



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface East

on 03/13/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory:95.83%
Percent of indicators rated Limited:4.17%
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

Latrice Covington, Contract Manager, Florida Department of Juvenile Justice

Heather Prince, Director, Stewart-Marchman ACT



Quality Improvement Review

CDS-Interface East - 03/13/2014

Lead Reviewer:Keith Carr

Cindy Heatherington, LMHC, Anchorage Children's Home of Bay County

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 4 Case Managers | 0 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor | 3 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 7 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input 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 checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 0 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 12 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 9 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 13 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 12 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 8 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 5 Youth 5 Direct Care Staff 5 Other

Observations During Review

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

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program (IYP) East provides both residential and non-residential Child in Need of Services and Family in Need of Services (CINS/FINS) programs. CDS-East provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The agency's primarily provides services in Bradford, Union and Putnam Counties. This CDS East program site is located in Putnam County in Palatka, Florida.

The CDS agency also operates other residential and non-residential programs in Gainesville and Lake City, Florida respectively. All three (3) CDS-IYP program locations report to the agency's Chief Executive Officer and Chief Operations Officer that are located in the agency's headquarters in Gainesville, Florida. The daily operations of CDS-East residential and non-residential programs are overseen by a Regional Coordinator. The Regional Coordinator position is the highest ranking position for the Palatka service region. The agency also has residential Direct Care and non-residential counseling 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 operate under standardized operating protocols for all three (3) service locations in their respective service areas. Other uniform agency protocols for all 3 locations include monthly reporting, data and trend analysis, as well as training and professional development exercises.

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 that conducts internal assessments of operational and program data across its three (3) residential youth shelters. This information is evaluated by specific teams and reports are generated on a monthly and quarterly basis.

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

The CDS-East program received an additional Homelessness grant award for the current fiscal year.

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 has new funding to create two (2) new positions that include a Life Skills Specialist and an Outreach Specialist to market and promote its program and overall CDS-East services.

The CDS agency received funding to provide additional non-residential services to outlying rural areas in need of CINS/FINS services.

The agency has installed a new camera system and display monitor.

CDS-East staff members were extremely professional and responsive to all requests for clarification and assistance throughout the entire 2-day Quality Improvement review.

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

Standard 1: Management Accountability

Overview

Narrative

The CDS Behavioral Healthcare agency conducts background screenings prior to hiring of all staff members through their centralized Human Resources offices located in Gainesville, Florida. All CDS 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's organizational structure includes designated Regional Director positions at each location. The Regional Coordinator position is the highest ranking local level position for the agency at the CDS-East location. The agency also has a Residential Supervisor.

The agency has Centralized Human Resources and fiscal departments that are responsible for all personnel and financial matters respectively. All CDS residential shelters and Non-Residential programs have implemented uniform operating protocols for all three (3) service locations in their respective service areas. Other uniform protocols for all 3 locations include training and professional development exercises.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that aligns with the DJJ Background Screening Policy and Procedures. For this indicator, seven (7) staff files were reviewed. Of the files reviewed, four (4) were hired within the last six (6) months and have documentation that their background screening was completed by DJJ prior to their hire date. All staff was rated eligible so no exemption was required. The three (3) remaining files were for ongoing staff and all had documentation that their five year rescreen was completed prior to their initial hire date. There was E-Verify documentation on all staff. The Annual Affidavit of Compliance was completed and sent to the DJJ Background Screening Unit by January 31st.

No exemptions were required.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has policies in place on Florida Abuse Reporting, Standards of Conduct, Behavioral Expectations for Staff, and Rule violations that support provisions for an Abuse-Free Environment. All the agency's policies meet the report requirements. The agency has documentation of all internal incidents with follow-up. Youth are given the Hotline numbers in their intake packets and it is posted in the shelter. The shelter was clean and orderly with no graffiti. A review of the internal incidents reported the Department was in agreement. Personnel actions were reviewed on site. There was one grievance for the past six months. The program director has an open door policy so staff is able to call on behalf of youth to resolve any concerns. A review of the youth surveys indicate they are knowledgeable about and the location of the abuse hotline number and the grievance process. Youth surveys also report there has been no abuse from staff. Staff surveys indicate they are aware of the reporting requirements.

The review of this indicator included a review of internal incidents for the past six months and the DJJ reported incidents. Internal incidents include follow-up.

No exceptions were noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that meets the reporting requirements for DJJ, Partnership for Strong Families (PFSF), Substance Abuse and Mental Health (SAMH), and CARF. Internal incident reports for the past six months were reviewed for this indicator. The incident reports were legible and clearly describe the incident. Youth and staff surveys indicate they are aware of the reporting requirements and procedures. There was one incident for contraband that was not reported to the CCC.

