



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface NW

on 06/07/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%
 Percent of indicators rated Limited: 14.29%
 Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory: 96.30%
 Percent of indicators rated Limited: 3.70%
 Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Forefront LLC, Lead Reviewer and Consultant

Shawn Block, Anchorage Children's Home, Shelter Program Administrator

Jason Kasten, Arnette House, Direct Care Supervisor

Mike Marino, Department of Juvenile Justice, Regional Monitor

Persons Interviewed

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

Documents Reviewed

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 7 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 3 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 4 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

5 Youth 4 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

A new Regional Coordinator was assigned to the shelter in the last month.

The Residential Supervisor position at the shelter was vacant. There were plans in place to begin interviewing for the position very soon.

The agency is working on moving the environment of the shelter towards an environment more conducive of Trauma Informed Care.

The agency has created a “calm room” in the shelter to give youth a place to go to relax and calm down if needed.

Standard 1: Management Accountability

Overview

Narrative

CDS Family and Behavioral Health Services, Inc. – Interface Youth Program Northwest provides both residential and non-residential services. This program site is located at 1884 Southwest Grandview Street 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 Columbia, Dixie, Hamilton, Lafayette and Suwannee Counties. CDS-NW also operates other Residential and Non-Residential programs in Gainesville and Palatka, Florida respectively. All three (3) program locations report to the agency’s Chief Executive Officer and Chief Operations Officer that are located in the central office in Gainesville, Florida.

The CDS-NW in Lake City, Florida location is operated by a Regional Coordinator. 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 a Residential Supervisor. At the time of the on-site review this position was vacant. The shelter also employs eleven (11) Youth Care Workers, an Administrative Assistant, a Registered Nurse, and a Residential Counselor.

The agency also has Licensed Clinicians, Residential and Non-Residential counselors, Residential Direct Care and Non-Residential staff members.

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, the agency consolidates trainings to simultaneously train its staff on various training topics across all work sites and to create better camaraderie amongst staff members assigned to various youth shelter locations.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

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

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

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

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit on January 12, 2017.

Exception:

One five year re-screenings was completed seventeen days late.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has comprehensive policies and procedures related to providing an abuse free environment. These include Florida Abuse Reporting with a quick reference guide last reviewed in 2/2009, Standards of Conduct last reviewed in 8/2015, Rule Violations last reviewed in 1/2016, Complaint/Grievance for Participants or Companions with Disabilities last reviewed in 2/2017 and Behavioral Expectations for Staff last reviewed in 10/2010.

Together these policies and procedures clearly outline the professional conduct expected from the staff to ensure clients are treated with respect and dignity and prohibits the use of physical abuse, profanity, threats, and intimidation. The focus of the policies are also to provide a way to address concerns and create a positive environment.

The program has comprehensive policies and procedures related to providing an abuse free environment; these include Florida Abuse Reporting with a quick reference guide, Standards of Conduct, Rule Violations, Complaint/Grievance for Participants or Companions with Disabilities and Behavioral Expectations for Staff. Together these policies and procedures clearly outline the conduct expected from the staff to ensure clients are treated with respect and dignity and prohibits the use of physical abuse, profanity, threats, and intimidation.

The program has information regarding the Florida Hotline, as well as other reporting information, openly posted and easily seen both in the female and male day rooms.

The program has a tracking system for maintaining reports made to the abuse hotline in the Unusual Event Reports binder. During this review period, the information in the binder showed there was one report to the Florida Abuse Hotline by staff. This is documented on the Florida Abuse Hotline Fax Transmittal Form which also has the fax receipt attached.

The program has comprehensive policy and procedure regarding the grievance procedures through their policy Complaint/Grievance Process for Participants or Companions with Disabilities. This policy also states that complaints/grievances are to be addressed within 72 hours. The program has three Orientation Packets which it provides to its clients; one is for residential services, one is for non-residential services, and there is a parent packet. These packets provide the requirements for reporting abuse and neglect as well as the complaint/grievance procedure. Also included in the packet is a copy of the complaint and grievance form.

The program has a simple and easy to follow complaint/grievance form which allows the client to describe their concern in writing and what they want to see happen to resolve their concern. The form also shows the chain of command and the review process. These forms are located in all three of the day rooms in the program. In the main day room there is a locked box in which grievances are placed. This box is accessible by the counselor or supervisor.

The program has a tracking system for complaints/grievances. The tracking log for the review period only had one complaint/grievance; it was completed by the youth on 4/30/2017, followed up by the Resident Supervisor on 5/1/2017 and resolved with the youth on 5/1/2017. The complaint/grievance form also shows it was reviewed by the Site Supervisor on 5/1/2017.

Three youth were interviewed regarding the complaint/grievance process. All three youth reported a clear understanding of the grievance process; they knew where the forms were located and that they could give the forms to the counselor or supervisor or place the form in the locked box. They also reported they could take the form to direct care staff and have them give it to the counselor or supervisor. The three youth interviewed reported no concerns regarding abuse or neglect. They also reported being treated with respect; no issues of staff talking inappropriate or using inappropriate language towards them or any other youth in the program. The youth interviewed reported no concerns.

