



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface Central

on 05/22/2013

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	Limited
1.05 Interagency Agreements and Outreach	Satisfactory
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 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 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 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

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

Brent Musgrove, Contract Manager Florida Department of Juvenile Justice-Office of Prevention

Melissa Temme, Clinical Support Manager, Boys Town-Central Florida



Shireen Shaw, Quality Assurance Specialist, Youth Crisis Center

Raylene Coe, Street Outreach Coordinator, Crosswinds Youth Services, Inc.

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 1 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 4 Clinical Staff | 4 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 3 Food Service Personnel | 5 Other |
| <input type="checkbox"/> DMHA or designee | 1 Health Care Staff | |

Documents Reviewed

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Reports | <input type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input type="checkbox"/> Logbooks | 9 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input type="checkbox"/> Medical and Mental Health Alerts | 8 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 7 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 12 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input type="checkbox"/> Program Schedules | Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | Other |
| <input type="checkbox"/> Fire Drill Log | <input type="checkbox"/> Table of Organization | |
| <input type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 8 Youth 5 Direct Care Staff 0 Other

Observations During Review

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

Comments

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

Rating Narrative

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

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

Strengths and Innovative Approaches

Rating Narrative

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

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

The agency has access to the agency's Chief Operation Officer who is a licensed Mental Health Counselor. These staff members administer suicide risk assessments and provide consultation 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 dot format to effectively manage multiple medications in order to reduce the rate of medication distribution errors.

The agency hosted its 14th annual "Spotlight on Youth" community outreach event. This event is a community wide event to promote the talent of the youth they serve and those in the general with a goal toward highlighting positive progress toward improving their individual lives and to improve local prevention efforts in the community.

The agency utilizes volunteers through partnerships with colleges and universities located across the state and nation. The agency currently has interns working in the residential programs from St. Leo University, Florida State University and Walden University.

Standard 1: Management Accountability

Overview

Narrative

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

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

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

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The Program was able to reference background screening of employees/volunteers in the employee handbook. In addition, the Program reference compliance of background screening by DJJ and DCF regulations and protocols. The Program has a process for New Hire Employee/Volunteers. The procedures are established in the event for staff to hire staff accordingly.

The Program was able to illustrate that the new hire employees' files had background screening prior to employment with documentation upon the review period of June 2012 through May 2013. Furthermore, the Program was able to establish appropriate current employees were re-screened within a five (5) year period during their employment. The Program completed Annual Affidavit of Compliance with Good Moral Character Standards (Form IG/BSU-006) by January 31 of each year for its employee's.

Upon review of the Program, the Program was provided a preliminary finding of limited compliance for background screening indicator.

Upon review of volunteer files for review period of June 2012, through May 2013, with background screening prior to employment without documentation the Program had four incidents:

- Rebekah McDonald
- Ashley Tensley
- Mindy Lowey
- Brenda Fitz

Department of Juvenile Justice - CCC report (#201301705) involving a volunteer/intern’s employment prior to completing background screening the Program was able to demonstrate responsive action once they were made aware of the incident and were able to find the cause of the issue as to how the volunteer/intern gained employment/access to youth prior to background screening.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. The agency policies related to this indicator are called Behavioral Expectations for Staff, Standards of Conduct and Florida Abuse Reporting. The agency code of conduct requires all staff to report any incident of abuse immediately as a mandatory requirement. A review of formal reporting documents and surveys were reviewed and conducted onsite to determine the past and current existence an abusive youth shelter environment.

A total of eleven (11) DJJ Central Communications Center (CCC) incidents, three (3) documented youth shelter grievances, seventy-four (74) Unusual/Internal incidents were reviewed to assess if there was evidence present to substantiate concerns that youth do not feel safe, secure and not threatened by any form of abuse or harassment. The agency also maintains a binder that documents any calls made from the agency to the Abuse Hotline. One (1) grievance and 1 DJJ CCC incident referenced a youth that reported that a staff person stating intimidating remarks about the youth's parent in December 2012. The agency took action to investigate this incident and placed employee on Administrative Leave without pay due to substantiating this event. The employee was placed on leave and the event was also investigated by the Department of Children and Families (DCF). There is additional evidence of follow up and monitoring of the employee's on-going behavior and work performance by agency supervisors. The agency reported a total of four (4) administrative reports including the aforementioned grievance related to staff work performance or not adhering to agency code of conduct and general work requirements.

A total of eight (8) youth surveys were conducted onsite to determine if any physical abuse, profanity, threats, or intimidation were present. Seven (7) out of 8 youth indicate that they are familiar with how to report incidents of abuse. Seven (7) out of 8 youth indicate that the staff member are respectful when talking with them and other youth. Of these surveys, all 8 residents indicate that youth feel safe and that the services provided by the agency are Good to Very Good. Seven (7) out of 8 youth indicate that they are familiar with the program's Grievance process. Five (5) Direct Care staff surveys were completed onsite during the program review. Four (4) out of five (5) staff surveys indicate that there were no reports of threats, use of profanity, abuse or intimidation.