There was an exception noted for this indicator. One (1) applicable incident related to contraband that was required to be reported, but it was not reported to the DJJ CCC.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that outlines the required and suggested trainings listed for this indicator. The policy addresses first year and ongoing training requirements for all staff members. There is an approved training plan for FY 2013-2014. There are individual training files for all staff. Nine (9) staff training files were reviewed for this indicator - two first year and seven ongoing. One of the first year staff files had documentation of 80 hours of training, but there was no documentation of fire safety training. The other staff is still in the first year with several trainings remaining and is on track to complete all the required trainings.

Exceptions were noted for this indicator. Of the seven (7) ongoing staff training files reviewed, one file had documentation of the required hours of training. The remaining six (6) files did not have documentation of the required hours of training. None of the 7 ongoing staff files had documentation of universal precautions training. The training hours tracking forms and related documentation were not completed or missing from all files.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

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

The CDS agency conducts systematic documentation of Meeting Minutes, Quarterly Files Reviews, Annual Training Plan/Calendar Enhancement, Strategic Plans are all agency. Goals are set to increase proper implementation of the agency facilitating activity and communicating effectively (FACE) (BMS) by staff. Another agency goal is to decrease unusual event reports related to meds issues. The agency aims to do this by reducing errors by mastering and following the agency's policies and procedures. The agency plans to maximize opportunities for Domestic Violence Respite Admissions.

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

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

Agency produces a monthly Incident report for each of its programs. The report tracks runaway, Physical Fight, Law Enforcement, Maintenance, Computers, Medication Error, Outside Medical, Abuse Reporting, Other. The agency utilizes this data to track major risks impacting its programs. A review of its current incidents was conducted onsite. The agency had a total of four (4) incidents documented by the DJJ CCC. The agency had two (2) that involved the discovery of contraband in the facility. A review of the agency's meeting minutes was conducted. Agency meeting minutes indicate agency discussions and briefings on searches and contraband incidents in the shelter.

The agency generates a Five (5) Year Strategic Plan 2013-2018 for its Risk Management planning for all of its programs across the entire agency. The agency produces an annual update on its progress toward addressing goals developed in the 5 year plan. See the 2nd Year plan for more details.

The agency developed goals to address two (2) major quality improvement initiatives so far this fiscal year. The agency has a plan to address

training that identified and created orientation topics that will be used across all 3 of its youth shelters. This helped agency Youth Care Workers, Counselors and Case Managers with new topics that are now standard. The agency has also added the PREA and DCF Deaf and Hard of Hearing topics to first mandatory training requirement. The second key initiative involves addressing issues regarding the Domestic Violence Referral (DVR) process and Circuit eight (8).

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

The agency Stake holder Surveys are conducted on an annual basis by community stake holders. Employee Satisfaction Surveys are conducted on an annual basis. Results are reviewed by the agency EMT and Leadership. Client and family Satisfaction Surveys are conducted upon client exiting the program.

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

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

The agency provided 2-3 cases that demonstrate its ability to follow-up regarding on violations of agency work performance or code of conduct violations. The agency had three cases of medication errors and the retraining conducted by the agency in each case. The CDS agency conducts systematic documentation of Meeting Minutes, Quarterly Files Reviews, Annual Training Plan/Calendar Enhancement, Strategic Plans are all agency.

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

The agency provided once (1) case of that demonstrated the agency's ability to follow-up regarding on violations of agency work performance or code of conduct violations. The agency had four (4) corrective actions due to medication errors that occurred between November 2013 and December 2013. As a result the agency conducted re-training sessions in November 2013 and for specific individuals in December 2013.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The CDS-East Non-Residential Counseling Program provides non-residential services for youth and their families that is primarily in Putnam, Bradford and Union Counties. The non-residential program consists of one (1) Family Action Senior Residential/Non-Residential and 1 Family Action Case Manager. The program receives requests for services from parents/guardians, system partners and the general community. The agency's screening determines eligibility of CINS/FINS youth and families that are referred to the program to start the intake process. 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 that are statutorily mandated committees that develop formalized treatment plans for status offenders when all other services have been exhausted. In the event that it is needed, the Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

The reviewer assigned to this indicator 2.01 reviewed several documents. A Participation Orientation Packet and Informed Consent and Participant Agreement are given to clients which outlines service options, rights and responsibilities of family members and possible actions through the CINS/FINS process. The non-residential orientation packet gives a brief overview of grievance procedures while the residential orientation packet has the parent sign saying this has been discussed with them. The reviewer interviewed Regional Coordinator Cindy Starling, Residential Counselor Angela Williams and Family Action Counselor Lytina McCullough.