Three staff were interviewed regarding the abuse reporting process; all three staff were able to communicate familiarity with the agency's policy and procedure. All three staff were able to communicate the process for a client to file a grievance. All three indicated that a client could put the form in the lock box or give it to the counselor or supervisor. All three staff indicated that they would direct the youth to put the form in the box or give directly to the counselor or supervisor. All three staff interviewed reported no concerns regarding how staff interacted and spoke with the youth; no inappropriate language, intimidation, or use of threats.

Records show that staff were trained in abuse reporting requirements.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has two policies related to this area; Incident Reporting Procedure last reviewed in 9/2016 and Unusual Event-Internal last reviewed in 3/2008.

The focus of the policies are to ensure that unusual incidents/events are reported as required not only internally but to the Abuse Hotline and the Central Communications Center (CCC) as well as to ensure consistency in reporting.

A review of the Central Communication Center reports showed one report for the review period. The documentation for this report shows it was reported to the CCC outside the two hour requirement. In this situation a youth had broken their leg due to a fall and the youth was taken for treatment; however, the event happened at around 6:55pm and the CCC was not contacted until 10:32pm. The CCC identified this as a failure to report.

Based on the review of the documentation, the program staff called the parents around 5:30 pm regarding the need for the youth to be assessed after the youth continued to complain about the leg hurting. At around 6:55pm the parents transported the youth for medical care. In this case the parents did the transport and the youth was not admitted nor spent the night at the hospital. When the parents returned with the youth to the program at around 10:15pm they informed the program staff that the youth was diagnosed with a broken leg. The staff then called the CCC at around 10:32pm.

The log book had documentation of the youth being picked up by the parents at around 7:25pm and being returned to the program around 10:15pm with a diagnosis of a broken leg.

The incident was documented by the program on the Incident Report-Central Communication Center form as well as on the Unusual Event Report form. The Incident Report-Central Communication Center form does not have a place requiring a program supervisor's or director's signature. The Unusual Event Report form was signed by program supervisor. The Incident Report-Central Communication Center form stated the youth's leg was broken; which was only generated after the youth returned from the hospital with the parents. However, there was no addendum to the initial report, Unusual Event Report form, stating youth was taken by parents to the hospital and was diagnosed with a broken leg.

The program responded to the CCC's follow up questions by e-mail on 5/26/2017, 6/2/2017, and 6/7/2017.

The program also conducted a retraining on the DJJ policy 63F-11 regarding CCC reporting criteria with their staff on 5/30/2017.

Exception:

Based on the CCC assessment of the incident, the report was outside the two hour reporting requirement

and therefor was identified as a failure to report.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Training Plan in place that is effective from July 1, 2016 – June 30, 2017.

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

There were no staff training files applicable for review for the new requirement of training completed during the first 120 days of employment.

There were three staff training files reviewed for training requirements during the first year of employment. All three staff met the 80-hour requirement with 113.75 hours, 80.5 hours, and 90 hours of training during the first year. However, all three staff were missing numerous required training topics. The three staff were missing between five and seven different trainings required during the first year.

There were four staff training files reviewed for in-service training requirements. All four staff documented all required trainings were completed; however, only one staff documented the full 40 hours of training for the year, with 60.5 hours. The other three staff did not reach the 40-hour minimum requirement, they documented 36, 28.5, and 27.5 hours of training for the year.

Exceptions:

All three training files reviewed did not document all required trainings were completed, with each staff missing between five and seven different trainings.

Three of the four staff training files reviewed for in-service training requirements did not document the required 40 hours of training for the year.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy for this area; Quality Assurance Program which was last reviewed in 8/2015.

The focus of the policy is to collect and analyze data from the program for the purpose of quality improvement.

The program collects and reviews data from several different sources of information to identify patterns and trends. The program reviews a monthly report, which also becomes a yearly cumulative report, as it builds throughout the year which is called the CDS Performance and Risk Management Report. This allows staff not to only look at the monthly trends but how the data compares to prior months. According to agency staff, there were no report ran in January and February; the most recent CDS Performance and Risk Management Report was for March. However, the program has a CINS/FINS Performance Report for April. The April report is cumulative for the review period up to April. The data for May is not yet available

for review.

There are no incident summary reports for January and February; however CDS Performance and Risk Management Report for March and April's CINS/FINS Performance Report provides that information. The April report is cumulative for the review period up to April. The Data for May is not yet available for review.

The program holds monthly meetings with staff; this is documented in the Staff Meeting binder and includes minutes and a sign-in sheet. Based on the meeting notes there was a meeting for all months of the review period through May except for March. According to the documentation, areas of need and strength are reviewed with a focus on the quality improvement and risk management.

According to program staff, the program does not have a report of the customer satisfaction data in order to review.

Peer case reviews were completed in January on four case files for the first quarter covering January through March. In May there were a total twelve peer reviews completed for the second quarter covering April through June. The program changed to a more comprehensive review form starting in the second quarter. They also significantly increased the number of cases being reviewed.

Exceptions:

The most recent CDS Performance and Risk Management Report is only through March; no report was ran in January and February.

The program does not have a report of the customer satisfaction data in order to review.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy regarding client transportation, Vehicles Use and Safety Inspection, which was last reviewed in 12/2015.

The focus of the policy as it relates to client transportation is to ensure best practice when transporting clients to prevent situations of alleged impropriety.

