



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface East

on 04/08/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Tim Langlo, CINS/FINS Non-Residential Supervisor, YFA

Stacy Sechrist, VP of Clinical Services, YCC



Quality Improvement Review

CDS-Interface East - 04/08/2015

Lead Reviewer: Ashley Davies

Heather Prince, Director of Adolescent Services, Stewart Marchman Act

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 6 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 checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 5 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 11 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 2 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 3 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 8 Youth | 5 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|--|--|--|
| <input 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 type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input type="checkbox"/> Searches | <input type="checkbox"/> 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 checked="" type="checkbox"/> Medical Clinic | <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Since the last Quality Improvement review the agency has added and filled the position of a Life Skills Educator. The shelter was in its second year of the Basic Center Grant which made it possible to add this position.

The agency has worked on extending its web publicity, including creating a Facebook page and has been working on more creative ways to bring youth in.

The agency has been working on growing the SafePlace Program over the past year.

The agency was recently re-certified through CARF.

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 service locations in their respective service areas. Other uniform protocols for all three 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. There were eight new staff hired since the last on-site Quality Improvement Review. All eight staff had documentation their background screening was completed prior to their hire date. All staff were either rated "eligible" or "eligible with charges" so no exemptions were required. There were three staff who were due for a five-year re-screening during the review period. There were two re-screenings that were completed three and four days, respectively, after their initial hire date. The third re-screening was completed prior to the staff's initial hire date as required. The Annual Affidavit of Compliance was completed and submitted to the DJJ Background Screening Unit on January 23, 2015.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

When reviewing the Unusual Events book there were several instances in which staff properly called the abuse hotline for suspected abuse. No grievances on staff stating that the youth felt abused. Staff surveys did not show any indicators of an abusive environment. The youth surveys stated that the youth were familiar with the abuse hotline and that they did not feel threatened by staff.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The reviewer reviewed the Unusual Events book from October 2014 to March 2015 and three incidents were reportable CCC incidents. The incidents were two medication errors and one contraband issue. All of the reports were submitted in the correct timeframe of two hours.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There were three staff training files reviewed for first year training requirements. Two of the three staff have completed their first year training and the third staff still has two months left to complete all required trainings. This staff has documented 54.5 hours so far and is on track to receive all required trainings and hours. The remaining two staff documented 116 and 111 hours. One staff did not document CINS Core training and the other staff did not document Crisis Intervention/Safety training and Trauma Informed Care. All other required trainings were documented.

There were four staff training files reviewed for annual training requirements. All four staff documented more than the required number of annual training hours. All staff documented fire safety training, suicide prevention training and had a current First Aid and CPR certification. There were also numerous other trainings documented throughout the year.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has very detailed reports that go out on a monthly basis in the CDS Performance and Risk Management Reports. These reports include performance analysis reporting on bed days and CINS nonresidential. It is broken down to review all of the admission, discharge and care day information per facility for the agency. This monthly report also includes a data lag report and analysis and projections of contractual requirements from NETMIS. The monthly report also includes an incident report summary for all programs. In addition to those reports there is an analysis of the residential and nonresidential admissions, daily populations, average length of stay and bed days for the last 5 fiscal years. The program is conducting quarterly peer reviews on the files. The agency is also reviewing customer satisfaction data bi annually with their management team.

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 two Non-residential Counselor/Case Managers. 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.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

There were three non-residential (one open and two closed) and three residential (two open and one closed) files reviewed. All screenings were completed within the seven days of referral. Parent/Guardian and child were presented with information of the program, rights and responsibilities, and service options. Signatures were documented on all forms.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

There were three non-residential (one open and two closed) and three residential (two open and one closed) files reviewed. Each of the three non-residential met the requirements of the indicator. Needs assessments were all completed by Bachelor's/Master's level staff and reviewed by a supervisor. There were no indications of suicide for any of the youth.

Each of the three residential files reviewed were completed within the designated time frames by Bachelor/Master's level staff and reviewed by the supervisor. In one file the child was readmitted per court order on 3/31/2015. The needs assessment readmission form was not completed until 4/7/2015. However, the NETMIS intake paperwork noted that the intake was initiated on 3/31/2015 and a case note indicated that the counselor/case manager did request the guardian come in to complete the paperwork.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

There were three non-residential (one open and two closed) and three residential (two open and one closed) files reviewed.