Standard 2 involves the indicators for the Screening and Intake process. This agency has policy and procedures for all of the indicators in this Standard. This reviewer examined a total of 10 charts, 7 open charts and 3 closed, which consisted of 3 open non-residential and 2 closed with 4 open residential charts and 1 closed. This reviewer interviewed Cynthia Starling, CDC Regional Director; Pam, Residential Director; and Angela, Residential Counselor; and Latina, Non-residential Director.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

Both residential and non-residential screenings reviewed appeared to have been completed within 7 days of referral and intakes were completed promptly. Both residential and non-residential files had writing showing youth and parents were told of available service options. Non-residential files specifically cited that parents and youth were given the Guide to C/F Services for Parents and possible actions through the CINS process and the grievance procedures. Residential files showed the C/F brochure was given as part of the Voluntary Placement Agreement.

Of eight (8) files reviewed, four (4) were for residential clients;- three (3) open, one (1) closed. The residential files were unclear as to whether parents were given a Parent/Guardian brochure, what they were told about the grievance procedure and CINS/FINS services. Parents and youth sign that they are aware of an array of services and youth sign they are told of grievance procedures, but the paperwork is not specific.

One exception was noted for this indicator. There did not appear to be a reference to the C/F Guide for Parents.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The CDS-East agency has policies and procedures that require the completion of a Psycho-social Assessment process which begins with the initiation of the screening and requires a psycho-social assessment completed by a bachelor's or master's level staff and signed by a supervisor. If the suicide risk screening, which includes the six questions required by the Network requires a suicide risk component of the assessment, this will be reviewed or written by a licensed staff member. The psycho-social assessment is designed to capture and document all relevant social, emotional, educational, health, employment and family history.

The reviewer assessed eight files. Of these files three are open and one closed non-residential and three open and one closed residential. All shelter files indicated the Psycho-social Assessment was initiated within 72 hours of admission. All Psychosocial Assessments were done within 2-3 face-to-face contacts after the initial intake. All files had a supervisor's review signature within a timely manner. The persons completing the Psychosocial Assessments are not required to use their credentials so it is unknown by looking at these reports if they were completed by someone with a bachelor's or master's degree as required by the standard. None of the youth were identified as having an elevated risk of suicide. The six lethality questions required by the Network are asked in a form called Intake Assessment/Netmis. The Psycho-social Assessment then reports any concerns. In residential files, both Intake Assessment and Psycho-social Assessment are signed by the completing worker and reviewed by a supervisor.

There is an exception noted for this indicator. The non-residential Intake Assessment/Netmis is not signed and there is no written documentation as to who asked these questions and recorded them. The non-residential worker does sign the Psycho-social assessment that references any suicide concerns.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The CDS-East agency has policies and procedures that require the participation of clients in service planning. After eligibility is established and an intake is completed, an individual plan is developed with the youth and family within 7 working days of the assessment completion. The policies and procedures require that the plan be reviewed every 30 days for the first three months and every six months thereafter. Counselors are to review the plan to assess progress towards goals and objectives.

The reviewer assessed a total of eight files. Of these files, three are open files and one closed residential file and three open files and one closed non-residential file. All files were developed within 7 working days of the Psychosocial Assessment. Each assessment is individualized to each client and specified the type frequency and location of services including who is responsible, target dates and completion dates, signatures of all participating parties, and 30 day plan reviews.

An exception was noted for this indicator. One individual plan did not address both presenting problems. This service plan only addressed one.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The CDS-East agency has policies and procedures that addressed the requirements of the indicator. A total of eight(8) files were reviewed. Of these three were open and one was a closed residential files. In addition three were open and one closed non-residential files. All appeared to show consistent contact with client and families, monitored progress and made referrals as appropriate to community agencies.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The CDS-East agency has policies and procedures that addressed the requirements of the indicator. The monitor reviewed eight files - three open and one closed residential files. In addition, the monitor reviewed three open and one closed non-residential files. The Supervisor keeps a file with all staffings of open cases to ensure there is a clinical review conducted on all open cases, what is discussed and any recommendations. Presenting problems are addressed in the psychosocial assessment, service plan and service plan reviews. Residential and non-residential counselors appear to keep notes on all services as well as attempted services and contacts.

No exceptions are noted for this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The CDS-East agency has policies and procedures that addressed the requirements of the indicator. They have not had a case staffing since the last Quality Improvement review. When speaking with the program they stated that they have not been receiving the referrals from the schools. This reviewer was present for their last case staffing and witnessed that the process met the requirements of this indicator.