Youth surveys completed on site indicate that one (1) out of 8 reported that they had been prevented from being able to contact the Abuse Hotline. One (1) out of 8 youth indicate that the staff members are not respectful when talking with them and other youth. Three out of 8 reported that they have heard adults use curse words when speaking with them or other youth. One (1) out of 8 youth indicate that they are not aware of the agency's Grievance process. The agency had one (1) staff member reported that they Have you ever observed a co-worker using profanity when speaking to youth.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The Program was able to reference Incident Reporting in its manual. In addition, the Program was able to established set guidelines for staff regarding reporting CCC and reportable incident types as such:

- Program disruption Incidents
- Medical Incidents
- Mental Health and Substance Abuse Incidents
- Complaints Against Staff Incidents
- Youth Behavior Incidents

The Program policy shows staff is aware of the policy. The Program was able to provide very structured CCC reports. The Program was able to illustrate clearly describe incident reports upon the review period between Nov through May with a total of eleven (11) reports.

Upon review of the Program, the Program was able to validate a satisfactory compliance for Incident Reporting with exception.

The Program had a CCC report regarding staff not reporting an incident on February 25, 2013, (CCC #201300795). The Program policy shows staff is aware of the policy.

With that being stated, documentation shows management acted in accordance to CCC set guidelines once they became aware of the incident. Furthermore the Program was able to show responsive action once they were made aware of the incident. Corrective Action was place upon appropriate staff due to non-compliance of CCC set guidelines and Program policy.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

The program maintains an individual file for each staff person. The program provided the reviewer with 12 employee training files (6 at or close to the end of their first year of employment and 6 established for two years or more) from which to verify training requirements are being met. The program also provided its "Training Plan July 1, 2012 - June 30, 2013", which meets all the requirements of the indicator.

The program's training plan was difficult to verify in the individual employee files as there was a recent conversion from manual documentation of trainings attended to a computerized recording method. The reviewer immediately noticed there were required first year trainings not indicated as being received by the two (2) employees who had just completed their first year of employment - one lacked the required CPR certification. Upon questioning program administrators regarding the situation, the program was able to discern that, in transferring from the manually-kept records to the computerized version, certain courses and/or hours were missed or miscategorized. Program administrators were able to produce the CPR certification training roster indicating that the first-year employee had, in fact, received the training and this is supported by the invoice receipt showing the program was billed for CPR certification training on the date indicated on the roster.

Most of the files reviewed after the program administrator audited and organized the files, showed that employed staff had met the standards of the indicator for both number of hours and required courses and certifications. Four new-hire employees still had not completed their first year of service and so had not completed their required courses. The 2 employees, who had completed their first year of employment with the program, had the required number of training hours and received CPR/First Aid certification, but missed some required courses for which exceptions are noted. The program has scheduled trainings for next week that should bring all of these 'new hires' into compliance with the indicator. The six (6) long-term/established employees' files reviewed all had the required hours completed and most of the required courses as well.

The lead reviewer instructed that a review of intern/volunteer should be performed since the program administrators indicated that such personnel were providing direct care, which enhanced the program. The two files reviewed showed that the interns had attended orientation training, but had only an abbreviated training plan in their files for which an exception is noted. A better practice would be to use the same training plan as employees to ensure that required training is provided on a regular schedule for all direct care staff.

The program has an established written training policy and establishes an individual training plan in each employees' file. Program administrators revised and audited the training files after the reviewer noted deficiencies. Despite this there were still deficiencies in training noted for the only two employees' files that had completed their first year of employment. The interns' files revealed that the program established only an abbreviated training plan for them that did not include the same required courses or number of hours of training that direct care employees are required to complete in their first year.

After the program administrator audited the files, the two (2) employees who just completed their first year of employment were both still found to be lacking two required courses: Title IV-E procedures and CINS/FINS CORE. One of the two also lacked completion of the required Crisis Intervention training. The program has scheduled training next week to bring all new-hire employees into compliance with the standard.

The 2 intern/volunteer training plans reviewed did not include CPR certification, First Aid or several other 'first year' training courses. It did not appear that these training plans required the direct care interns to attend this indicator's required 80 hours of training for direct care staff. However, the program administrators indicated that interns seldom serve at the shelter for a year so this indicator's requirement cannot usually be met.

1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place which generally addresses interagency agreements and outreach. The policy complies with the indicator in that it requires the program to "cooperatively develop[] and implement[]" prevention outreach efforts.

In addition to its policy, the program also provided a written "Outreach Plan for Targeting Youth for Program Services" (hereinafter "plan"). This plan specifically outlines the processes and outside agency collaborations the program uses to target high crime zip codes delinquency prevention. For example, as an informational component of the plan, the program maintains a 24/7 YOUTH TALK phone line to link homeless or locked out youth to their facilities. The plan outlines that it maintains "Cooperative Service Agreements", which meets the indicator's requirement for written agreements with community partners outlining services provided and referral processes. The program provided this reviewer with a notebook containing 60 interagency agreements and all were in effect within the last 3 three years as required by the indicator.

The program's Community Outreach/Safe Place Specialist, Ms. Radha Selvester, explained the documentation maintained in her Community Outreach notebook with this reviewer. The materials in Ms. Selvester's notebook were samples of advertisements, articles published, event announcements and other similar materials. Ms. Selvester showed this reviewer samples of the articles she writes and publishes in the "North Florida School Days" magazine each month for 9 months of the year. The subject matter of the articles varied, but each demonstrate the program's efforts to reach the target population as required by the indicator.

The program also provided a notebook designated as "Outreach-CIN/FINS" from January 2013 to present, which contained completed forms containing appropriate NetMIS data on events and meetings attended by the program's Community Outreach specialist or other program staff. This documentation indicates that the program's Community Outreach specialist is regularly attending community providers' meetings. The

program is also a participant in the National Safe Place program and, as such, routinely gives presentations to youth in classrooms and other settings as evidenced by the completed data forms provided. Given the number and various types of outreach activities documented in the NetMIS database, this program meets the indicator's requirements for provision of, and participation in, outreach activities.