All case/service plans, in all three non-residential files, were initiated/completed within seven days and indicated the needs/goals of the clients, people responsible, type, frequency, and location of services, and the date the plan was initiated. The 30,60, and 90 day reviews were being completed as required, with the minor exception of one file documenting the 60 day review two days late and another file documenting the 60 and 90 day reviews one day late.

All Case/Service plans, in two of the three residential files, were initiated/completed within seven days and indicated the needs/goals of the clients, people responsible, type, frequency, and location of services, and the date the plan was initiated. An Individual Plan was not completed in the third file; however, the file was still within the seven day window for completion of the plan.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

There were three non-residential (one open and two closed) and three residential (two open and one closed) files reviewed.

In the non-residential files reviewed, two were closed cases of which, only one met the criteria for a 30 day follow up, which was completed. Appropriate referrals were made in two of the three files reviewed. Documentation in all three files indicated the counselor/case manager implemented the service plan goals with the family with follow up and monitoring.

The documentation in the residential files indicated that the Individual Plans are being executed well in terms of implementation and monitoring of services. The Counselor/Case Manager is coordinating the process.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There were three non-residential (one open and two closed) and three residential (two open and one closed) files reviewed.

In all three non-residential files reviewed, the child's presenting problems were addressed in the needs assessment and service plan, with documentation in the case/progress notes.

In the two of the three residential files reviewed the child's presenting problems were addressed in the needs assessment and service plan, with documentation in the case/progress notes with the exception of one child who, per the Individual Plan, was to have Individual Counseling three times per week and family counseling one time per week. The case notes indicated that the child received two individual counseling sessions on 12/1/2014 and there were no noted family sessions between the child's admittance and discharge. The service plan in the third file was still in the process of being developed. Group counseling is provided a minimum of five days per week and is well documented.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency did not have any files with adjudication/petition process. However, The process is addressed in the Operations and Procedure Manual. The manual contains the process as set forth by the Florida Network of Youth and Family Services Policy and Procedures.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

All files are marked confidential and maintained in a neat and orderly manner. According to staff interviews, files are kept in a locked file cabinet. The files are kept in a file cabinet in the shelter. The cabinet was locked and was only accessible by the program staff.

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 Worker 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, eighteen (18) Youth Care Workers, an Administrative Assistant, a Community Outreach/ Safe Place Specialist, a Life Skills Educator, and a House Manager. A Residential Counselor is assigned to provide counseling and case management services to the residential program. The Youth Care Workers are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision and general assistance.

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 also has an effective grievance process. When submitted, grievances are responded to within twenty-four to seventy-two hours of being submitted to staff or the Residential Supervisor.

At the time of the quality improvement review, the shelter was providing services to eight (8) CINS/FINS youth.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

Facility, interior and exterior is well maintained evidenced by observation and interviews. Nice touches of decorations to help place feel more comfortable for all visitors and staff. Organizational system is efficient and clear. Licenses and policies are clearly displayed with distinct labels, whether in binders for staff or display boards for visitors and clients. The facility shows clear safety and security measures in place through practice and policy.

There is no grievance box for youth to place grievances. They give their grievance to a staff member to be moved through the organizational chain for resolution. The practice of having a clearly accessible grievance box can increase a youth's comfort level in having a voice about any concerns they may have as opposed to giving it to a staff (dependent upon their view of adults, authority figures, program staff etc.)

The agency disaster plan has a letter of memorandum from the COO that indicates his review and approval for the plan as a whole, including any revisions and additions that were made since the prior review however, the manual itself doesn't show any revision, review or update indicators in the footnotes. All dates are showing at least 2013 or older.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

Based on the 5 youth records, some opened some closed, the program has an established orientation process in place. The files had clear documentation indicating youth and parent participation in the process. The file also showed clear documentation of the youth indicating orientation to the required components per Florida Network of Youth and Family Services, Policy 4.01. The room assignment process had great

questions to help staff identify components necessary to quickly making a determination on room assignment. Alert system on side of binder for risks is a quick method of communication and helpful reminder for staff.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

Based on documentation and an interview, the room assignment process demonstrates a comprehensive interview and classification system is in place. The entire intake process appears to be used to determine the most appropriate room assignment and sleeping circumstances. Based on an interview, there is a process in place to accommodate youth that may need to have special needs met in sleeping arrangements.