There were no exceptions noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The CDS-East agency has policies and procedures that addressed the requirements of the indicator. This monitor reviewed eight files. Of these files, four (4) were residential and 4 non-residential files. All client files, both closed and open were marked confidential. They are kept in locked files and in rooms that are locked and not accessible to the public. Files were neat and orderly and information was easily accessed.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS East program is located at 2919 Kennedy Street in Putnam County in Palatka, Florida. The facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children (DCF) and families for twelve (12) beds. The agency serves both CINS/FINS and DCF program participants. The shelter is comprised of a detached building that has a separate split level design with female and male sections of the facility. Each residential section of the shelter can accommodate up to six (6) youth on each side. The female and male sides of the facility are equipped with a large dorm, bath rooms and a dayroom. The facility includes a kitchen and dining area, Youth Care Work station, staff offices and a meeting room and multi-purpose room. The program staff for the Residential staff includes a Regional Coordinator, a Residential Supervisor, seventeen (17) Youth Care Workers, and 1 administrative. A Senior Residential Counselor is assigned to provide counseling and case management services to the residential program. The Direct Care Worker staff members are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision and general assistance.

The shelter's direct care staff members are trained to provide the following services for the youth: screening, medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR) and referrals. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis. 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 Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The medication and first aid supplies are stored in the staff office in a locked cabinet with multiple locks affixed on the cabinet. The residential shelter also includes administrative offices for the Regional Coordinator, Residential Supervisor, Counselor and other staff offices.

There is no onsite school. Youth attend local area schools if they are not on suspension, expulsion or suffering from an illness. 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.

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 for the current 2013-2014 fiscal year. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the Chief Executive Officer. The exterior of the facility is well maintained and the grounds are landscaped. The agency features an exterior makeover that included installing new plants, a vegetable garden, tree swing, meandering walkway, benches and patio furniture that was complete with donated supplies and labor.

At the time of the quality improvement review, the shelter was providing services to five (5) CINS/FINS youth. The shelter is not designated by the Florida Network of Youth and Family Services to provide staff secure services.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and operation practices in place that addresses all of the key elements of this DJJ QI indicator. The shelter is a 12 bed facility located in Palatka, Florida.

The facility has a very comfortable, almost "home-like" feel to it. It is very well maintained, very clean and organized. Each resident bedroom includes hand painted murals on the wall for decoration and offers a creative feel. At the time of this onsite review, there was no evidence of graffiti sighted on the furniture or throughout the facility.

The facility grounds are landscaped and well maintained. The agency has ample recreation space and open green areas for large muscle activity and exercises. The agency also has an active vegetable garden that is maintained by staff and youth. The agency's grounds also include a walking path that curves around to make a half circle around the rear of the yard. The outside area also includes a basketball hoop and an open court area for court games.

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

The facility has an updated camera surveillance system with sixteen (16) view points to ensure youth safety and program security. The camera observation monitor is located in the Youth Care Work station. The Department of Health Residential Group Care health inspection was last conducted in March 2013 was rated Satisfactory. The fire inspection was conducted by the Palatka Fire Department and was satisfactory. The

facility fire extinguishers were inspected in September 2013.

The program provides structured daily activities and program schedule is posted and accessible to both staff and youth.

There were no exceptions documented for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure in place that addresses the major requirements for this indicator. All youth receive a copy of the Client Handbook upon admission to the facility which explains all program services. The current process involves the agency conducting an orientation checklist during the intake process for each youth admitted to the shelter. The current checklist contains eighteen (18) items. The criteria listed on the checklist meet the Program Orientation requirements indicator. The orientation form is signed and dated by the youth and the staff member following the review of the major sections of the intake process.

A review of five (5) residential files revealed that all 5 files contained an orientation checklist that included a signature and date completed during the initial intake process. Each youth is given a list of contraband items and informend of disciplinary action. In addition, they are explained the dress code, medical and mental health services, procedures for visitation, mail and telephone calls. The parent/guardian sign off on the orientation packet. On site interviews conducted with YCW staff and the Residential Counselor indicate that the orientation process is consistently completed on each resident admitted to the shelter.

No exceptions were noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and current practice that address the requirements of this indicator. The CDS-East youth shelter is a 12 bed shelter consisting of two (2) large bedrooms with six (6) beds set up in each sleeping room. One room is for females and one for males. All beds are numbered in each room to ensure that an individual bed is assigned to each resident.

The agency uses the CINS Intake Form during the intake process to determine room assignment. As demonstrated by the review of the client files and the participamtn room assignment form, the program utilizes a process that includes an initail classification of the youth for purposes of room or living area assignment with consideration given to potential safety and security concerns.

The current room assignment process includes criteria that covers age, gender, physical build, behavior history and history of aggression.