Summary Statement:

There is a written policy that is augmented with a specific outreach plan that outlines the processes and outside agency collaborations the program uses to target high crime zip codes delinquency prevention. The program provided specific examples of its efforts to provide informational and educational material to families in the community via a monthly article in a local magazine. The program has a designated lead staff member who coordinates and provides outreach to the community. The program's outreach efforts are documented in the NetMIS database and current interagency agreements are maintained.

1.06 Disaster Planning

Satisfactory Limited Failed

Rating Narrative

The program has a written disaster plan that is contained in a multi-page policy/plan notebook. There is indication that the program's disaster plan was reviewed and/or revised annually (indicated by footnote).

The program meets the requirements of the indicator in that there are procedures to follow given specific emergency situations (both natural and man-made), which include conditions under which an evacuation would occur, what items (such as food, medicine, log books etc...) must be brought and where evacuees would go. The program has written protocols for chain-of-command communication, which includes notification to the Florida Network, as well as task listings for preparation, mitigation, response and recovery. These task lists establish how frequently the task should be done and the person(s) responsible for ensuring its completion.

The program participates in the Universal Agreement for Emergency Disaster Shelter for Florida Network Member Agencies and a copy of this is in the program's Cooperative Service Agreement notebook.

Although this reviewer found the program met the requirements for this indicator, the process to be followed by program staff in an emergency/disaster situation was a bit difficult to discern. Instead of detailing separate task lists, communication lists and various scenario procedures, the better practice might be to incorporate the items currently tasked in the preparation, mitigation and response lists into a generally-applicable step-by-step procedure, which includes chain-of-command communication, that staff could easily follow.

The program produced training rosters indicating that staff are trained in disaster preparedness. A better practice would be to include this training on the employees' training plan to ensure that all staff actually receive the training.

The program has a multi-page written disaster preparedness plan that ultimately meets the requirements of the indicator. A generally applicable procedure containing all components the program currently establishes under separate headings would be recommended. By footnote the program records that the plan has been reviewed or revised at least annually, as required by the indicator. However, there is no log or form kept to record the exact date of the program's disaster plan revision from year to year. The program maintains a copy of its participation in the Universal Agreement of Emergency Disaster Shelter. Disaster preparedness training is provided to the program's staff; however, employees' training plans do not require such training.

1.07 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

Agency has specific monthly and quarterly reports that it generates to assess its performance regarding major risks, operations and programmatic trends and issues. Agency reports track agency trends, patterns and risk management issues. The agency also utilizes several internal plans that include a Risk Management plan; a Strategic Plan (5 yr) Business Plan; Performance Improvement Plan; Technology Plan; Accessibility Planning; Cultural Competency & Diversity; Training; Emergency Plan; and Youth Participation.

The agency's Risk Management plan addresses the exposure to the chance of injury or loss. Risk can be external, such as natural disasters, injury that occurs on the property of the program or fire. The risk can be internal to the organization that include things such as work related accidents, it can involve liability issues such as the sharing of information about a person served without consent or it can jeopardize the health of those internal or external to the organization due to such things as infection control policies.

The agency produces a five (5) year Strategic plan to establish a foundation for success through strategic planning by focusing on taking advantage of strengths and opportunities and addressing weakness and threats. The agency's strategic plan incorporates the expectations of persons served, stakeholders, competitive environment, financial opportunities and threats, and capabilities. Further, the plan identifies the service area needs, demographics, relationships, regulatory and legislative environment. Includes use of technology to support efficient operations, effective service delivery and performance improvement. Monthly analysis of performance measures, and needs for corrective

action.

The agency has a process in which it develops and executes Performance Improvement Plans. These plans are developed to provide on-going information to persons served and other interested stakeholders. The goal is to effect change. CDS is committed to the continuous improvement of organizational quality and service excellence. Information from the analysis is used for completing improving organizational quality and service excellence. These plans are primarily developed to address individual employee work performance or behavior in the work environment.

The agency has a company-wide competency-based Training Plan. This plan is recognized by professional associations, part of a formal training curriculum, or approved for continuing education units (CEUs) by a credentialing or licensing body. The agency assesses competency by observing work and documenting that the skills or knowledge presented are being used on the job, through supervision and clinical review when assessments can be made regarding the retention and use of the training information, or through post-tests that are administered.

Additionally, the agency utilizes volunteers to augment its staffing. The agency has a CDS plan for using volunteers effectively and efficiently in our agencies operations. The agency also has a CDS plan for engaging youth in the development of programs and services.

The agency provided samples of detailed follow-up regarding violations of agency work performance or code of conduct violations. There were a total of four (4) cases of administrative reports related to employee work rules and code of conduct violations. The agency completes administrative reports and provided evidence of the written reports to the reviewer assigned to this indicator. The agency's Residential Supervisor and Regional Coordinator addressing each issue. In general CDS-Central management monitors the effectiveness of all work-related issues, violations and other issues detected or report by program participants and staff members. Just as their other program sites in Palatka and Lake City, the Gainesville program's monitor, identify and address collectively with the CDS-Central Residential Supervisor and Regional Coordinator. If applicable the agency notifies the DJJ CCC or the Abuse hotline. Dependent on the specific workplace situation the agency notifies the CDS Chief Operations Officer to discuss situations and then determines an outcome. The CDS-Central management then conducts or develops a plan to address the issue by either documenting the issue, retraining the staff member(s), coach and counsel staff members if needed, place staff on probation/suspension and terminate their employment with the agency if needed.

