Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface NW

on 02/04/2014

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	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 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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 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 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

Melissa Quinn, Clinical Support Manager, Boys Town of Central Florida

Mark Shearon, Chief Compliance Manager, Arnette House

Susan Spinella, VP of Quality Assurance, Youth Crisis Center, Inc.

Brent Musgrove, DJJ, Office of Prevention and Victim Services

Persons Interviewed

- [x] Program Director
- [x] DJJ Monitor
- [x] DHA or designee
- [ ] DMHA or designee

1 Case Managers
1 Clinical Staff
1 Food Service Personnel
0 Health Care Staff

1 Maintenance Personnel
2 Program Supervisors
0 Other

Documents Reviewed

- [x] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [x] Fire Drill Log
- [x] Fire Inspection Report
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

4 Health Records
4 MH/SA Records
6 Personnel Records
6 Training Records/CORE
5 Youth Records (Closed)
3 Youth Records (Open)
0 Other

Surveys

2 Youth
5 Direct Care Staff
0 Other

Observations During Review

- [ ] Admissions
- [ ] Confinement
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [x] Meals
- [x] Medical Clinic
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [ ] Sick Call
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Transition/Exit Conferences
- [ ] Treatment Team Meetings
- [ ] Use of Mechanical Restraints
- [ ] Youth Movement and Counts

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Standard 1: Management Accountability

Overview

Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Northwest provides both residential and non-residential programs. This program site is located in Lake City, Florida. CDS-Northwest provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The CDS-NW agency primarily provides CINS/FINS services in Bradford, Union and Putnam Counties. CDS-NW also operates other Residential and Non-Residential programs in Gainesville and Lake City, Florida respectively. All three (3) program locations report to the agency's Chief Executive Officer and Chief Operations Officer that are located in Gainesville, Florida. The CDS-NW location is operated by two (2) Regional Coordinators. The Regional Coordinator position is the highest ranking position for the agency at this location. The agency assigns the daily operation and direct responsibility of each shelter to the Residential Director at each youth shelter. The agency also has Residential and Non-Residential counselors, Residential Direct Care and Non-Residential staff members. The agency has a Centralized Human Resources and fiscal departments handle all personnel and financial matters. Each area program has a licensed clinician that oversees and review all youth that have suicide risk issues. Each program also provides general counseling and mental health services to youth and families. These services are delivered at their respective location. All CDS residential shelters and Non-Residential programs have implemented uniform operating protocols for all three (3) service locations in their respective service areas. Other uniform protocols for all three locations include training and professional development exercises. The CDS-NW program agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency trainings combine trainings so that staff members at each location to be trained simultaneously on various training topics.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Background screening documentation was reviewed, and showed that appropriate level of screening was completed on all new employees, five, and one intern. In addition, a re-screening was completed on one employee who was due for a 5-year re-screening. All documentation showed that screened staff/interns were rated as eligible. These reports covered the past year, since prior review in 2013. New staff who were screened were checked against date of hire in table of organization, and they matched.

Background screening policies and procedures are in place within written manual, and are consistent with FL Network guidelines. The annual affidavit was filed in January 2014.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policies and procedures reflect an environment that protects the rights of clients. Language is included that ensures that any consequences for violations do not punish an entire group for the actions of one, that no basic rights are withheld, that no isolation or locked room restriction is used, and that hitting, physical threats, verbal threats, and humiliation are prohibited.

Grievance forms are utilized if clients have concerns about treatment. The forms are observed to be easily accessible to clients who may wish to complete grievance form.

Behavioral expectations of staff are well outlined in Policies and Procedures Manual.

A file of Grievances from past year (dating back to last site review) was reviewed by this writer, and all grievances were minor, were addressed by staff, and were typical of residential facilities for teens.

There are extensive policies and procedures regarding the reporting of abuse, which includes Florida Law. All indications show that these policies are followed. Please see examples below:

Incident Reports that addressed any abuse concerns were called in and documented properly. When there was an issue with staff, it was documented, and review was completed, which resulted in employee being terminated.

Client rights and hotline numbers are plainly visible and accessible to program participants.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Incidents reported appear to fall within the range of normal occurrences in a facility of this type.

The most frequently occurring incident was contraband, and each instance was handled appropriately. Parents were notified and investigations were conducted, as appropriate.

There was one incident involving a staff member (Youth Care Worker) reporting to work late, but falsifying her log entry, indicating that she had been in prior to her actual arrival. An internal investigation was conducted, and staff member was ultimately terminated.