The program has a comprehensive policy which has language that reflects the Florida Network's policy on client transportation. There is language in the policy that states it is "best practice" to have a third party present in the vehicle while transporting a client. The policy provides for exceptions in situations when there is not a third party available for transporting. The policy also states that a third party may be an approved volunteer, intern, agency staff, or other participant.

The program only uses staff to transport clients who have a valid Florida driver's license; all transporting staff are covered by the program's insurance.

The program has two forms used for transportation of clients: Travel Log/Van form and Transportation Exceptions Approval Log (Single/Third Party) form. The program uses the Transportation Exceptions Approval Log (Single/Third Party) form to approve single client transports; this form is signed by the supervisor approving the transports. At the top of the approval form there is language reflecting the agency's policy. The program's form allows the supervisor to approve specific clients and specific staff for single client transports for up to seven days. The program has a binder in which it keeps all the approved single client transport forms. All the forms completed for the review period were signed and dated by the supervisor.

A random review of ten single transports showed all were approved by a supervisor except one.

The program's Travel Log/Van form includes the date, destination/purpose, departure time, number of clients, start mileage, return time, ending mileage, 2nd adult passenger (when present) and driver's signature. A review of the logs for the review period was completed. The logs are being completed as required and were up-to-date.

Exception:

A random review of ten single client transports showed there was one not approved by a supervisor.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program has two policies related to outreach: Roles and Responsibilities - Prevention Outreach and Outreach Plan for Targeting Youth for Program Services. Both policies were last reviewed in 9/2015.

The focus of the policies is to target outreach to youth and areas of the community identified with risk factors; this includes youth who are more likely or at risk of running away, being habitually truant, become adjudicated delinquent and high crime zip codes. The policies also focus on educating the community on the needs of these youth and connecting the youth and their families with services.

The program has a binder in which they keep the meeting agendas from Circuit 13 Juvenile Justice Advisory Board Meetings. Based on the documentation in the binder, the program attended both quarterly meetings during the review period, one in January and another in April.

The program also keeps a log of all their outreach activities using an outreach form. The review of the documentation for this review period showed the agency had 26 outreach events. This included meeting with other community agencies, schools, and attending community meetings.

The agency has a Cooperative Service Agreement dated 1/27/2016, which list 59 other community agencies.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The program provides counseling and case management services via their Interface Residential Program as well as the Family Action Non-Residential Program. Residential services are being provided by one (1) Counselor. Non-residential services are being provided by three (3) Counselor/Case Managers, one whom is a Licensed Mental Health Clinician (LMHC). The non-residential counselors provide services in the family's home, at a local community space, or in the counselor's office. All clinical staff and supervisors' interactions demonstrated a solid understanding of program expectations and are conscientious about service delivery and meeting contractual standards.

The agency also leads and coordinates the local Case Staffing Committee, a statutorily-mandated committee that develops 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

Policies 1112 and 1151 address screening and intake. The purpose of the policy is to ensure youth and families have access to services 24 hours a day, seven days a week, as well as to ensure youth are properly screened upon admission and provided with all necessary program information during intake. A cover sheet for the policy and procedure manual documented a review and approval of all policies and procedures on January 20, 2016.

The program has a 1-800 number for youth and families to call at any time (24/7) if in need of services. The procedure also identifies services are available 24/7 through Safe Place. Youth are to be screened to determine eligibility as well as for health and mental health issues upon admission to ensure any critical issues are addressed immediately. The program provides youth with a participant handbook and parents/guardian with a parent brochure and orientation packet; each of which provides information regarding services available, rights and responsibilities of youth and parents/guardians, possible actions that could occur through involvement in CINS/FINS services, and grievance procedures.

Four non-residential files (two open, two closed) and four residential files (two open, two closed) were reviewed. Initial screenings were completed upon intake in each file to determine youth eligibility well within seven days of the initial referral. Each file documented youth were provided with a participant agreement and packet. The participant agreement and packet included all required intake and orientation information, to include rights and responsibilities of the youth and parent/guardian and the grievance procedure. The review of the participant agreement, to include orientation information, was acknowledged by youth signature.

Seven of the eight files documented the parent/guardian was provided with a parent brochure and orientation packet. The receipt of the brochure and review of the orientation packet with the parent/guardian was acknowledged by signature in the seven files. In the remaining file, the progress note indicated the parent/guardian brought the youth to the shelter, but acknowledgement forms for receipt of the parent brochure or review of the orientation packet were not in the file.

Exception:

In one of the eight files reviewed, there was no documentation of the parent/guardian being provided the orientation information. The signature forms for the parent/guardian for informed consent and brochure were not in the file.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

Policies 1019 and 1151 address the completion of needs assessments. The stated purpose of the policy is to ensure each youth is properly assessed in order to identify services needed. A cover sheet for the policy and procedure manual documented a review and approval of all policies and procedures on January 20, 2016.

The procedure requires needs assessments be completed within 72 hours of admission for shelter youth and by the third face-to-face contact with the youth and family for non-residential youth. Needs assessments are to be completed by bachelor's or master's level staff and reviewed by a supervisor. Assessments of suicide risk, if needed, are to be reviewed or completed by a licensed mental health professional. The procedure details all elements to be addressed and included in the needs assessment.