There is nothing to indicate any assessment related to gender identification. This would be an area of assessment that needs added to the intake process to ensure youth's overall safety and well being are fully getting assessed.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Based on documentation, The log books are kept in a legible, clearly documented manner showing consistent signs of brief entries to outline the activities and locations of the youth. The log book entries reviewed also clearly show the direct care staff and shift supervisor signing that they have reviewed the previous shifts and days. The system is designed well with an extra signature line indicating the need for program directors signature every seven days, serving as a reminder as well as, a checks and balance to ensure it gets done. Most errors are marked out with a single line, initialed and dated by the staff that made the error.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

Based on an interview and documents, the behavior management has been well researched, thought out and executed in regards to training staff. The documentation surrounding the expectations and documentation are well drafted and detailed. The process includes feedback and allows for a supervisor to review and approve at various levels. The program has clearly laid out policies for the protocol associated with aggressive behaviors, stating physical intervention by staff is a last resort, as well as outlining examples of interventions that are not permitted.

The documentation shows specific topics addressed in more detailed manner in an effort to point out necessary components of a successful behavior management system, such as the various degrees of behaviors, staff interactions impact on the behavior as well as, considering the importance of fundamental skills such as manners, hygiene, and various citizenship behaviors that may not have ever been taught to youth prior to admittance in to the program.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

Based on documentation, the program has clearly defined policies in place regarding staffing and youth supervision. All supporting documentation and observations support that this practice is in place. I reviewed the program log books, bed check log books, staff schedule, which is posted in a central staff location along with the on call list with the list of staff phone numbers near by and conducted an interview with the Program Director. The documentation and the interview concluded that at least 2 staff are scheduled and log books indicate that this is in practice, meeting the Florida Administrative Codes of 1 staff to 6 youth ratio during awake hours and 1 staff to 12 youth during sleep periods. Through log books and bed check logs, staff are observing youth at a maximum, every 15 minutes. The program uses an electronic bed scanner system overnight but also has a backup system in place anytime there are issues with that system.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The facility has a procedure in place for all special populations. The facility did not have any staff secure or probation respite youth since the last review period. The facility received two domestic violence youth since last review. The facility had documentation of prior approval for the DV placement. The files had proof of a DV charge and being screened by a JAC. The length of stay did not exceed 14 days and when the youth remained in shelter past 14 days there was clear documentation on the youth transitioning to a CINS bed. The service plan had a goal in regards to anger management and family coping skills. The services provided were consistent with the other youth in shelter. The only exception is that the youth who transitioned from the DV bed to a CINS bed had 2 service plans and they had exactly the same objectives even though the first plan had completion dates on the plan.

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 agency's Chief Operation Officer (COO) is a Licensed Mental Health Counselor.

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 policies P-1117 and P-1118 to address screening for all past or current medical conditions. The policies state each youth will be provided a preliminary physical health screening and also staff will complete the Intake/Assessment form. Information obtained from the youth's initial screening is recorded on the Intake/Assessment form and the staff person completing the form will note on page 6 if there are any areas of concern or needed follow-up and will initiate the Medical/Mental Health Alert System. Once the intake process is complete, the intake staff and supervisor will review the packet. If there are any health concerns that require a follow-up they are addressed at that time through consultation with the parent/guardian and documented on a Medical Health Follow-Up Form.

A total of four open files and one closed file were reviewed to assess requirements of this indicator. Of the five files reviewed, all contained Intake/Assessment for with all health screening sections completed. The agency also captured additional health screening information on a "Screening Health Addendum". This form captures whether the youth is eligible to receive services and screens for any yes response to six health related questions. These questions ask the youth "In the last 48 hours have you experienced any Fever; Diarrhea; Vomiting; Sore Throat; Continuous coughing and/or sneezing; and cold like symptoms". None of the youth required any follow-up medical care; however, there are procedures in place if it is needed.

The agency utilizes a Medical Health Follow Up form. This form aids the staff regarding any health issue that has been confirmed during the health admission screening. Once a staff person identifies a major health issue a specific form with information on the health issue is placed in the youth's file. The form is designed to help increase awareness and knowledge of staff serving the youth of any potential health symptoms or identifiers for them to be aware of. This form is only utilized for specific health issues that include eleven (11) health issues.

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.