Incidents involving suicidal ideation were handled appropriatedly with sight and sound placement and close monitoring by staff. Baker Acts were completed when situation warranted it.

Incident Report binder contained other items called 'unusual events, which included facility maintenance items.

Staff interviewed were very familiar with Incident Report policy, and there have been training programs on this topic.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A training plan is in place which outlines the training goals of agency and explains how training is documented. Each position has its own training plan which is specific to the position. These were found in each staff member's training file. Although training files were separated by calendar year, not fiscal year, it was easy to look back at 2013 for each employee, to ascertain that all training goals for fiscal year were met. In addition, sign-in sheets appear in each staff training file, to verify that employee was present for training.

There is a comprehensive training calendar by each year, which outlines the courses and times offered. Training includes both online and classroom training. CINS/FINS required training courses are included in training schedule and in training plan. Upon review of staff files, it appears that staff training is documented appropriately, that staff is meeting annual training requirements, and that the training offered matches and sometimes exceeds FL Network requirements.

Training topics include grievance procedures.

Training plan for each position (and located within each staff member's file) is a creative and effective way to ensure that all training goals are met.

First year staff: One staff did not appear to have CINS/FINS core or fire safety training yet, however, this staff has not completed thir first year, as she was hired 6/25/13. She still has four months to complete this training. Another staff has not completed CINS/FINS core training; however, her first year is not up until April 26th. Review team was told that she will complete this training in next two months. Because she is non-residential, Title IV training is not required.

Ongoing staff: One staff will be due for CPR and First Aid Training this month. However, he is a volunteer firefighter, who has had the training externally, and is emailing documentation of such today.

The team was told that CPR/First Aid training is coming up on February 15th for all staff who are due. This writer was shown documentation of this upcoming training schedule.

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’s accreditation is valid through April 2015. CARF International is an independent, nonprofit accreditor of health and human services.

The policy addresses the method in which the agency conducts its review of internal program and operational reports to assess trends, events and activities.

The agency has specific 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 agency 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 at CDS, Total Served, High Risk, and Target Zip Code. 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 three youth residential and its non-residential program.

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 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 its program agency wide. 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 major quality improvement initiatives so far this fiscal year. The agency has a plan to address Training that identified and create orientation topics and to be used across all 3 of its youth shelters. This helped to YCW, Counselor and Case Manger Staff that are now required and 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 its local DJJ Circuit 8 DJJ JAC provider. The agency worked with its local JAC to create an initial referral form to receive official notification and referrals for DVR services. The goal was to address concerns regarding referrals being made to the CDS-NW shelter and to established and clarify the type of referrals that program is to receive. The agency required the JAC to provide referral that captured more information to determine eligibility for its CINS/FINS shelter settings.

The agency recently conducted an annual Medication Distribution Training. The agency conducted a Medication Distribution training that was conducted by a local RN that has been providing this training for several years at the CDS-NW residential shelter.

The agency conducts Peer File reviews to determine the accuracy and completion of its clients files. 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 results in identifying deficiencies, trends, patterns and completeness of files.

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.

The agency Stake holder Surveys are conducted on an annual basis by community stake holders.
Employee Satisfaction Surveys on an annual basis that is reviewed by the agency EMT and Leader
Client Satisfaction Surveys conducted when individual client

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 one (1) case that demonstrated the agency's ability to follow-up regarding on violations of agency work performance or code of conduct violations. The agency had one termination due to work performance issues in January 2014. The CDS agency conducts systematic documentation of Meeting Minutes, Quarterly Files Reviews, Annual Training Plan/Calendar Enhancement, Strategic Plans are all agency.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The non-residential Counseling Program provides non-residential services for youth and their families in primarily Columbia, Dixie, Hamilton, Lafayette and Suwanee Counties. The non-residential component consists of a one (1) Family Action Senior Residential/Non-Residential and one (1) Family Action Case Manager. The program's Direct Care initially handles calls for service from the public, as well as, calls through the crisis intervention and screening services. The screening determines eligibility and eligible youth and family are referred to the program to start the intake process. If the program is full at the time of referral the agency will make a referral for the family to another appropriate community agency, according to the youth's zip code. The program has the capability to offer both case management and substance abuse prevention education on an as needed basis. The agency coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plans for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court if needed.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were eight files reviewed, four residential files and four non-residential files. The agency has a detailed policy that follows and outlines indicator 2.01

The Informed Consent and Participation Agreement Participation Orientation Packet was comprehensive and contained the following information: rights and responsibilities of youth and parents/guardian, available service options, grievance procedure along with program rules and systems.