The agency assessed its current medication distribution systems in summer of 2012. As a result of this assessment, the entire agency including all sites (Gainesville, Palatka and Lake City) 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 all 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, CDS conducted an agency wide review and assessment of screenings to determine the contributing factors to that did and did not result in a shelter admission. The agency requested that their data department create a monthly report showing screenings that did and did not result in shelter intakes listed by staff members completing the screening. All agency managers monitor for any patterns on a monthly basis, such as staff whose screenings result in more intakes and the opposite to try flush out successful techniques to increase screening to intake ratios.

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

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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

The program has the capability to offer both case management and substance abuse prevention education on an as needed basis. The agency conducts Case 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 schools systems regarding the options available for status offenders and the overall petitions process and displayed a high level of knowledge and insight regarding their involvement in the community in this area.

2.01 Screening and Intake

Satisfactory
 Limited
 Failed

Rating Narrative

The CDS-Central program has a policy meeting the requirement for this standard. Eight files were reviewed, (4 residential & 4 non-residential). All files contained documentation supporting: Youth & Parent/Guardians receive available service options, rights & responsibilities for both youth & parents, services provided by CINS/FINS services & grievance procedures. The centralized intake services include: eligibility for CINS, crisis counseling information & referral sources. The initial screening for eligibility occurred within 7 days of the referral on 7 out of 8 files reviewed.

One (1) residential youth was referred on November 29, 2012, however the screening wasn't completed until December 13, 2012

2.02 Psychosocial Assessment

Satisfactory
 Limited
 Failed

Rating Narrative

The CDS-Central program has a policy meeting the requirement for this standard. Nine files were reviewed, (4 residential and 5 non-residential). This included a sample of youth hits on suicide. All psychosocial assessments were initiated within 24 hours of admission, exceeding the 72 hour requirement. All psychosocial assessments were up to date and current, completion was within days of intake. Non-residential files were also completed within 1-2 face to face contacts with the youth after the initial intake. All psychosocials were signed by a supervisor. Documentation confirms a licensed clinical supervisor is reviewing and signing off on youth and suicide history.

No credentials were included after signatures therefore you couldn't determine if staff was Bachelor's or Master's level.

2.03 Case/Service Plan

Satisfactory
 Limited
 Failed

Rating Narrative

The CDS-Central Program has a policy meeting the requirement for this standard. A service plan is initiated the same day the psychosocial assessment is completed. One non-residential file showed the service plan was created on 2/26/13, however the psychosocial assessment was not finished until 3/11/13, the counselor stated she made an error on the date and corrected this immediately. The plan appears to be developed based on information/observation during initial screening, intake and assessment in the program. The service plan includes; date of initiation, type, frequency and location of services, person responsible, target dates and actual completion dates. Signatures of youth, counselor & supervisor are included. 5 out of 8 case files reviewed did not have parent signatures on the service plan. Documentation stated the service plan was verbally reviewed with the parent. CINS counselor states a copy of the service plan is then given to the parent at departure. The service plans are reviewed with the youth and parent on a weekly basis.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

Each youth is assigned a counselor upon intake. There is a referral sheet given to families who are not eligible for services. There is family contact documented in the progress notes via telephone. Progress notes reflect youth's behavior and participation in services offered from both direct care staff and assigned counselors. All youth had at least one referral given upon departure. 180-day follow-ups were provided and within the allotted time frame. If the phone number was out of order, the agency sent a letter to the home. CDS provides transportation for youth to attend their current school. Evidence of communication with the schools to monitor youth progress was found in files. Counselors coordinated implementation of the service plan and monitored youth/family progress in services. On-going support was provided for families and evidenced by communication in progress notes. Referrals were made to case staffing committee as needed. Continued case monitoring and case termination with follow-up referrals was also evident in youth files.

One (1) non-residential file did not have current progress notes documenting youth's progress in services. Youth's intake was on 3/11/13 and 3 progress notes were completed.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

Youth and families received counseling services in accordance with the service plan, exceptions were documented in the progress notes. Residential provided individual and family counseling. Group counseling is also offered 5x/week for residential youth. Non-residential provides therapeutic community-based services to meet the families needs. Services are usually provided at the child's school or in the office, seldom in the home. Individual case files were completed on all 8 files reviewed and files are kept confidential. The majority of files contained chronological case notes on the youth's progress. Staff maintain an on-going internal process that ensure clinical review of case records.

All files coordinated services with the presenting problems and the psychosocial assessment, however 2 residential files and 1 non-residential file did not address these problems on the service plan. The non-residential youth had truancy identified as a referral problem at intake, however this wasn't addressed on the psychosocial assessment or service plan. Both residential youth had substance abuse and truancy identified as referral behaviors, however these were not addressed on the service plan. One non-residential file contained 3 progress notes since intake March 11, 2013, therefore youth progress was unable to be determined.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The program was only able to produce one file of a youth who had been adjudicated a CINS through another provider. The youth was ordered into staff secure shelter at this program for 90 days, but staff did not participate in the case staffings leading up to this court order. By letter, the program relays the youth's status and progress back to the originating program, who in turn drafts the material for judicial reviews and any additional court recommendations.