A review of the five (5) active residential files was conducted to determine the agency's adherence to the indicator's requirements. A bed assignment was documented on each CINS Intake Form as required. In addition, on site interviews with YCW staff and the Residential Counselor resulted in a confirmation that that bed assignment is consistent part of the client intake process. Further, the room assignment of each resident is also documented on the client information board in the youth care staff office.

No exceptions were documented for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key components of the indicator. The agency maintains a daily log book to document program activities and communicate information across staff from shift to shift on a daily basis. The agency uses a customized log book that was developed by the agency and is utilized in all 3 CDS youth shelters. A review of the logbook was conducted. The majority of the written logbook entries are clear and legible and made in ink and are signed and dated by the individual staff person. The log book is properly documenting the daily activities, events and incidents in the program and is reviewed by direct care and the shift leader at the beginning of each shift. All corrections are completed according to agency policy and QI requirements (single line strike through with staff initials). In addition, the agency uses a four (4) color coded system to highlight important documented entries. The review found that the

majority of staff are consistently following agency documentation requirements.

Program activities and events are consistently documented and highlighted in four (4) different color codes according to agency policy. The agency logbook is an effective tool that is a best practice.

There is an exception documented for this indicator. One (1) out of 3 CCC incidents was not documented in the log book.

Rating Narrative

The CDS-East agency has a written policy and procedure that addresses all of requirements of this indicator. The agency has a behavior management system (BMS) in place that is known as Facilitating Activity and Communicating Effectively (FACE System). There are three (3) levels in the FACE system that includes Assessment, Daily and Achievement components.

The current process involves residents remaining on the assessment level for a total of three (3) days. Residents then have a 72 hour period to complete their initial assessment and adjust to the program rules accordingly. During this phase of the process, the behavioral target goals are identified for the resident to work towards achievement.

CDS-East Residents can then move up to the Daily level. Youth are assigned 3,300 points that they have to work off by completing daily activities. Residents must earn 250 points daily to earn privileges on this level. Further youth must earn 100 points to earn their privileges on this level.

Residents can move up to the achievement level where there they can earn additional privileges. On this level, residents must earn 100 points daily to earn privileges. Residents can remain on the achievement level for the remainder of their stay unless they violate major or primary program rules. An interview with the Program Supervisor was conducted to verify and confirm the components of the system.

The FACE documentation sheets show that the behavior management is done correctly on a consistent basis. The staff are properly trained and evaluated on the execution of the BMS.

No exceptions were noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the major elements of this indicator. The CDS East program YCW staff schedule includes a three (3) work shifts. The current work shift are conducted from 8:30 AM-4:30 PM, 4:30 PM-12:30 AM, and 12:30 AM-8:30 AM.

Program demonstrates that it meets the ratio criteria, the overnight shift consistently maintains a minimum of two staff present, the program consistently have at least one staff of the same gender as the youth on each shift.

The current makeup of the afternoon work shift includes two to three staff depending on the number and composition male and female youth in the facility. The overnight work shift schedule generally consists of two staff on duty, a male and female, seven days a week. Additionally, there is one staff who is bi-lingual that works on the overnight shift. The current work schedule also includes On-Call YCW staff to assist with vacancies due to staff on vacation or those that have called out sick. Further, the agency utilizes certain staff to augment their staffing need at certain times of the day while youth are at school and to provide additional coverage when youth return from school. Interview with the Supervisor confirmed the staffing patterns are in general compliance with staffing requirements. An on site review of staff schedules for the past six months also indicates that the shelter staffing patterns are mostly in compliance.

The agency is equipped with functioning surveillance cameras with backup coverage for 30 days. The program uses an electronic scanner system for bed checks. At the time of this on site review, the system malfunctions and is not showing all of the scans from the checks. Review of the camera system did show that the staff are properly checking the beds.

However, the monitor did confirm that there were some infrequent exceptions noted over the last six month period as it relates to staffing male staff members on the overnight work shift. Similar to last year's findings, the agency stated that they have been challenged to locate and consistently employ qualified male staff members to be employed at the CDS-East location.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place to address domestic violence respite referrals made to the CDS-East program. The agency had a total of two (2) cases referred to the program within the last 6 months. The agency received approval from the Florida Network state office for both cases as required. The youth admitted had a pending Domestic Violence charge and were screened by DJJ Detention. The placement of the youth did not exceed 14 day maximum length of stay. The case plans for the said residents contained a goals on anger management and other related behavior and family issues. The services provided by CDS-East to the Domestic Violence resident were consistent with all other general CINS program requirements.

There were no exceptions documented for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-East 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 East 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 Regional Coordinator and or Licensed Clinician are notified immediately if risks and alerts are present and recommendations regarding placement and supervision are provided to the direct care staff.