The Parent/Guardian Brochure was given to each family upon intake, this was documented on the orientation packet form. Parents are informed of potential actions within CINS/FINS services through the brochure as well.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were eight files were reviewed; four residential and four non-residential.

All Psychosocial Assessments were initiated or attempted within 72 hours of admission & completed within two face to face contacts in residential and non-residential files reviewed. All Psychosocial Assessments reviewed were completed after one face to face contact in all non-residential files reviewed and within two days of intake in all residential files reviewed. One youth was at risk for suicide and correct protocol was followed by having youth assessed by a crisis stabilization unit and then a full suicide assessment was completed by a licensed therapist at the facility. All Psychosocial Assessments were completed by a Bachelor's or Master's level staff; however, four of the eight files reviewed did not list the credentials of person completing report. Psychosocial Assessment also included a supervisor review signature upon completion on seven of the eight files reviewed.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy states the Individual Plan shall comply with requirements outlined in DJJ Quality Assurance Standards and the CINS/FINS Operations Manual.

There were eight files reviewed, four residential and four non-residential.

Each service plan was developed with the youth and family within one day following completion of the assessment. Each plan was developed based on recommendations from the assessment, the family, and the youth's input when available.

Service plans included; service type, frequency and location with two exceptions; two of eight files reviewed did not include a detailed frequency. Person responsible was included in all files reviewed, target dates for completion and actual completion dates were included in all service plans. Signatures of youth, parent/guardian, counselor and supervisor were included on all plans reviewed. Date the service plan was initiated was also included.

Two of the eight files reviewed were opened beyond thirty days and both files had documented service plan reviews within the specified time frame.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were eight files reviewed, four residential and four non-residential.

Each youth is assigned a counselor/case manager to ensure the service delivery of the case plan and provide referrals when needed.

Two of the eight files reviewed left the referral section blank due to one youth being in the shelter less than forty-eight hours and another youth successfully completing services. CDS states their referral source is limited

Counselor/Case Managers establish ongoing referral needs to youth/family, coordinate service plan implementation, provide support for families, monitor out of home placement, accompany youth to appointments when needed and provide case monitoring.

Case termination is provided with 180 day follow-ups.

More recent files have updated therapy progress notes.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were eight files reivewed, four residential and four non-residential.

CDS Policy and Procedure matches the Florida Network Standard

Youth and families receive counseling services congruent with youth's individual service plan. Shelter program provides individual/family counseling and holds group counseling sessions a minimum of five days each week.

Counseling Services offered reflect coordination between presenting problem upon intake, the psychosocial assessment, service plan, and case

plan reviews.

Case files are marked confidential and kept in a locked and secure office.

Chronological case notes on youth's progress are kept and CDS completes quarterly peer reviews on two to three open and two to three closed case files, as part of their on-going internal clinical review process.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Policy coincides with the CDS procedure for case staffing. CDS has had no youth/families referred for the case staffing process within the last year.

CDS has Family Action Counselors, who attend court hearings for Columbia and the surrounding counties to advocate for the case staffing process; however, this area also has a Truancy Intervention Program (TIP). CDS has found that judges are now court-ordering youth to complete TIP rather than complete a case staffing. CDS continues to educate the courts about the case staffing process and has a case staffing committee comprised of a DJJ representative, a CINS/FINS provider and a school representative in case this changes.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has procedures and practices to ensure youth records/information is kept in an organized manner. All Program files were marked “confidential” as required under the indicator 2.07 Youth Records. In addition, Program files requiring behavior, allergies, medication, runaway, medical, sexual and suicide issues were mark appropriately for Program staff. Furthermore, Program files were only accessible to Program staff in a secure room in the Program facility.

Overall the youth files were in order with the evidence provided during the QI Review for CDS-IYP Northwest (Lake City) during the time period in question.

