and expectations. CDS Central staff members 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 members on duty at the time of admission immediately identify youth who are admitted with special needs and risks; such as risk of suicide, mental health, substance abuse, physical health, or security risk factors. The agency's Non-Residential Regional Coordinator is a Licensed Mental Health Counselor (LMHC).

When a youth indicates positive for suicide risk they are placed on Constant Supervision or One-to-One Supervision. The agency utilizes a daily logbook documentation system and an alert board as part of its internal medical/mental health alert system. The agency operates a detailed medication distribution system using the Pyxis Med-Station 4000 Medication Cabinet.

The program has a Registered Nurse (RN) on-site at least five days a week. The shelter has a list of staff members that are authorized to distribute medication. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques and various emergencies. As of the date of this onsite review, all fire safety equipment is up-to-date and functioning as required.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency utilizes policy P-1117 to address screening for all past or current medical conditions. The policy titled Residential Admission: Preliminary Physical Health Screening was last reviewed in November 2016.

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

A total of five files, three open and two closed, were reviewed to assess requirements of this indicator. Of the five files reviewed, all contained the Intake Assessment form with all health screening sections completed. Four of the five files reviewed documented the youth were on medications. The medications were listed, as well as, the reasons for the medications. Three of the files documented the youth had some type of allergies. The RN documented an intake note in each file, documenting a review of the youth's medication and medical history. The Intake Assessment form was reviewed by the RN the same day of completion in all five files.

The agency utilizes a Medical Health Follow Up form. This form aids the staff regarding any health issue that has been confirmed during the health admission screening. Once a staff person identifies a major health issue a specific form with information on the health issue is placed in the youth's file. The form is designed to help increase awareness and knowledge of staff serving the youth of any potential health symptoms or identifiers for them to be aware of. This form is only utilized for specific health issues. In the five files reviewed, three of the files contained this form. One file had follow-up form for Asthma, one youth had a follow-up form for an Allergic Reaction and also one for a Special Diet, the third file had a follow-up form for an Allergic Reaction.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency utilizes policy number P-1247 to address suicide screening and assessments. The policy titled Suicide Assessment (Residential) was last reviewed in August 2011.

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

The agency has two levels of supervision. One-to-one supervision is the most intense level and is used for youth waiting to be removed from the program by law enforcement for a baker act. One staff member, who must be the same gender as the youth, will remain within arm's length of the youth at all times. The second level of supervision, Constant Sight and Sound Supervision, is for youth who are identified as being high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed, and uninterrupted sight of the youth and be able to hear the youth. Staff assigned to monitor the youth must document his/her observations of the youth's behavior at intervals of thirty minutes or less for both one-to-one supervision and constant sight and sound supervision.

There were four youth files reviewed for youth who had been placed on suicide precautions. All four files were closed files. All four youth were placed on suicide precautions at intake due to issues identified during the screening process. The youth were placed on sight and sound supervision. Three of the four youth were seen and assessed, by a master's level counselor, within twenty-four hours. The fourth youth was placed on sight and sound supervision on a Friday night and was seen first thing Monday morning by the counselor. All four files documented a suicide risk assessment was completed by a master's level counselor and documented consultation with the LMHC and program director. Both the LMHC and program director signed all four assessments prior to the youth being removed from suicide precautions. The youth were placed on normal supervision. All four youth had thirty minute observations documented the entire time on suicide precautions, with the exception of one youth who documented a gap in the observations from 9am one day until 1:10pm the following day when the youth was removed.

Exception:

One youth was missing thirty minute observations from 8/20/2017 at 9am until 8/21/2017 at 1:10pm.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency uses policy P-1120 to address the medication administration process. The policy titled Medication Provision, Storage, Access, Inventory, and Disposal was last revised in September 2016.

The policy has detailed procedures for Prescription Medication, Verification of Medication, Medication Provision, Supervision, and Monitoring, Utilization of the Pyxis Med-Station 4000, Proper Storage of Medication, Medication Inventory, Medication Counting Procedures, Medication Errors and Refusals, Discharge of Youth with Medication, and Disposal.

The shelter provided a list of staff who are trained to supervise the self-administration of medications. There were two staff on that list who were listed as "Super Users" for the Pyxis Med-Station.

The shelter has a RN who has been employed at the shelter since February 2016. The RN is on-site seven days a week, totaling approximately twenty hours a week. The RN is on-site every morning, Monday thru Friday, for about an hour, to distribute morning medications and every evening, Monday thru Sunday, for about two hours, to distribute evening medications. The shift leader distributes any afternoon medications when the RN is not on-site. The RN does complete various trainings with the staff, including medication administration. The shelter began using the Pyxis MedStation at the end of March 2016. The RN reported most discrepancies produced by the Pyxis Med-Station were staff getting confused with the beginning count versus the actual count. These discrepancies were easily fixed by the RN or the staff member. At the time of the review the shelter had no open discrepancies. The RN reported not using the Knowledge Portal on a consistent basis to run reports.