The agency has a Senior Residential Counselor and Family Action or Non-Residential/Case Manager that is a Registered Mental Health Counselor (RMHC). The agency's Chief Operation Officer (COO) is a Licensed Mental Health Counselor. The aforementioned staff members have state licenses that are authorized by the State of Florida, Department of Health, Division of Medical Quality Assurance are active and still in effect.

When a resident 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. Youth are admitted to the shelter with prescribed or over the counter medication. The agency secures these medications at that time. Medications are stored in a secure location that is inaccessible to residents. The facility is equipped with a metal detection wand, 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. 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 utilizes policy P-1117 to address screening for all past or current medical conditions. The said policy requires that the agency screen for all potential health or medical conditions that could impact the health of the shelter environment. The agency policy P-1117 involves a 2 stage process that includes a preliminary physical health screening and a completion of an Intake/Assessment. The preliminary physical health screening includes current medications; symptoms of active tuberculosis; physical health problems; medications; allergies; recent injuries and pain or other physical stress. The CDS admission process includes a comprehensive fourteen (14) page Intake Assessment/NETMIS form.

The health screening portion of this form includes all elements of the indicator: Allergies (general, medication and food allergies); Medications including Dosage Instructions; Restrictions; General, Physical Health Screening Questions; Current Observation of Behavior and Physical, Emotional or Mental Health Status. The general health screening section screens for a total of thirty (30) health-related questions that include recent injury; current pain; head injury or chronic headaches; vision problems; history of seizures/blackouts/epilepsy; chronic pain; sexually transmitted diseases; high blood pressure; heart murmur/condition; hemophilia; alcohol/drug abuse problems; orthodontic appliance being utilized; fainting/dizziness; skin problems; diabetes; asthma; kidney problems; 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. The agency also screens for the observation for the presence of scars, tattoos, or other skin markings. These marking are 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 CDS P-1118 policy requires residents to be screened and any areas of concern and/or need to follow up and that the agency initiate necessary medical follow up through consultation with the parent/guardian and physician. 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 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. In cases where no immediate concerns are noted, the assigned counselor is responsible for follow-up with the parent/guardian. The practice also indicates that staff members are to contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medications and general precautions in the case of an emergency. All medical/health related incidents/referrals are required to be documented on a daily log.

A total of five (5) open files and two (2) closed files were reviewed to assess requirements of this indicator. Of the 5 open client files reviewed, all files contain the fourteen (14) section intake form that contains the health screening sections. All major sections health screening questions were documented in each client file. All major areas are completed in four (4) out of seven (7) client files. The agency also captured additional health screening information on a "Screening Health Addendum". This form captures whether the resident is eligible to receive services and screens for any yes response to six (6) health related questions. These questions ask the resident "In the last 48 hours have you experienced any Fever; Diarrhea; Vomiting; Sore Throat; Continuous coughing and/or sneezing; and cold like symptoms". All seven (7) client files reviewed contained the required forms. The written procedures addressed the referral process and follow-up medical care protocol performed by the

agency.

The agency utilizes a Medical Health Follow Up form. This form aids the staff regarding an health issue 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 that include eleven (11) health issues.

An exception is noted for this indicator. The general health screening section screens for a total of thirty (30) health-related questions. Two (2) out of the seven (7) health screening questions contained empty or blank boxes. This is not consistent with five (5) client files that contained checked marks for all 30 sections.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The CDS-East program utilizes an agency wide Suicide Prevention Policy. Each CDS-IYP location utilizes a standardized suicide prevention plan in each of its three (3) emergency shelters located in the North Central Florida. The CDS-East location adheres to the agency's Suicide Prevention process. The agency's current policies related to this area are Mental Health, Substance Abuse and Suicide Risk Screening and Suicide Assessment. The Suicide Assessment policy addresses the essential requirements of the Quality Improvement 4.02 indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS. This policy was initially approved in August 2011 and has not been revised since the initial approval date. 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. In the event that a resident responds "Yes" to any of the 6 suicide risk assessment questions, the staff conducting the observation places the youth on sight and sound and then contacts the parent/guardian and Residential Supervisor. The observation log is then initiated for direct documented observation of the youth until the youth can be assessed by the designated counselor. The Close watch supervision counts are documented every 30 minutes for Constant Sight Sound Supervision and One to One Supervision is documented every 15 minutes. The agency charts all sight and sound documentation on the agency Observation Log. All checks are required to be conducted in 30 minute or less intervals and fully documented on the Observation form. Once the youth is on sight and sound observation, a full assessment is completed by the Residential Counselor. Supervision status is maintained by agency during the assessment process until the Residential Counselor completes a full assessment and reviews the results with the Licensed Mental Health Counselor (LMHC) and receives direction to maintain or remove from the said supervision status. If the LMHC authorizes removal from observation status, the resident is removed from the said supervision status and the counts are stopped and the resident is returned to the general population. The agency then faxes the completed assessment to the LMHC for review and signature. A copy of page 5 of the assessment form is reviewed by the LMHC and is faxed back to the program for placement in the resident's file. This form is also reviewed and signed by the residential director.