It was recommended that all closed files be organized with cover sheets to seperate information in the same manner open files were organized, to make finding information in the closed files easier.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS IYP-NW youth shelter is located in Lake City, Florida in Columbia County. The facility operates twenty-four hours per day, seven days per week, every day of the year and is licensed by the Department of Children and families for twelve (12) beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of one (1) youth in the shelter. The shelter is comprised of a detached building that has separate split level design with female and male sides of the facility. Each residential side of the shelter can accommodate up to six (6) youth. The female and male sides of the facility are separated by a dayroom. The facility includes a kitchen, Direct Care Work station, dual function dining areas and multi-purpose room. Youth that are not in school spend a majority of their free time in the dayroom either engaged in planned life skills activities, playing video games, watching television or completing homework assignments on the computers. There is no onsite school. Youth attend local area schools if they are not on suspension, expulsion or suffering from an illness. There is a kitchen onsite where all meals are prepared. The program staff for the Residential staff includes two (2) Regional Coordinators, one (1) Senior Youth Care Worker, fifteen (15) Youth Care Workers and 1 administrative. A Senior Residential Counselor and three (3) Case Managers are also assigned to provide counseling and case management services to the residential program. The Direct Care Worker staff members are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision and general assistance. The shelter's direct care staff members are trained to provide the following services for the youth: screening, medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR) and referrals. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis. The medication and first aid supplies are stored in the staff office in a locked desk behind a locked door near the dining/office area. The Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The residential shelter also includes administrative offices for both Regional Coordinators, Counselors and Case Mangers and the administrative Assistant. Residential services, including individual, family, and group services, are provided to youth and families. Case management and substance abuse prevention education are also offered. The program also has an effective grievance process. When submitted grievances are responded to within twenty-four hours of being submitted to management.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The facility is a very well kept program that is licensed for twelve beds. The exterior is very well kept and the interior shows that the staff really take pride in there program. The lighting is very adequate and all bathrooms appear clean, odor free and working appropriately. The Daily Schedule is clearly posted and meets all Florida Network requirements for faith-based activities, reading, and large muscle exercise periods. All the common areas are clear of any hazardous items and the sleeping areas are free of graffiti. Youth have safe and lockable areas to place personal items if requested.The program has under went a Residential Group Care Inspection preformed by the Local Health Department conducted on 1-30-14 and passed it with a satisfaction. A Fire Safety Inspection was Conducted on 1-10-14 by the Local Fire Department which the program passed with a satisfactory. The Program had it's last Pest Control done on 12-26-13. It appears to this reviewer that the Administration and staff truly care about there facility and take pride in there environment.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has very clear and precise policy and procedures in place for passing along the Program information to the youth they serve. Each youth is given a handbook upon arrival to the program. Staff than goes over all the program rules and expectations with the youth. Six youth files were reviewed by this reviewer, one open chart and five closed charts. Of all the charts reviewed all Youth had all concractual required documentation within them. All the documentation was clear and easily found.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a clear and precise policy on Youth Room Assignments. Six youth files were reviewed and all files had clear documentation on all contractual requirements for Youth Room Assignments. Staff observed the history of violence in the youth, age,sex, disabilities, physical size, and alerts for substance, suicide or health issues. Alerts were added to the youth's files as needed and also to the youth status board located in the staff office.

Of the six youth files reviewed by this reviewer one of the youth was alerted as a suicide risk however the youth was assigned to a room according to the documentation and no alert notice was placed on the youth file.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This Agency has developed there own logbook system that captures all contractually required information in a easy to read system. The Program Supervisor reviews the logbook on a very regular bases and initials all pages at the bottom as well as making a logbook entry. The oncoming supervisor reviews and signs the logbook at the beginning of every shift and the Direct Care staff reviews and signs the logbook sometime throughout the shift. All entries are clear and mistakes are struck through appropriately.

Rating Narrative

The Agency has a very clear policy in place for the Behavior Management System. The Agency has a a policy on Behavior Intervention however after interviewing the Program Supervisor no restraints have been used within the program. The Agency uses a points system for there Behavior Management system and the youth earn points based on exhibiting certain behaviors throughout the day. As youth gain points they are given more responsibility around the Facility as well as more privileges. There are clear guidelines in place for all staff and youth to know the do's and don'ts of the Behavior Management System. The Behavior Management System is reviewed quarterly at staff meetings and recommendation for changes is presented and implemented.

There were five personnel training files reviewed and also an interview with the Administrative Assistant. In reviewing the files it was found that two files had clear documentation that staff were trained in the Behavior management system. However, the other three files it was told that the individuals had received that training during their new employee training and the training for the intake process. For best practices the Agency should adopt a procedure on the training and stick to it across the board.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Staff schedules were reviewed for the last six months and all contractual requirements were met according to staffing and supervisor. A one to six ratio was kept for all shifts. The Agency has a video surveillance system that records twenty to twenty-four days of camera recording time. Logbooks were reviewed and fifteen minute reviews are conducted during sleeping hours and documented accordingly.