The program fully utilizes the school district's services and processes to address youth truancy issues. The program regularly attends meetings of the School Attendance Review Board (SARB), which is comprised of members who would either be required or discretionarily included in a CINS Case Staffing Committee. The program offers CINS/FINS services at the SARB meetings, but if those services are declined (or the parent/youth do not attend the meeting) the school board takes the lead in developing and managing a plan of services to redress the youth's truancy. By their attendance at the SARB meeting, program staff are aware of the youth's truancy issues. However, a CINS case is not opened unless and until the youth is court-ordered into the program's shelter under an order of contempt of the school board's Truancy Petition. Program staff assured this reviewer that truancy petition youth are not staff secured. However, the court order reviewed was from May 2013 and specifically restricted the youth from participating in shelter outings and other privileges such as home visits or leave of absences from the shelter.

The program has written policies in place, which establish the circumstances underwhich a case staffing would occur, the time frames underwhich they must be scheduled and the content of the plan of services which results. The program complies with the indicator in so far as it's written policies reflect. However, since it has no actual CINS petitions adjudicated, the program's participation in the SARB Truancy Petition process was viewed as a substitute for the CINS/FINS truancy/status offender adjudication process.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

A general review of CDS-Central program files was conducted. The following findings were identified.

- The Program was able to reference youth files in its manual. In addition, the Program was able to established set guidelines for staff regarding youth files standards for the Program.
- The Program maintains and marks "confidential" on all youth files.
- All youth files our accessible to appropriate staff.
- The Program was able to confirm secure locations for youth files. In addition, Program had separate secure locations for closed and open youth files on Program facilities. The Program further demonstrated the separation of open youth files by gender.

Upon sample size of youth files for review, it was observed the Program's youth files were very neat and organized.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS IYP-Central youth shelter is located in Gainesville, Florida in Alachua County. The CDS-Central facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and Families for twelve (12) beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of ten (10) youth in the shelter on day one of the onsite program review. The shelter is comprised of a detached building that is a one level landscape or ranch style design. The shelter has both a front and side entrance. The building is designed with equally sized dorms and day rooms for female and male residential clients. Each residential section of the shelter can accommodate up to 10-12 residents. The female and male sides of the facility are equipped with a large dorm, bath rooms and a dayroom. The facility includes a kitchen and dining area, Youth Care Work station, staff offices and a smaller meeting rooms, multi-purpose recreation and a 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 program's Continuity of Operations Plan (COOP) has been approved by the Florida Network. The Florida Network received the program's emergency response plan and hurricane plan that was revised on August 2012. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the Program Director. The exterior of the facility is well maintained and the grounds are landscaped. The facility site has limited green space, but does have a open court in the rear of the facility. The rear area of the facility is enclosed by a private wood fencing.

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

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

The Direct Care Worker staff offices are located inside the youth shelter. The medication and general supplies are stored in the Youth Care Worker staff members office in a locked cabinet. The residential shelter also includes administrative offices for the Regional Coordinator, Residential Supervisor, Counselor and other staff offices. Residential services, including individual, family, and group services, are provided to youth and families. Case management and substance abuse prevention education are also offered. The program also has an effective grievance process. When submitted, grievances are responded to within twenty-four to seventy-two hours of being submitted to staff or the Residential Supervisor.

The shelter is designated by the Florida Network to provide staff secure services. However, the agency has not received a court-ordered staff secure referral in the past several months.

3.01 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The CDS-Central program has a clear policy and procedure regarding room assignments. Interviews with direct care staff as well as a review of eight (8) client files (6) open and (2) closed revealed that the program does a consistent job with assigning youth to their rooms based on several factors. These include but not limited to: review of youth's history or exposure to trauma; initial observations of youth; age of youth; violent history or lack of; suicide history; sexual history; and victimization.

After reviewing the client charts it was observed that (2) of the charts were missing documentation for the youth having a physical disability on the Intake Assessment form. Best practice would be to use the Intake Assessment form to its fullest when completing youth room assignments.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The CDS-Central program's policy and procedures regarding program orientation is very clear and well organized. The program goes above and beyond in their documentation when it comes to this standard. A review of (8) client files, (6) open and (2) closed as well as interviews with staff revealed that each youth are properly oriented into the program. A check list is completed with each youth going over items such as contraband, disciplinary actions, dress code, facility tour, grievance procedures, room assignments, and disaster procedures to name a few. The youth is

also given a client handbook and the orientation process is also reviewed with the parent.

3.03 Shelter Environment

Satisfactory
 Limited
 Failed

Rating Narrative

Facility's furnishings are very well kept and free of graffiti. The grounds are very well maintained and the lighting is adequate. The program has a disaster plan that is updated annually. The last update was on 3/13. The facility is in compliance with the local fire marshal and the last inspection was completed on 2/4/13, the program conducts several fire drills a month which is above the standard requirements.

However, after reviewing the last six months of the fire drill log it was observed that on 11/9/12 and 12/5/12 that those fire drills were over the required two minute time period. According to best practice all fire drills should be under two minutes. According to best practice staff should be completing 1 mock emergency drill per shift per quarter. There were only two emergency drill reports completed within the past 2 years one on 8/12/11 and the other on 3/14/13. It would be best practice to create a monthly calendar as a reminder to complete these drills.

3.04 Log Books

Satisfactory
 Limited
 Failed

Rating Narrative

The CDS-Central program has a very clear policy and procedure for log books and goes above and beyond in there documentation when it comes to this standard. Log book documentation was reviewed from 11/20/12 to 5/8/13. A thorough review revealed clear and consistent documentation by staff. The log book contained pertinent information related to daily activities, events, and incidents. The program manager reviewed the log book weekly.