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 instances, a direct care staff person will immediately refer the youth for assessment to Putnam County Hospital, Stewart Marchman Act, and Flagler Hospital. The agency also refers all crisis stabilization referrals to Meridian Behavioral Healthcare and Shands Vista for a Baker Act screening. Upon return and clearance from the said facilities the resident is then placed on constant sight and sound.

A random sample of six (6) client files over the last six (6) months was conducted on site during the QI program review. A total of five (5) closed files and one (1) open file was reviewed on site. 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 Residential Supervisor. All counselors have access and all assessments are reviewed by a licensed clinician. All youth that are screened positive as a suicide risk, were placed on sight and sound supervision until they are assessed by a counselor who is under the supervision of a licensed mental health clinician/professional. In all cases reviewed, the supervision level was not changed or reduced until the resident was assessed by the Master's level counsel whose work is approved by a licensed professional. All 6 cases were applicable for requirements of a suicide risk assessment and were applicable for sight and sound supervision requirements. Six (6) out of 6 youth were placed on the appropriate level of supervision based on the suicide risk assessment results. Supportive documentation was reviewed to include precautionary observation logs and thirty minute checks were confirmed on all 6 case files reviewed. All 6 cases contain chronological notes documenting the youth being placed on sight and sound that are highlighted in Blue.

A review of the agency logbook regarding close watch supervision was conducted on site for evidence of consistent documentation of general suicide activity. Evidence of youth being removed from sight and sound status is required to be documented in the agency program log book. The reviewer was able to determine the status of all 5 youth placed on supervision from the agency's logbook. The documented note referring to close watch supervision are high-lighted in blue to easily identify the resident's suicide watch condition or status.

There is one exception noted for this indicator. A total of one (1) active case out of the 6 clients files does not contain check marks indicating the Current Mental Status in the applicable boxes. The remaining 5 client files does contain check marks indicating the Current Mental Status in the applicable boxes.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Medication policy that addresses all major areas of medication distribution and assisting in the delivery of Medication. The policy is called the Medication Provision, Storage, Access, Inventory, and Disposal. The agency medication policy was last updated in July 2012. The current policy P-1120 includes twelve (12) sections that address the following: Prescription Medication; Procedure for Verification Medication; Non-Prescription Medication; Medication Provision, Supervision, and Monitoring; Medication Distribution Away from the Shelter; Medication Errors and Refusals; New Prescription, Change in Medication and New Month; Medication Storage; Access to Medication; Inventory Procedures; Medication Counting Procedures; Discharge of Youth with Medication; and Disposal.

The agency does not provide residents with over the counter (OTC) medications. All residents that require and over the counter (OTC) medication must have a doctor's prescription accompanying the youth at admission to the program.

The current medication verification process involves sending a three (3) step process that requires sending an "Informed Consent and Participant" to the pharmacy for verification; Confirming that the form is completed by the pharmacy and returned to the program; and documenting that the verification is documented on the resident's medication distribution log (MDL). The agency maintains a color-coded dot system to ensure the accuracy of each medication that is distributed to the resident. All residents with at least one or multiple MDL charts have a corresponding colored red, blue, green or yellow dot that corresponds with the appropriate controlled or non-controlled medication.

All medications in the shelter are stored in the Youth Care Work station office that is a separate, secure area, which is inaccessible to youth unless authorized. The agency's oral medication storage practice requires that all oral medications are to be stored separately from topical medications. There were no injectable medications on site. The agency does permit an Allergy Epi Pen as needed on a case by case basis for CINS/FINS youth. All medications are locked in a four (4) drawer metal cabinet behind that requires a key to access medication. The agency keeps all controlled medications in a key locked metal box in the same 4 drawer metal cabinet. Oral and topical medications for all youth are stored in individual plastic snap-lock containers with labels with the client's name on it.

An inventory is maintained and documented for controlled and prescribed medications. All controlled medications are required to be counted three (3) times per day, once on each shift. These counts are documented on the agency's Medication Distribution Log (MDL). All other prescribed medications are counted on a perpetual basis. All non-controlled medications are counted 1 time per week and on each instance that it is given to a client.