Program Supervisor was interviewed as a result of reviewing the Staff schedule and reviewer noticing that there were some shift that had only one person on shift or two females on a shift. As per this standard there must be at least one staff per gender on each shift unless a credible effort is being made to correct this. Upon interviewing the Program Supervisor it was reported that the Agency has under gone a staff turnover in the last few months and also a low census count.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has clear and precise policies and procedures for handling the Special Populations that the network handles. The Agency does not handle Staff Secure youth in this program those youth are sent to there sister agency in Gainsville. The Agency is participating in the Domestic Violence Respite program that the Florida Network and DJJ offers. However the Agency has only served two youth under this program. Both youth files were reviewed and all required documentation is present with in the chart. After interviewing the Program Supervisor, she states that they have had some problems with adapting this program but they are working with there local Probation department to work out the kinks.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-NW program has specific procedures related to the admission, screening, interviewing, client inventory and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will conduct a full intake interview with the youth and parent/guardian. An initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the residents' health and mental health status, physical characteristics, maturity level, history including gang or criminal involvement, school performance, and family dynamics. Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Regional Coordinator and or Licensed Clinician are notified immediately if risks and alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. The agency has a Senior Residential Counselor that is a Licensed Mental Health Counselor (LMHC) and Family Action or Non-Residential/Case Manager that is a Registered Mental Health Counselor (RMHC). In addition, the agency's Chief Operation Officer (COO) is a Licensed Mental Health Counselor. All of the aformentioned staff members has state licenses that are authorized by the State of Florida, Department of Health, Division of Medical Quality Assurance still in effect. When a resident indicates positive for suicide risk they are placed on Constant Supervision or One-to-One Supervision. This information is documented in the daily log, on the alert board, and in the youth files using internal medical/mental health alert system. Youth admitted to the shelter with prescribed or over the counter medication the agency secures these medications at that time. The agency then conducts a verification of the medication by contact the pharmacy the originally filled the script. Medications are stored in a double locked cabinet, and topical and/or injectable medications are stored separately from oral medication. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques. As of the date of this onsite review, all fire safety equipment is up to date and functioning.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a policy, procedures and practices to ensure medical care for youth who are admitted with medical conditions are provided the proper care at the time of admissions. At the time of admission, each youth shall receive a preliminary physical health screening with CDS-IYP Northwest Intake/Assessment Form which includes: Current medications, Specific inquiry in symptoms of active tuberculosis, Physical health problems, Allergies, Report of recent injuries or illnesses, Presence of pain or other physical distress,and Physical markings with scars, piercing, tattoos.

The Program has an additional medical health assessment that inculded: Suicide Assessment, Psychosocial Assessment, Asthma, Cardiac Disorder, Diabetes, Head Trauma, Hemophilia, Petit mal seizure, Pregnancy, and Tuberculosis

Furthermore, when the assessments are completed the Program utilizes the "participant board", which allows staff to utilize the Programs Medical/Mental Health Alert Process codes and helps staff recognize any youth's medical or mental health problems based on the preliminary physical health screening with CDS-IYP Northwest Intake/Assessment Form.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed suicide prevention policy in place. All youth are screened for suicide risk using the Florida Network approved six

suicide risk questions. Youth whose screening indicates a risk of suicide are placed on one-to-one supervision or constant sight and sound supervision dictated by need, until a clinical assessment is completed by a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional. The shelter utilizes two different levels of suicide precautions, one-to-one supervision and constant sight and sound supervision. One-to-one supervision is the most intense level of supervision and is used while waiting for the removal of the youth from the program by law enforcement or parent/legal guardian for the purpose of Baker Act consideration if necessary, or until an assessment is done. One staff member, who is the same gender as the youth will remain within arm's length of the youth at all times. Constant sight and sound supervision is used for youth who are identified as being at high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed, and uninterrupted sight of the youth and be able to hear the youth at all times.