According to best practice all incident reports should be recorded in the log book. A medication error that occurred on 4/22/13 was not documented in the log book.

Rating Narrative

The CDS-Central program has a daily programming schedule that is posted throughout the facility that includes education, recreation, counseling services and life skill classes. A review of the daily schedule, staff interviews, and log book documentation revealed that the program does an outstanding job with this particular indicator. Youth are provided the opportunity to participate in faith based activities. Daily programming includes opportunities for youth to complete homework through an after school tutorial program that is offered at the facility.

3.06 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The CDS-Central program uses the FACE (Facilitating Activity & Communication Effectively) system as their behavior management system. The program has a detailed written description of the behavioral management strategies. 10 point cards were reviewed and all had more rewards than consequences. Point cards are reviewed with youth after school with the school note. Consequences appeared logical and consistent. Youth Care Worker (YCW) stated youth would receive an alternate snack if they didn't make their privileges or wouldn't be able to go to the park. Program has assessment, daily and achievement levels for youth. All staff are trained in the theory and practice of FACE by Coordinator Cassandra Evans-McCray and Senior YCW Sheila Parker. This was evidenced in training files, performance evaluations and staff meeting minutes. Supervisors review point card documentation to monitor the use of rewards and consequences. Youth are able to purchase items from "Joe-Mart" once they are on achievement.

3.07 Behavior Interventions

Satisfactory
 Limited
 Failed

Rating Narrative

The CDS-Central program has a policy and procedure in place which identifies behavioral interventions utilized by the staff with the least

amount of force necessary to address situations and ensure that basic youth rights are not violated. Interviews with clients and staff revealed that the staff does a satisfactory job with behavioral interventions when dealing with the youth in their care. Group punishment is never used and only the staff administers discipline. Room restrictions are never used and the staff does not take away or deny youth meals or snacks, clothing, sleep, physical or mental health services, and education due to negative behavior. According to staff if a youth's behavior becomes beyond the staff's control no physical intervention takes place, instead law enforcement is called.

3.08 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The CDS-Central program has very clear policies and procedures for staffing and youth supervision in place. All shifts are covered according to the standard with a 1:6 ratio during waking hours and 1:12 ratio during the sleep period. Schedules are posted in a book that is visible to staff. There is always at least one staff on duty of the same gender as the youth. There is an on call schedule which includes staff that may be accessed when additional coverage is needed. The program has a scanning system for the overnight bed checks which clearly shows that bed checks are completed every 15 minutes. This is documented in the bed check log book and also in the program log book which is clearly above and beyond the standard.

3.09 Staff Secure Shelter

Satisfactory Limited Failed

Rating Narrative

The provider has a policy and procedures in place to include the provision of a higher level of services, interventions, supervision, and security for youth placed at the agency residential facilities under "Staff Secure" status. The procedures include the documentation of the staffing provided, in-depth orientation, name of staff assigned to the youth, and documentation of assessments, interventions, and referrals made on behalf of the youth. There was only one (1) staff secure client since the last review. One (1) staff member of the same gender as the youth on each shift is directly assigned to supervise the staff secure youth.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

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

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

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency/local service provider has written procedures to address the admission process to include an in-depth health screening through the completion of a fourteen (14) Intake Assessment form. At the initial screening the agency reviews with the parent/guardian all health issues prior to admitting the youth into the residential youth shelter. In this process the agency screens for acute health and existing medications and mental health diagnosis. During the Intake phase the agency completes a battery of health questions. The form asks for current doctor information. The health screening form addresses all elements of the indicator: Allergies (general, medication and food allergies); Existing Medications including Dosage Instructions; Health/Nutrition concerns and restrictions; general, Physical Health Screening; Current Observation of Behavior and Physical, Emotional or Mental Health Status. The general health screening section screens for a total of twenty-eight (28) health –related questions that include recent injury; current pain; head injury or chronic headaches; vision problems; history of seizures/blackouts/epilepsy; chronic pain; high blood pressure; heart murmur/condition; sexually transmitted diseases; hemophilia; alcohol/drug abuse problems; orthodontic appliance being utilized; fainting/dizziness; skin problems; diabetes; asthma; digestive system; chronic cough; abnormal gynecological concerns; pregnancy/possible; history of bed wetting or problems sleeping; eating disorder; hepatitis; tuberculosis; disability/physical /mental; immunizations; and prenatal exposure to alcohol, tobacco and other substances. Observation for the presence of scars, tattoos, or other skin markings is also screened for on page one of the Intake form. The Screening tool addressed all elements of the indicator with no exception on the form used by the agency.

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

The psycho-social assessment asks if they are receiving counseling, experienced an accident, is client on medications, substance and alcohol abuse, and prior residential history.

Counselors also document health or on-going events on Behavior Intervention Response and Plan form is a weekly counseling progress note or

SOAP.

All medical incidents/referrals are required to be documented on a daily log. A total of six (6) cases (4 open and 2 closed files) were reviewed to assess requirements of this indicator. All files contained documentation of the CINS/FINS Intake form that was completed the day of the youth's admission. Of the client 6 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" form. The health addendum 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". Five (5) out of 6 health addendums had evidence that these were completed. If necessary, the written procedures addressed the referral process and follow-up medical care.