All sharps are maintained in a locked 4 drawer metal cabinet. A total of fifteen (15) resident craft scissors are maintained in the left bottom drawer in the control room. A total of seven (7) medical scissors are maintained by the agency in four (4) first aid kits in a metal cabinet in the control room and in one (1) transportation van. The agency maintains record of the weekly sharp counts. The counts were recorded on a computer generated print out. The current form documents the date when sharps counts were counted each week. A second form documents the staff person that conducted the count and the date that the count was completed. At the time of this on site review, sharps counts from August 2013 to present February 2014 were reviewed. All sharps counts are documented as required and maintained in a three (3) ring binder notebook.

The program utilizes a customized Medication Record Log (MDL). The MRL contained all the necessary information to include: youth's name (printed); youth picture; medication; strength; doctor name; current month; year; allergies; method of administration; special procedures; side effects/precautions; participant signature; participant initial; date received; time received; amount received; received from; sticker-Px initials/container; and staff receiving. The document is 2 pages. The remainder of page 1 included information such as a 31 day dose calendar with 3 shifts to document medications if needed. The form captures staff and youth initials, medication codes and daily doses times. Page 2 captures MRL reviewer's signature and date when MRL reviews are conducted. Page 2 also captures Controlled Substance Shift-to-Shift Inventory, Non-controlled Weekly Inventory for tracking medication counts across the 3 shifts (overnight, day, evening). The page also documents the agency's medication verification activity.

The agency does have a medication specific refrigerator place for refrigeration of medication if needed. However, at the time of this on site review there was no medication that required refrigeration. First aid and general supplies are captured on a sixty-three item list.

A review of youth currently in the shelter on medications was conducted. A sample of the medication record log of one (1) current youth in the shelter and four (4) closed files were reviewed to assess the agency's adherence to standard. All cases reviewed contained evidence with documentation of the recent medication verification procedure. All 5 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 Record Log (MRL) captures evidence of the dosage being given, staff member's signatures and initials, client's signature and initials and dosage given on the MRL. Youth initials are documented, but no full signatures are documented. Page two (2) of the MRL captures the shift to shift count and weekly inventory count of each medication given to each clients. The MRL on 5 out of 5 client files indicates that youth medication records include all required documentation in the aforementioned areas.

The agency has an active incident report process related to medication errors. 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-training of the respective staff that were involved in medication errors.

The MRL contained information that indicated that refill dosages of multiple medications were supplied prior to the resident depleting their current medication supplies.

The agency has self-reported four (4) medication errors to the DJJ Central Communications Office. Of these errors all occurred between November 2013 and December 2013. These incidents involve 3 staff members. One (1) staff member cited involved that the staff person not completing a correct medication count. The agency produced evidence of documentation that indicates each employee involved the said medication incidents and administrative report addressing their work performance. Each employee involved in improper medication error is cited with a written letter documented the agency's acknowledgement and corrective action that is issued. The written letter cites subsequent disciplinary action that could be taken up to and including termination.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Medical and Mental Health Alert policy that addresses all major areas of medication distribution and assisting in the delivery of Medication. The policy is called the P-1119 Medical Mental Health Alert. The agency medication policy was last updated in July 2012. A total of five (5) Open charts were reviewed for adherence to this indicator. All charts reviewed had an alert that was appropriate to their screening and assessment results. Several clients had a medical, food allergy or mental health condition all were marked consistently on the client record and on the client board in the staff office. The program has a process that is generally being followed in a consistent manner. The system of numbering is available to staff, but is limited access to clients. The clients are not aware of the alert process coding.

The agency has an effective medical and mental health alert system policy. The current policy is call P-1119 Medical and Mental Alert Process. The agency has a detailed alert system that is comprised of several components. The agency has a comprehensive Participant Code that includes eighteen (18) codes. The agency places the appropriate number on their large General Alert board for all staff to quickly locate as needed. The code definition sheet is placed taped to the work desk located in the YCW work station. The agency also places participant codes on client information strip located on that is affixed to the client file. The agency also marks allergy codes in a 3-ring notebook located in the kitchen. The logbook also contains four (4) color codes that include yellow-general information; pink-medication; Blue-Suicide; and Orange-completed a review of the last 2 shifts. The agency also utilizes the pass-down section of the logbook to communicate codes and other pertinent client care and program operations information.

No exceptions were noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that addresses all of the key elements of this QI indicator. The agency policy is called P-1166 **Episodic/Emergency Care**. The Reviewer assigned to the indicator requested any documented incidents that had occurred over the prior six (6) months that require off-site emergency services. The agency reported no cases involving emergency medical or episodic care. The Reviewer did not examine the DCF youth files. The Lead Review requested that the agency provide any client cases that received off-site emergency services back to the last QI review in order to assess the agency's adherence to this standard.

The reviewer requested that the agency provide evidence of any emergency or medical events. The agency has two (2) knives for life and a wire cutter. The agency has four (4) first aid kits in the shelter and 1 in the transportation van.

No exceptions were noted for this indicator.