A review of four non-residential files (two open, two closed) found needs assessments were completed on the date of admission in each case. A review of four residential files (two open, two closed) found needs assessments were completed within 72 hours, with most being completed on the date of admission. Needs assessments were reviewed and signed by a supervisor in seven of the eight files reviewed. In the remaining case, the supervisor reviewed and signed the NETMIS needs assessment, but not the CDS Interface needs assessment.

The needs assessments addressed all areas required by program procedure. Three of the eight were identified with an elevated risk of suicide during the needs assessment. Each youth was placed on precautionary observation pending the completion of an assessment of suicide risk. Each assessment of suicide risk was completed or reviewed by a licensed mental health professional on the same day the risk was identified.

Exception:

In one of the eight files reviewed, the CDS Interface needs assessment was not signed by the supervisor. The NETMIS needs assessment was signed by the supervisor.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Policy 1162 addresses individual service plans. The stated purpose of the policy is to ensure each youth is provided with an individualized service plan to best address his/her needs. A cover sheet for the policy and procedure manual documented a review and approval of all policies and procedures on January 20, 2016.

The procedure requires individual plans be developed within seven days of completion of the needs assessment. The procedure describes, in detail, all elements to be reflected in individual plans, to include type, frequency, and location of services; persons responsible for objectives within the plan; and target dates for completion. The procedure also requires completion dates for objectives to be documented and that individual plans to be signed by youth and parents/guardians. The procedure also requires the individual plans be reviewed every 30 days with the youth and parent/guardian during the first three months of services and then every six months thereafter.

Four non-residential files (two open, two closed) were reviewed. An individual plan was developed after the completion of the needs assessment and on the date of admission in each case. Four residential files (two open, two closed) were reviewed. An individual plan was developed within seven days of completion of the needs assessment in all four cases. All eight individual plans included objectives to address needs identified in the needs assessment. Page one of the plans had standard service provisions (i.e. individual counseling, family counseling, case management). The objectives did not always reflect these services,

though the objectives were appropriate. Each objective included target dates for completion and persons responsible for completion of the objective. Target dates were modified if needed and completion dates were documented when objectives were completed. Each plan was signed by the youth, parent/guardian, counselor, and supervisor. For youth receiving services for longer than 30 days, reviews of the plan with the youth and parent/guardian were documented within every 30 days.

Exception:

Case plans had standard service provisions (i.e. individual counseling, family counseling, case management) on page one. Subsequent objectives did not always reflect these services, though the objectives were appropriate.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Policy 1163 addresses case management and service delivery. The stated purpose of the policy is to ensure staff make appropriate referrals for services and ensure service delivery. A cover sheet for the policy and procedure manual documented a review and approval of all policies and procedures on January 20, 2016.

The procedure reflects the requirements of the indicator, outlining how staff must ensure services delivery and follow-up with families after release from the program.

Four non-residential files (two open, two closed) and four residential files (two open, two closed) were reviewed. Four youth were applicable for referrals to outside agencies for services, which was reflected in all four cases. Documentation on individual plans and progress notes documented coordination of services and monitoring of youth and family progress. Support for families in each case was evident in the progress notes as well. In the four closed files, documentation showed the programs followed up with the family within 30 days of release and again within 60 days of release.

No exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Policies 1163, 1199, and 1046 address counseling services. The stated purpose of the policy is to ensure each youth is provided counseling based on identified need. A cover sheet for the policy and procedure manual documented a review and approval of all policies and procedures on January 20, 2016.

Program procedures address the indicator requirements. The procedure details all counseling services to be provided, to include individual and family counseling for all youth and group counseling five days a week to youth in the shelter. Services are to be provided in accordance with the individual plan and documented in the progress notes. Internal reviews are to be completed monthly to ensure counseling services are provided as required.

Four non-residential files (two open, two closed) and four residential files (two open, two closed) were reviewed. Counseling services and other services were provided in accordance with objectives listed in case plans, though page one of each case plan included standard service provisions, to include the frequency of services, such as weekly individual counseling and monthly family sessions. The actual services provided did not always reflect the frequency of services for individual and family counseling listed on page one of the service plan. Group counseling was documented five days a week for youth in the shelter.

A review of the supervision binder found reviews were completed in four of the past six months, with reviews completed in December 2016, and January, March, and May of 2017. The review in March addressed program standards, but did not indicate any files were reviewed. The program's policy is for monthly reviews to be completed.

Exception:

Services were provided in accordance with objectives listed in case plans; though page one of each case plan included standard service provisions, to include the frequency of services, such as weekly individual counseling and monthly family sessions. The actual services provided did not always reflect the frequency of services listed on page one of the service plan.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

Policies 1160, 1157, and 1159 address case staffing committee meetings. The stated purpose of the policy is to ensure a case staffing committee is appropriately convened if a youth and/or family is determined to be in need of services and a staffing is needed to ensure services. A cover sheet for the policy and procedure manual documented a review and approval of all policies and procedures on January 20, 2016.

The procedures detail when a case staffing committee meeting is required, what participants must be included, and other participants who may be included. The procedure outlines time frames for scheduling and notifications to be completed prior to and following the completion of a case staffing committee meeting.

The program has not had any youth require a case staffing committee meeting during the review period.