Of the cases, one (1) closed case did not document the correct health question number responses on the twenty-eight (28) question General, Physical Health Screening section to match the resident's existing medical conditions. Five (5) out of six (6) case files reviewed did not have evidence of a completed Health Care Addendum.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency's CDS Family and Behavioral Health Services agency utilizes a standardized suicide prevention plan in each of its three (3) emergency shelters located in the North Central Florida. The CDS-Central location also had a written plan that outlined the suicide prevention and response procedures. The monitor reviewed this standard to determine its adherence to the requirements of this indicator. The title of this policy is Suicide Assessment and Mental Health, Substance Abuse and Suicide Risk Screening. 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 required revision since the initial approval date. The policy was last updated on August of 2011. The plan indicated each youth admitted to the shelter will be screened for suicidal risk by using the six (6) suicide risk questions on the CINS/FINS Intake form. Policy was approved by the Florida Network of Youth and Family Services in August 2011.

The CDS-Central residential program uses a fourteen (14) page document to conduct the screening and intake process on youth admitted to the youth shelter. The CDS-Central region's non-residential program uses a twelve (12) page document to conduct the screening and intake process on youth admitted to the youth shelter. The multiple page document includes a Suicide Risk section that asks the six (6) Suicide Screening Questions. If the youth answers "YES" to any of the 6 questions, the staff place the youth on sight and sound and then contact the parent/guardian and Residential Supervisor. The non-residential program goes directly Suicide Assessment if the answer is YES to any of the 6 Suicide Risk Screening section.

The agency's residential program is staffed with a residential program with a Senior Counselor with a Master's of Science and an additional master's level counselor. The agency's COO is a licensed mental health clinician MHC and is accessible to all counseling staff upon request for consultation and oversight. The Non-Residential program is staffed with one (1) level PhD. Non-Residential Counselor, an additional Non-Residential Counselor MS, and 1 Registered Intern that is currently attending school working towards a master's degree in Counseling.

The agency has 2 levels of supervision. The first level of supervision is One to One which is most intensive level and requires a designated staff to be no more than an arm's length from the youth at all times. The second supervision level is constant sight and sound. This level requires that the agency there be constant monitoring of the youth and that the agency document that status of the youth on an on-going basis. Supervision status is maintained by the agency during the assessment process until the Residential Counselor consults the Licensed Mental Health Counselor (LMHC) and receives direction to maintain or remove from the said supervision status. During this assessment process, the agency faxes the completed assessment to the LMHC for review and signature. A copy of the completed Suicide Assessment form is submitted to the LMHC for review and consultation. Follow the consultation and review with the counselor it is faxed back to the program. The counselor discusses prior history, include Baker ACTs, attempted self-harm incidents, what medication the youth is on and family situation or home environment.

If necessary, the agency contacts law enforcement to consider a Baker ACT and transport to a local mental health receiving and treatment facility. In these cases, a youth care worker will immediately refer the youth to Meridian Behavioral Healthcare for a Baker Act screening. Upon return and clearance from Meridian the resident is then placed on constant sight and sound. Youth on sight and sound are monitored within sight and sound of a staff person at all time. Supervision is documented every 30 minutes for Constant Sight Sound supervision and One to One Supervision is documented every 15 minutes. Youth on this status sleep in the boys or girls living/day room respectively. Once the youth is on sight and sound observation, a full assessment is completed by the Residential Counselor. The exceptions to this 24 hour rule are weekends and holidays. Once the full suicide assessment is completed by either the LMHC or the Masters level under the supervision of the LMHC the resident 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 observation log tracks documented status checks on all youth on close watch observation. If the resident is removed from the said supervision status, the counts are stopped and the resident is returned to the general population.

Non-Residential Staff

The non-residential counseling staff also consults with the LMHC by faxing the Suicide Risk Assessment to the Central Office. The LMHC reviews the assessment and advises the staff person accordingly. The LMHC reviews with the counselor and discussed the current status of the youth and parent relations and past history. Following the review of the assessment with the Counselor, the LMHC will render a decision to either refer them for a Baker and or a plan for a follow up visit with the Non-Residential program. The LMHC may even consult with the Non-residential counselor on various options for subsequent meetings.

If a child remains on the current level of supervision, the agency the reassesses the child every 24 hours during the week day. If it is the weekend that child is reassessed the next business day.

A review of files included a selection of six (6) client files over the last six (6) months. A total of five (5) residential files and one (1) non-residential file were reviewed. All 6 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 assigned Masters Level counselor and the supervisor who was also the licensed mental health counselor overseeing the assessment process. All counselors have access to a licensed clinician. All 5 residential cases that screened positive as a suicide risk were placed on sight and sound supervision until assessed by a licensed professional. In all cases reviewed, the supervision level was not changed or reduced until approved by a licensed professional. Supportive documentation was reviewed to include precautionary observation logs and thirty minute checks. All 5 residential cases contained chronological notes documenting the youth being placed on sight and sound. Evidence of youth being removed from sight and sound status is documented in the agency daily log across and the agency program log book.