The shelter employs two staff, a supervisor and a counselor, who are Licensed Mental Health Counselors (LMHC). There were three youth files available for review for youth who had been placed on suicide precautions. Two of the three files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. The third youth was placed on suicide precautions after admission due to making comments of self harm. The shelter attempted to have the youth Baker Acted; however, law enforcement would not take the youth. All three youth remained on sight and sound supervision until assessed by a qualified professional. All youth were seen and accessed by a LMHC, using a suicide risk assessment, within twenty-four hours. All Youth were returned to normal supervision levels upon completion of the suicide risk assessment. All three files contained documentation the youth slept in the dayroom, within direct supervision of staff, during the overnight shift. All three youth had thirty minute observations documented the entire time they were on suicide precautions. All changes in supervision levels were documented in the youth's file.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy in place for Medication Provision, Storage, Access, Inventory, and Disposal. The policy addresses prescription medication, verification of medication, medication provision, supervision, and monitoring, medication distribution away from the shelter, medication errors and refusals, new prescriptions, medication storage, access to medication, inventory prcedures, medication counting procedures, discharge of youth with medication, and disposa. The policy addresses requirements outlined in the DJJ Health Services Manual. The shelter provided documentation of all staff who are trained to help youth in self-administering medication.

Observations of medication storage revealed medications are stored in a locked cabinet, inside a locked box, in a locked closet only staff have access to. Each medication is stored in individual zip lock bags with the youths name on the bag. A seperate box is used for all topical medications so they are stored seperatley from oral medications. At the time of the review, the shelter had no youth currently on any topical medications and only one youth receiving oral medications. There is a small refrigerator located in the staff office for any medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration. The shelter does not provide over-the-counter medications, unless the youth comes in with it and has a doctor's order, so they did not have a stock of over-the-counter medications.

The policy also requires that staff members must follow measures/steps to ensure that all medication entering the shelter originate from a licensed pharmacy. The policy addresses that all medications that enter the facility with a resident admitted to the program must be accompanied by a doctor’s prescription. Of the cases reviewed onsite, all cases had evidence that the medication entering the facility included documentation that the agency verification process was completed by a staff member. The Verification section on the MDL included the actual date that the verification was conducted, the time it was completed, the amount received, and the staff member that completed the process.

The shelter also keeps a supply of sharps in the locked cabinet, in a box. The supply includes fifteen pairs of scissors. There were no youth in the shelter at the time of the review who had razors. The sharps were inventoried weekly for the past six months and were also signed in and out when used.

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.

At the time of the review there was one youth in the shelter on medications, this youth's file, as well as, three additional closed files were reviewed to verify the medication administration process. The youth's Medication Record Log is maintained in the youth's individual file. All MRLs reviewed documented the youth's name, a picture of the youth, allergies, side effects, medication the youth was taking with doage and time to be given, method of administration, side effects/precautions, special procedures/instructions, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. All MRLs documented medications were given at the time specified or within the one hour time frame before or after the time specified. A perpetual inventory with running balances was maintained on each MRL, as well as, shift-to-shift inventories for controlled medications and weekly inventories for non-controlled medications.

Observations of medication storage revealed medications are stored in a locked cabinet, inside a locked box, in a locked closet only staff have access to. Each medication is stored in individual zip lock bags with the youths name on the bag. A seperate box is used for all topical medications so they are stored seperatley from oral medications. At the time of the review, the shelter had no youth currently on any topical medications and only one youth receiving oral medications. There is a small refrigerator located in the staff office for any medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration. The shelter does not provide over-the-counter medications, unless the youth comes in with it and has a doctor's order, so they did not have a stock of over-the-counter medications.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a policy in place regarding Medical/Mental Health Alert Process. Staff are made aware of the policy. In addition, Program staff receive training in the following areas: Signs and symptoms of mental illness, Substance abuse, Suicide risk assessment,and CPR/First Aid.

The Program has a Medical/Mental Health Alert Process and provides codes for such things as behavior, allergies, medication, runaway, medical, sexual and suicide issues. In addition, the Program provides an alert process codes for transportation and guardian as well. Also, the Program provides a “participant board”, which allows staff to utilize the Programs Medical/Mental Health Alert Process codes and helps staff recognize any youth’s medical or mental health problems.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a policy in place regarding Episodic/Emergency Care. Staff are aware of the policy. In addition, the Program’s policy outlines life threatening injuries and non-life threatening injuries and procedures to follow for each for Program staff. Furthermore, Program staff are trained on emergency medical procedures with practices such as CPR and First/Aid. Also, the Program conducts quarterly drills for staff such as: Bomb threats, Violent/Threatening Situation, Medical Emergency, Natural Disaster, and Utility Failure.

The Program supplied Knife for life and wire cutters as required within the indicator 4.05 Episodic/Emergency Care. First Aid Kits/Supplies were produce within the Shelter and Program Vehicle.