No exceptions noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Policy 1046 addresses maintenance of youth files. The stated purpose of the policy is to ensure files are maintained in an orderly manner and to ensure the confidentiality of youth files. A cover sheet for the policy and procedure manual documented a review and approval of all policies and procedures on January 20, 2016.

The procedure reflects the indicator, requiring files be marked confidential and kept in a secure room or locked file cabinet. When moved outside the facility, files are to be transported in an opaque container that is marked "Confidential."

All eight files reviewed were marked confidential and maintained in an orderly manner. Files were secured in offices within secured file cabinets. The program has three black briefcases marked "Confidential", which are used when having to transport files outside the facility.

No exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS-NW youth shelter is located in Lake City, Florida in Columbia County. The facility operates twenty-four hours per day, seven days per week and is licensed by the Department of Children and families for twelve (12) beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of nine (9) youth in the shelter. The shelter is comprised of a detached single building that has separate split floor plan design with female and male sides of the facility.

CDS-NW staff members are primarily responsible for completing all screening, intake and paperwork. These staff members are also responsible for orientation and providing necessary supervision and general assistance. The shelter's direct care staff members are trained to provide the following services including the youth screenings; medication administration; health, mental health and substance abuse screenings; first aid; cardio pulmonary resuscitation (CPR); and case specific 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 Regional Coordinators, Counselors and Case Managers, and the Administrative Specialist.

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 reported, they are generally addressed within seventy-two hours of being submitted to management.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (P-1122 and P-1137) that addresses the elements of Indicator 3.01. The shelter facility is located at 1884 SW Grandview Street, Lake City, FL. 32055. The shelter facility is licensed by DCF through March 31st, 2018.

At the time of the review all health and fire safety inspections were recent and up-to-date with no violations found. A fire safety inspection was completed on 1-4-17, all fire extinguishers were inspected and serviced on 2-28-17, the Health Department inspection was completed on 1-5-17, the kitchen fire suppression system was serviced on 2-22-17, and a heat and air service/tune up was completed on 12/5/16. The program conducts a minimum of one fire drill per month on each shift and logs the time and number of participants on a calendar kept in a binder. All fire drills are further documented by a fire drill checklist which indicates whether emergency lights and fire horn are working properly, pull stations are functional, and the building is vacant. The agency has an emergency disaster plan that is updated annually. The program conducts one mock disaster drill per shift each month and maintains logs in a separate binder. All mock drills were completed for the review period.

Current DCF license, audio/video recording sign, point of contact for deaf or hard-of-hearing/limited English proficiency, safe place sign, abuse hotline number, daily schedule, menu, exit signs, and escape routes were all posted and visible at time of review.

During the tour, the shelter appeared clean and well maintained. The shelter was free of any graffiti except for underneath the top bunks in the female's rooms. All furnishings appeared to be in good condition. Bedrooms, bathrooms, and t.v. rooms are all separated by male/female use. Youth share the kitchen, dining room, and a large common room. Each youth are assigned their own individual bed with clean

covered mattress, pillow, and sufficient linens and blanket. Youth have access to a safe lockable space to keep valuables when requested. Non-valuables are kept in the contraband closet and valuables such as money or cell phones can be locked in a box in the nurse's office. The knife for life is also located in the nurse's office which is centrally located in the facility.

The kitchen and pantry area were clean and well organized. Weekly menus were posted and signed by a registered dietitian.

The shelter maintains a posted weekly schedule which includes dedicated time slots for academics, faith-based activities, recreation, social skills, outdoor LMM, and quiet time for reading. The shelter maintains a stocked book shelf with age appropriate books for the youth. Staff indicated that youth typically participate in basketball, volleyball, and throwing the football around when outside on property and that they also go to the local park for recreation activities as well. The shelter has a faith-based activities policy (P-1137) that addresses youth having access to faith-based activities but is non-punitive for those youths who choose not to.

During inspection of the grounds large amounts of standing water was visible on both the side, and rear of the buildings. Heavy rains have been in the area but suggestion provided is to consider finding a drainage solution to address the problem and prevent any potential safety issues. The parking area appeared to have only one non-functioning light pole towards the rear of the building which did not contain a light bulb or housing cover. The shelter basketball hoop is also broken at this time and in need of replacing.

The shelter has one van which was locked at time of review. The van contained a first aid kit, emergency kit, window breaker, and up-to-date fire extinguisher.

Exceptions:

Sink in female bathroom is loose and detaching from the wall.

Shower in hallway bathroom appears to have mold or dark spots on the grout.

Outside parking lot light is missing the bulb and housing.

A/C cutoff box cover is detached on one side.

Small section of roof overhang is sagging.

The program director provided a detailed work estimate from 2/28/17 for planned repairs and upgrades. The estimate did not list any of the items found during the review; however, the program director stated those items were discussed with the repair company.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (P-1114) that addresses all the key requirements of Indicator 3.02. The policy was last revised in 7/14.

The facility has a written policy (P-1114) indicating program orientation will begin at time of intake and will be completed within 24 hours. Initial orientation includes staff following a comprehensive orientation checklist covering the key areas of expectations, program rules and behavior management strategies. At time of intake, youth are also given a tour of the facility, introduced to key staff, and given a client handbook. The client handbook contains information regarding client rights, program rules, visitation and telephone policies, available services, dress code, grievance procedures, and accessing the Florida Abuse Hotline. The client files contain a signature page acknowledging receipt of an orientation packet.