The notes indicate that the Warning Section box at the bottom of the Observation Log is not being completed consistently. Only one (1) out of the five (5) observation logs is not signed consistently. The agency should finalize decisions on whether the new practice of determining the whether this section is to be signed or not.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

The agency has a detailed medication policy that includes a policy with multiple procedures on several items that address the general requirements of the indicator. The policy is called the Medication Provision, Storage, Access, Inventory, and Disposal. The agency medication policy was last updated in July 2012. The current policy includes sections that addresses Prescription Medication; Procedure for Verification Medication; Non-Prescription Medication; Medication Provision, Supervision, and Monitoring, Offsite Medication Distribution; Medication Errors and Refusals; New Prescription, Change in Medication and New Month; Medication Storage; Access to Medication; Inventory Procedures; Medication Counting Procedures; Discharge of Youth with Medication; and Disposal. The policy now requires that staff conduct several medication verification steps. The process requires that all medication entering the shelter originate from a licensed pharmacy. The current medication verification process involves sending a three (3) step process that requires sending an "Informed Consent and Participant" to the pharmacy for verification; Confirming that the form is completed by the pharmacy and returned to the program; and documenting that the verification is documented on the resident's medication distribution log (MDL). The agency maintains a color-coded dot system to ensure the accuracy of each medication that is distributed to the resident. All residents with at least one or multiple MDL charts have a corresponding colored red, blue, green or yellow dot that corresponds with the appropriate controlled or non-controlled medication.

All medications in the shelter are stored in the Direct Care Staff control room/office in a secure area that is inaccessible to shelter residents. The agency maintains list of all staff members that are designated as being authorized to be able to assist in the delivery of medications to shelter residents. All medications both prescribed and controlled are stored in a locking five (5) drawer metal cabinet. All controlled (narcotic) medications are stored in the metal locking cabinet in separate rubber/nylon composite bags that are secured with pad locks. All prescribed medications are secured in the locking cabinet in non-locking containers. The observations made during the on site review indicates that both oral, topic medications are stored separately. The agency does not provide over the counter medication unless they are prescribed by a physician. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review. The agency conducts shift-to-shift counts on controlled and non-controlled medication three (3) times per day and when the medication is given to the resident. A perpetual inventory is maintained and documented for controlled and prescribed medications and running balances are documented.

Agency utilizes sharps that are maintained locked in a secure area. The agency maintains record of the weekly sharp counts. The counts were recorded on a computer generated print out. The current form documents the date when sharps counts were counted each week. Sharps counts from November 2012 to present May 2013 were reviewed onsite. All sharps counts are documented as required and maintained in binder.

The program utilizes the DJJ Medication Distribution Log (MDL). The MDL contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff members and youth initials on MAR when medication is disbursed and received. A review of current youth in the shelter currently on Medications was conducted.

A sample of the medication distribution records of two (2) current youth in the shelter and four (4) closed files were reviewed to assess the agency's adherence to indicator. All cases reviewed contained evidence with documentation of the recent verification procedure. All files have major sections completed including the client's name, picture, current month and year, medication, strength, doctor name, allergies, time received, method of administration (oral, topical, inhalant, ear and eye), special procedures, amount of medication received, directions, side

effects/precautions (list top 3), and staff receiving medications. The first page of the Medication Distribution Log (MDL) captures evidence of the dosage being given, staff member's signatures and initials, client's signature and initials and dosage given on the MDL. Youth initials are documented, but no full signatures are documented. Page two (2) of the MDL captures the shift to shift count and weekly inventory count of each medication given to each clients. At the time of this on site review, 6 out of 6 client files indicates that youth medication records meet all generally required documentation in the aforementioned areas.

There were a total of four (4) reported medication incidents reported to the DJJ CCC in the last six (6) months. All medication error incidents had evidence of follow up that included written deficient workplace performance related Memorandums and re-trainings of the respective staff members that were involved in medication errors.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

A general review of CDS-Central's Medical and Mental Health Alert process was conducted. The following findings were identified.

- The Program was effective in referencing Medical/Allergies/Mental Health Alert system process in its manual. In doing so, staff are inform of youth admitted with medical/allergies or mental health conditions including, but not limited to precautions related to medical/allergies and/or mental illnesses.
- The Program was able to substantiate with documentation employee staff was provided training to recognize and respond to any emergency as a result of medical/allergies and/or mental health issue.
- Program assesses all youth admitted into the Program for Medical/Allergies and Mental Health through their Intake/Assessment form and the Medication Record Log.
- Upon sample size of youth files for review, the Program was able to support with documentation the youth were appropriately place on the program's alert system and displayed the youth's medical/allergies and/or mental health conditions within the youth's file and on the Program's Alert Board.
- The Program's Alert system include an alert board which include such items such as:
 1. Picture I.D. of youth
 2. Color Codes for medication times for youth
 3. Codes for events such as sexual activity, suicide, runaway, mental, allergies, medical condition.

4.05 Episodic/Emergency Care

Satisfactory
 Limited
 Failed

Rating Narrative

A general review of CDS-Central program files was conducted. The following findings were identified.

- The Program was able to reference the responsibility of all staff to assist in responding to emergencies and injuries of either a life threatening or non-life threatening and to ensure an appropriate response is rendered in their policy. The Program's policy gives direct direction to notify off-site emergency services in the event of an emergency injury and/or life threatening injury.
- The Program was able to provide documentation to validate appropriate staff were given proper training for medical procedures during their employment. In addition, provide guidance for certain types of medical emergency care injuries.
- The Program mandates a daily log for each shift of youth activities. The Program's daily logs were complete, organized, and easy to understand.
- The Program was able to confirm locations for First-Aid Kits in Program facility and vehicles. Furthermore, the Program was able to substantiate Knife-for Life/Wire Cutters in the Program facility.
- The Program documents medical services for youth in a medical log book. Very structured with information with medical services

provider, reportable or not, signature, youth, and date.

- The Program was able to substantiate with documentation upon review period of December 2012, through May 2013, with youth files for emergency medical and dental care issues all youth parents/guardians received proper notification.

Accordingly, the Program was provided a preliminary finding of satisfactory compliance for Episodic/Emergency Care indicator.