There were three youth files reviewed and all three files documented the CINS/FINS Intake form was completed during the initial intake and screening process and the youth answered "yes" to one of the six screening questions. All CINS/FINS Intake forms were signed by a supervisor. All three youth were immediately placed on suicide precautions until assessed by a qualified professional. In two of the three files the Suicide Assessment form was completed by a qualified professional within twenty-four hours. The third youth was admitted on a Friday evening and the Suicide Assessment form was completed on Monday morning as required. All assessments were completed by a master's level counselor and the form was then faxed to the agencies COO who is a Licensed Mental Health Counselor (LMHC), who then reviewed the assessment with the counselor via telephone and signed the assessment and faxed it back to the shelter. Youth youth's parent/guardian was also notified in all three cases, of the youth's suicide precaution status. In all three files the youth was removed from suicide precautions and placed on standard supervision. All three files documented thirty minute observations of the youth were maintained the entire time the youth was on precautions. The observation form were completed in their entirety and signed by the Residential Supervisor. There was documentation in the logbooks each time a youth was placed on suicide precautions and anytime there was a change in supervision status. This information was highlighted in blue making it easy to find.

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 October 2014. The current policy P-1120 includes twelve sections that address the following: Prescription Medication; Procedure for Verification of 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 youth with over the counter (OTC) medications. All youth that require an OTC medication must have a doctor's prescription accompanying the youth at admission to the program.

The current medication verification process involves calling the pharmacy to verify the prescription and documenting on the Medication Record Log (MRL) who the staff spoke to at the pharmacy. 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 MRL 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. All medications are locked in a four drawer metal cabinet that requires a key to access the medication. The agency keeps all controlled medications in a key locked metal box in the same four drawer metal cabinet. Oral and topical medications for all youth are stored in individual plastic snap-lock containers with labels with the youth's name on it.

All sharps are maintained in a locked four drawer metal cabinet. The shelter has a supply of sixteen medical related sharps which include: seven medical supply scissors, three knife-for-life's, and six tweezers. There was documentation of all these items being inventoried weekly. A computer generated checklist is maintained that lists all sharps and how many of each. A checklist is created for each month and as staff inventory the sharps weekly they sign and date the bottom of the checklist. This was completed for the last six months.

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-six item list. The list documents each item, the quantity, and the expiration date. The monthly inventory of the first aid kits documents any items that needed to be replaced and items pulled due to expiration dates. These inventories were documented for the last six months.

An inventory is maintained and documented for controlled and prescribed medications. All controlled medications are required to be counted three times per day, once on each shift. These counts are documented on the agency's MRL. All other prescribed medications are counted on a perpetual basis. All non-controlled medications are counted one time per week and on each instance that it is given to a youth.

At the time of the on-site review there were two CINS/FINS youth on medications, these two file, as well as, one additional closed file were reviewed to verify the medication administration process. All three files documented medication verification was completed, on the MRL's, for all medications administered. A MRL was maintained for each medication the youth is taking. The first page of the MRL documented the youth'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. All MRL's documented the full printed name and initials of any staff assisting with medication administration and also the full printed named and initials of the youth. The second page of the MRL captures the shift to shift count and weekly inventory count of each medication given to each youth. In all three files reviewed all medications were given as prescribed and documented accordingly on the MRL. Perpetual inventories were maintained on the MRL each time the medication was given. All shift to shift inventories of the controlled medications and weekly inventories of non-controlled medications were documented without exception.

The agency has an active incident report process related to medication errors. There were a total of two (2) 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.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

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 system that is comprised of several components. The agency has a comprehensive Participant Code that includes eighteen codes for various alerts that can occur in the shelter setting. The agency places the appropriate number next to the youth's name on their large General Alert Board, located in the Youth Care Worker (YCW) office, for all staff to quickly locate as needed. The code definition sheet is placed taped to the work desk located in the YCW work office. The agency also places participant codes on the youth information strip located on the spine of the youth's file. The agency also marks allergy codes in a 3-ring notebook located in the kitchen. The logbook also contains four color codes that include yellow-general information; pink-medication; Blue-Suicide; and Orange-staff reviews. The pass-down section of the logbook is also utilized to communicate codes and other pertinent youth care and program operations information. All alerts are up-dated as needed. If an alert is up-dated on the youth's file it is crossed out and initialed.

A total of five open files were reviewed for adherence to this indicator. All files reviewed had an alert that was appropriate to their screening and assessment results. All alerts documented on the youth's file corresponded with the alerts documented on the General Alert Board. There were no youth in the shelter with any food related allergies.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The facility has a procedure in which that enures the provision of emergency and dental care. The procedure includes obtaining off-site emergency services, parental notification requirements, incident reporting, daily log and verification of medial clearance. THE unusual event report book was reviewed from October 2014 to March 2015. There were several incidents that required medical attention and they were all properly documented with a report, The facility maintains a daily medical and dental log and it is well maintained. First aid kits are located in the staff office and in the van and all are well stocked. The facility had both a knife for life and a wire cutter in the staff office.