All youth medication is stored in the Pyxis Med-Station. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. Only the youth's prescription medication is stored in the Pyxis Med-Station. Medication storage will start in drawer one and once that drawer is full will continue into drawer two and so on. The shelter has a system in place for refrigeration of medication if needed. At the time of the review, the shelter had one medication requiring refrigeration and that medication was properly stored in the locked refrigerator.

All medications in the shelter are inventoried once per week, by the shift leader. This inventory is documented on the back of each individual Medication Record Log (MRL). All medications are also inventoried at admission with the parent present, when given, by maintaining a perpetual inventory with running balances, and at discharge also with the parent present. Controlled medications are inventoried shift-to-shift also. The shelter does not have any over-the-counter medications.

There were nine youth in the shelter on medications and those files were reviewed for medication administration. The agency still maintains hard copies of all documents relating to the medication process and enters all information into the Pyxis Med-Station, as required. The youth's MRL is maintained in a medication binder until the youth is discharged and then the MRL is filed in the youth's file. All MRLs reviewed, documented the youth's name, a picture of the youth, allergies, medication the youth was taking with dosage and time to be given, method of administration, side effects/precautions, special procedures/instructions, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. The back of the MRL documented all daily and weekly inventories and the verification of the medication with the pharmacist or by the RN.

All nine files documented the youth received medications at prescribed times. Perpetual inventories with running balances were maintained. One file reviewed documented six instances out of fifty-two shifts when a shift-to-shift inventory of a controlled medication was not completed. Another file documented five instances out of fifty-two shifts when a shift-to-shift inventory was not completed. Weekly inventories were completed for the non-controlled medications.

The shelter has had three CCC reports relating to medication errors in the last six months. One of the reports was in July 2017, one was in September 2017, and one was in January 2018. All three reports were

due to a missed dose of medication. A CCC report was completed in all case, as well as, an internal incident report. The youth's guardians were notified. The Pharmacist was notified and stated there would be no adverse side effects from missing the dose in any of the cases. There was documentation the staff involved in the incidents received some form of corrective action. All three incidents were successfully closed with the CCC.

Exceptions:

The RN was not consistently using the Knowledge Portal to run reports.

One file documented five shifts and another file documented six shifts in which a controlled substances was not inventoried.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

The agency uses policy P-1119 to address the alert process. The policy titled Medical and Mental Health Alert Process was last reviewed in November 2016.

Upon admission to the shelter, each youth receives a preliminary medical, mental health, suicide risk, and substance abuse screening. Any conditions are noted on the Intake/Assessment Form. All medication the youth is taking is listed on the Intake/Assessment Form and the Medication Record Log. Medication allergies, food allergies, and any other allergies are noted on the Intake/Assessment Form, the medical record log, and on the outside cover of the youth's file with either an "Allergy" or a "Medical/Mental Health Alert" label. In addition, youth issues, concerns, conditions, or physical restrictions are noted on the youth board using appropriate codes. All incoming staff review the youth board beginning of each shift.

A review of seven open youth files was conducted to verify the shelter's alert process. All seven files documented any applicable alerts on the spine of the youth's file. All medical related information was documented on the Intake/Assessment Form inside the file. All alerts documented on the youth's files corresponded with alerts documented on the alert board in the staff office. Alerts on the board were coded with numbers 1-18, with each number representing a different alert. Any dietary alerts/special diets were also documented on a separate form in the youth's file and in the kitchen.

There were also five additional closed files reviewed for verification of the alert system. All five files documented all applicable alerts on the spine of the youth's file. Additional information on the specific alerts was found inside the youth's file. These five youth had already been discharged from the shelter so verification of the alerts being documented on the shelter's alert board was not applicable in these cases. Staff interviewed were knowledgeable of the alert system.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory
 Limited
 Failed

Rating Narrative

The agency uses policy number P-1166 for Episodic Emergency Care. The policy was last revised in September 2013.

There are procedures in place for staff to follow in various types of medical emergency situations such as:

Skin Wounds, Dental Trauma, Convulsions/Seizures, Head Injuries, Stings and Bites, Burns and Scalds, Electrical Burns, and Accessing Emergency and Dental Care in Residential Shelters. Emergency drills simulating these events and other potential situations are to be conducted quarterly on various shifts. These drills should be critiqued and discussed during staff meetings.

Each program maintains its own first aid kit and supplies. The Regional Coordinator or his/her designee is responsible for ensuring adequate supplies are available for use and stored in areas in the facility that are accessible to staff. The first aid kits should be inventoried as a part of the weekly safety inspection and restocked as necessary. A knife-for-life and small wire cutters shall be maintained in a secure area accessible to staff in the event of a youth suicide attempt. All staff in direct contact with youth are to be certified in CPR and First Aid.

There have been four off-site emergency care events in the last six months. The shelter maintains an Emergency and Episodic Care Log that documents the date, youth involved, service needed, if the parent was notified, notification to the CCC, and discharge instructions. The shelter has completed a Medical Emergency Drill on each shift for the last quarter.

First aid kits are located in the staff office and in both the vans. The kits are checked weekly for expiration dates and replenished as needed. The shelter has both a knife for life and wire cutters in the staff office.

All employees at the shelter had current first aid and CPR certifications.

There were no exceptions to this indicator.