During the review, four open files were reviewed and found to contain all the indicators of Indicator 3.02 and policy (P-1114). All reviewed files contained a signed copy of the client orientation checklist as well as a signed acknowledgment form for receipt of an orientation packet.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (P-1116) that addresses all the key requirements of Indicator 3.03. The policy was last revised in 10/07.

The agency uses a variety of screening tools and in-person interviewing at time of admission to determine the most appropriate sleeping arrangements for the youth and to increase staff awareness of classification issues. Consideration is given to age, physical stature, disabilities, maturity level, level of aggression (past and present), predatory behaviors, criminal history, and susceptibility of victimization. Youth are also assessed for gang participation and suicide risk.

During a review of four youth files, staff interviews, and observations revealed that all of the aforementioned factors are considered when youth are assigned to a room. In the facility, there is only one large room for males and one for females. However, program staff were able to identify how the youth are assigned to specific beds based on the factors listed above.

Two out of the four open files reviewed indicated an initial alert for suicide ideations or recent history of suicide ideations. At time of screening, both youth were placed on close supervision until cleared by the facility licensed mental health professional and assigned a bed when approved.

There were no exceptions noted for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (P-1149) that addresses all the key requirements of Indicator 3.04. The policy was last revised in 2/08.

The agency has a procedure and process in place designed to target all requirements of Indicator 3.04. The log book is designed with separate sections for chronological events information, shift leader summary, residential counts, and assigned staff members. Pertinent information including med passes, visitations, incidents, or safety and security issues are documented during the shift and in the "pass on information" section. The agency's policy calls for recording errors to be struck-through with a single line, "void", and date, time, and signature which mimics the Indicator.

Log books were reviewed dating back to January 2017 for this review period. During the review, two occasions of recorded strike-throughs were found to have a single line strike-through but were not dated, signed or time stamped by the staff. Residential facility supervisor entries were consistent throughout the log books indicating that information was reviewed and notes were taken regarding needed follow-up. Staff entries indicating review of the previous two shifts was inconsistent. Highlighting throughout the book was inconsistent and made navigation of the book difficult.

Exceptions:

Recorded strike-throughs were not dated, signed, or time stamped.

There were inconsistent entries indicating oncoming staff had reviewed the two previous shift notes.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures (P-1123, P-1125, P-1126, P-1127, P-1128, P-1105, P-1222) that addresses all the key indicators of standard 3.05. The policies were last revised in 1/16, 1/16, 1/10, 9/7, 1/16, 1/12.

The agency has multiple policies and procedures addressing the proper use of the "FACE" BMS system. "FACE" (facilitating activity and communication effectively) is a comprehensive point and level program designed to encourage positive youth behaviors and staff interactions. The agency also has multiple staff policies outlining proper implementation of the BMS system including a "Do and Do NOT" sheet of appropriate and inappropriate ways to interact with the youth and how to better deescalate situations. The BMS system is designed to promote order, safety, security, respect, fairness, and protection of resident's rights; while providing positive reinforcements, recognition, constructive dialogue, and a peaceful resolution.

The "FACE" BMS system is introduced to the youth at time of intake and outlined in the client handbook. Clients have the ability to earn and even negotiate points by displaying appropriate behaviors and participation. Points may be exchanged in the agency's store (in the process of upgrading) or used for privileges. Points are maintained on the client's point sheet and monitored by the program director to ensure proper use of the BMS. The program director indicated she discusses the BMS during staff meetings or individually with staff if necessary.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures (P-1121, P-1132, P-1133) that addresses all the key requirements of Indicator 3.06. The policies were last revised in 4/13, 9/16, and 6/10.

Policy P-1121 requires a minimum ratio of one staff to every six clients during awake hours, one staff to every twelve clients during overnight, and one male/one female staff on all shifts. The agency has a protocol in place ensuring coverage when a staff member is unable to report to work. Overnight staff are required to do gender specific bed checks every 15 minutes with verification by way of a bar code scanning system.

The program director is responsible for developing a schedule ensuring staffing requirements are met for all shifts. Staff schedules are posted in a place visible to all staff members.

A review of staff work schedules revealed the agency consistently maintains appropriate staffing ratios. There was consistently one female and one male staff on all shifts.

The agency uses a bar code scanning system to verify overnight bed checks but the program director indicated that they are having continuous issues with the scanner not functioning properly. Video review of the overnight shift on 4-27-17 (11:00pm to 1:30am) showed that no male bed checks were completed from 12:34am to 1:29am. There was no documentation in the log book stating that bed checks were completed or a reason why they were not completed. The program director indicated they are looking for alternative solutions to the scanning system to better ensure bed checks are completed as per the policy.

Exception:

No male bed checks were completed on 4-27-17 from 12:34am to 1:29am. No entries made to the log book to indicate why bed checks were not completed.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures (P-1249, P-1267, P-1248, P-1279) that addresses all the key elements of Indicator 3.07. The policies were all last revised in 1/16.

Staff secure policies and procedures outline in-depth orientation, enhanced supervision, parental involvement, and collaborative aftercare. Domestic violence respite beds are provided as an alternative to placement in the detention center for those youth who qualify and have an appropriate referral from DJJ. The domestic violence respite policy outlines the referral process, transportation requirements, service requirements, and data management. Youth entering under the DV program may stay up to 21 days before being required to transition over to CINS/FINS or probation respite placement.

For the review period there was only one domestic violence respite youth admitted to the program. The youth's file contained evidence of pending domestic violence charges and a referral from the JAC/Detention center. Case plans were in place to begin intervention services designed to reduce reoccurrence of violence but the youth did not stay for the full allotted time. The youth was discharged to alternative therapeutic placement on his 8th day.

There were no other special population clients for the review period.

There were no exceptions noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy for their video surveillance system, Video Surveillance System, which was last reviewed in 9/2016.

The focus of the policy is to ensure the safety of the youth, staff, and visitors. The policy also focuses on ensuring camera footage review by a supervisor at least every 14 days as well as ensuring the safe storage of camera footage for at least 30 days.

The program has a policy for their video surveillance system which reflects the language in the Florida Network Policy. The policy includes language which covers request for video recordings for program quality improvement visits and for investigations of allegations of an incident.

The program has nine cameras located throughout the shelter (all are easily visible). There is a camera outside at the front entrance, one in the kitchen, dining room, one in each of the three day rooms, one in the hallway, one in the staff office, and one in the "conference room", which is currently not working due to the current weather, however, this not a location in the facility that clients frequent. The supervisor reported notifying the required agency staff regarding the issue. There are no cameras located in the bedrooms or bathrooms.

Based on this writer's observation of the computer screen of the camera system, the system is recording correct date and time frame and is able to capture images which would allow for facial recognition. From the position of the cameras, it is easy to determine the location of the footage. The program's camera footage is being recorded and can store footage for 40 to 45 days and will continue to record even during a power outage according to the supervisor. The computer system which does the recording is locked in a closet in a locked room. Only the supervisor has access to review camera footage at the program.

In the front lobby there is a written notice in red lettering informing individuals entering the building that

video recording is taking place.

There is only one camera outside which is located at the front entrance. This camera does not cover the parking lot or the outside activity area where the youth in the program frequent. According to the supervisor they are applying for a grant to upgrade and add cameras to their camera system.

Supervisor review of the camera footage was consistently completed for the review period; however, there were three times during the review period that the time between the reviews exceeded the 14 day requirement. One was 4 days late, one was 7 day late and one was 13 days late. As of 6/5/2017, the reviews are on track with the 14 day requirement. The program does not use a review tool so there is no specific detailed documentation related to the reviews. The supervisor places a general note in the log book that states a review was conducted; some of the notes include a time frame. If a time frame is noted it normally was the "past 48 hours".

Exception:

There were three times during the review period that the time between the reviews exceeded the 14 day requirement. One was 4 days late, one was 7 day late and one was 13 days late. As of 6/5/2017, the reviews are on track with the 14 day requirement. The program does not use a review tool so there is no specific detailed documentation related to the reviews.

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 if available. Staff on duty at the time of admission immediately identifies youth that 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 Coordinators and/or Licensed Clinicians are notified immediately if risks and alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. The shelter has one (1) Counselor that is a Licensed Mental Health Clinician (LMHC).

The agency operates a detailed medication distribution system using the Pyxis Med-Station 4000 Medication Cabinet. The program has a Registered Nurse (RN) on-site seven days a week. The shelter has a list of staff members that are authorized to distribute medication. The facility is equipped with multiple first aid kits, knife for life and wire cutters. The staff are trained to provide CPR and First Aid services in case of an emergency. Staff members are also trained on fire safety techniques and various emergencies. As of the date of this onsite review, all fire safety equipment are up-to-date and functioning as required.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

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

The policies state each youth will be provided a preliminary physical health screening and staff will also complete the Intake/Assessment Form. Information obtained from the youth's initial screening is recorded on the Intake/Assessment form and the staff person completing the form will note on page 6 if there are any areas of concern or needed follow-up and will initiate the Medical/Mental Health Alert System.

The youth and parent/guardian will also be interviewed upon admission about the youth's current medications. This is part of the Medical and Mental Health Assessment Screening process. This process is conducted by a Registered Nurse (RN) if one is on-site. Otherwise, this interview will be conducted by on-duty staff and reviewed by the RN within five business days. The Supervisor/Shift Leader on duty will review the youth's intake packet to assess the need of any immediate action.

A total of five files, four open and one closed, were reviewed to assess requirements of this indicator. Of the five files reviewed, all contained the Intake/Assessment form with all health screening sections completed. Four of the five files reviewed documented the youth were on medications. The medications were listed, as well as, the reasons for the medications. Three of the files documented the youth had some type of allergies. The RN documented detailed intake notes in all five files reviewed regarding the youth's medical history and interview with the parent/guardian. The Intake/Assessment form was reviewed by the RN the same day of completion in all five files.

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

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

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

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

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

There were three youth files reviewed for youth who had been placed on suicide precautions, two open and one closed. In two of the three files the youth were admitted to the shelter straight from a Baker Act facility. Both youth were seen immediately by the Residential Counselor who completed an Assessment of Suicide Risk (ASR). The youth were placed on normal supervision levels upon completion of the assessment. Both ASR's documented consultation with the Licensed Mental Health Counselor (LMHC) prior to placing the youth on normal supervision.

The third file documented the youth was placed on suicide precautions at intake due to issues identified during the screening process. The youth remained on sight and sound supervision until assessed by a qualified professional. The youth was seen and accessed by the LMHC, using the ASR, within twenty-four hours. The youth was placed on normal supervision levels upon completion of the ASR. The youth had thirty minute observations documented the entire time on suicide precautions. All suicide precaution events were documented in the logbook.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

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

The policy has detailed procedures for Prescription Medication, Verification of Medication, Medication Provision, Supervision, and Monitoring, Utilization of the Pyxis Med-Station 4000, Proper Storage of

Medication, Medication Inventory, Medication Counting Procedures, Medication Errors and Refusals, Discharge of Youth with Medication, and Disposal.

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

The shelter has a Registered Nurse (RN) who has been employed by the agency since October 2015. The RN is on-site seven days a week, from approximately 7am - 10am each morning and then again from approximately 7:15pm – 8:15pm each night. The RN distributes all morning and evening medications. The only medications direct care staff distribute are afternoon medications, if there are any. Due to this there have been very few discrepancies in the last year, approximately two to three for the year.

The RN does not have a specific training that is completed with staff on using the Pyxis Med-Station. It was reported training will occur as needed and is usually on-the-job training if the staff needs a re-fresher on how to use the machine. The RN does conduct training with new hires on using the Pyxis Med-Station.

All youth medication is stored in the Pyxis Med-Station. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. Only the youth’s prescription medication is stored in the Pyxis Med-Station. Medication storage will start in drawer one and once that drawer is full will continue into drawer two and so on. The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review.

All medications in the shelter are inventoried once per week, every Monday, by the RN. All medications are also inventoried at admission, when given, by maintaining a perpetual inventory with running balances, and at discharge. Controlled medications are inventoried shift-to-shift also. The shelter does not have any over-the-counter medications.

There were four youth files reviewed for verification of medication administration. All medications are verified by the RN. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Pyxis Med-Station. The youth's Medication Record Log (MRL) is maintained in the youth's individual file. All MRLs reviewed documented the youth's name, a picture of the youth, allergies, medication the youth was taking with dosage and time to be given, method of administration, side effects/precautions, special procedures/instructions, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. All MRLs reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MRLs reviewed for the youth also documented that all medications were given at prescribed times.

The shelter has had no CCC reports relating to medication errors in the last six months.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

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

Upon admission to the shelter, each youth receives a preliminary medical, mental health, suicide risk, and substance abuse screening. Any conditions are noted on the Intake/Assessment Form. All medication the youth is taking is listed on the Intake/Assessment Form and the Medication Record Log. Medication allergies, food allergies, and any other allergies are noted on the Intake/Assessment Form, the medical record log, and on the outside cover of the youth's file with either an "Allergy" or a "Medical/Mental Health

Alert" label. In addition, youth issues, concerns, conditions, or physical restrictions are noted on the youth board using appropriate codes. All incoming staff review the youth board at the beginning of each shift.

There were five open youth files reviewed. All five of the youth were on medications and an alert was documented on the alert board in the staff office and also on the medication board in the staff office. A "Health Alert" sticker was on the spine of all five files. Three of the five files also documented the youth had some kind of allergy, one was dust, one was Codine, and one was tuna. These allergies were not documented with the applicable code on the alert board. They were documented in the youth's file and had a "Health Alert" sticker on the spine of the files.

All medical related information was documented on the Intake/Assessment Form inside all five files. Alerts on the board were coded with numbers 1-18, with each number representing a different alert. Staff interviewed were knowledgeable of the alert system.

Exception:

Three youth with allergies were not documented on the alert board in the supervisor's office.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

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

There are procedures in place for staff to follow in various types of medical emergency situations such as: Skin Wounds, Dental Trauma, Convulsions/Seizures, Head Injuries, Stings and Bites, Burns and Scalds, Electrical Burns, and Accessing Emergency and Dental Care in Residential Shelters. Emergency drills simulating these events and other potential situations are to be conducted quarterly on various shifts. These drills should be critiqued and discussed during staff meetings.

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

The shelter has had one instance of emergency off-site care in the last six months. A youth hurt their leg playing basketball. The youth's parents were contacted and made the decision to take the youth off-site themselves to be evaluated. The youth's parents took the youth to the hospital, the youth did have a broken leg. The youth's parents returned the youth to shelter, once released from the hospital, with discharge instructions and medication. The CCC was contacted and a report was made. All required parties were notified.

The shelter has completed one emergency medical drill on each shift in the last six months. The three different drills were all conducted in May 2017 and consisted of a sunburn, a bee sting, and a choking. The drills documented the intervention used, if the intervention was effective, corrective action/follow-up required, number of youth, and number of staff.

The shelter has one main first aid located in the staff office and also a first aid supply closet used to restock the first aid kits as needed. There was documentation showing first aid supplies are inventoried and restocked weekly for the past six months. There is a knife-for-life and wire cutters located in the nurse's

office hanging on the wall.

All employees at the shelter had current CPR and First Aid certifications.

There were no exceptions to this indicator.