Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface NW

on 02/03/2016

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
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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/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

Juan Youman, DJJ Monitor, Department of Juvenile Justice

Susan Spinella, VP of Quality Assurance, Youth Crisis Center

Cindy Hoskins, Licensed Mental Health Counselor, Anchorage Children's Home

Patrick Minzie, Shelter Program Manager, Capital City Youth Services

Persons Interviewed

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

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

0 Maintenance Personnel
1 Program Supervisors
0 Other

Documents Reviewed

- [ ] 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

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

Surveys

4 Youth | 4 Direct Care Staff | 0 Other

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Medical Clinic
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] 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

Since the last on-site Quality Improvement review the agency had hired a new Residential Counselor who is a Licensed Mental Health Counselor (LMHC).

The agency also hired a Registered Nurse in November 2015 who is on-site at least five days a week.

In December, the shelter had a bed bug infestation. The situation has been resolved and new procedures/protocols have been put into place to avoid another infestation in the future.

The shelter has been operating consistently and with very few changes since the last on-site review in April 2015.

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 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 Regional Coordinator at each youth shelter. 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

There were a total of five staff hired since the last review. All of the staff received an initial background screening prior to their hire date. There was one staff eligible for a five-year screening to be conducted. The background rescreening was requested by the program on November 12, 2015 and was received back on February 4, 2016. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit on January 8, 2016.

There were no exceptions for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Abuse Hotline information is posted in the facility for youth to easily access the information. The agency has a comprehensive policy that addresses each of the elements of the indicator regarding an Abuse Free Environment. The agency also has a comprehensive policy that addresses their Grievance Procedures. The policy states that grievances/complaints will be addressed within 72 hours. The shelter did not have any grievances in the last six months.

All four staff surveyed knew the procedures to allow a youth to call the abuse hotline. All staff also reported they have never heard another staff member deny a youth access to the abuse hotline. All four staff also reported they

have never heard a co-worker use inappropriate language when speaking with the youth or use threats, humiliation, or intimidation.

All four youth surveyed reported they know about the abuse hotline but have never called. All four youth reported they have not been denied access to call the abuse hotline if wanted. All the youth surveyed reported staff are respectful when speaking with the youth and they have not heard staff use inappropriate language when speaking with the youth. All youth stated they felt safe with the exception of one—that stated they just wanted to go home.

There were no exceptions for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of Central Communication Center (CCC) reports was conducted and two were found. In both reports the CCC was contacted within two hours of the program learning of the incidents. Both reports were documented in the program log and on incident reporting forms. Both reports were successfully closed out with all supporting documentation in the file.

There were no exceptions for this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has an individual training file for each staff which includes an Annual Employee Training Hours Form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.

A review of staff records found one staff applicable for first year training. The staff had all of the required trainings. The staff also exceeded the minimum requirement of eighty hours with a total of ninety-one hours of training. There were four staff records reviewed for Annual Training. Three of the four staff had all of the required training and more than the required hours. The remaining staff had not yet completed all required; however, still had time remaining in the training cycle to complete required trainings.

There were no exceptions for this indicator.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program collects and reviews several sources of information to identify patterns and trends. A review of customer satisfaction data, incidents, monthly review of NetMIS data reports were conducted. The strengths and weaknesses were identified on reports reviewed. There was evidence of improvements and changes made from analysis through updated policies.

There were no exceptions for this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a comprehensive policy in place that closely reflects the policy on client transportation set by the Florida Network. Although having a third party in a vehicle while transporting a client is always preferred, there is a back-up plan for when this is not possible. Only authorized drivers within the CDS staff are allowed to operate vehicles for client transport, and they must pass a driver in-service training program prior to doing so. Drivers licenses are reviewed by HR, both at time of hire, and annually thereafter. Program supervisor is notified in the instances in which a third party is not available to accompany the transport, and his/her consent is documented. The vehicle log was reviewed by this writer, was up to date, and included driver signature, date, time mileage, number of passengers, and purpose for each trip.

There were no exceptions for this indicator.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy with a plan in place for outreach of targeted youth that have identified risk factors—youth who are most likely to become adjudicated delinquent and reside in high crime zip codes with highest number of delinquency referrals. The agency's outreach program provides the following: Early Intervention Services, Informational Services (to include Youth Talk advocacy phone line), Educational Services, Alternative Services, and Community Development Services. There is documentation of linkages with local schools and cooperative service agreements with social service agencies who provide services not specifically offered at CDS. A binder was reviewed, which contained all outreach activity documentation for 2015 and 2016, to date. This binder included meetings at DJJ Advisory Board, various schools and school boards, Chamber of Commerce, and a Pregnancy Care Center, among others.

There were no exceptions for 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 Senior Counselor who is also a Licensed Mental Health Counselor (LMHC). Non-residential services are being provided by two Counselor/Case Managers one whom is a LMHC. The Senior Counselor provides services on-site at the shelter. The non-residential counselors provide services in the family's home, at a local community space, or in the counselor's office. There is currently one vacancy for a non-residential Counselor/Case Manager. All clinical staff and supervisors' interactions demonstrated 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

There were four residential files (two open and two closed) and four non-residential files (two open and two closed) reviewed. All files met the requirements under screening and intake. Parents and youth are given an orientation packet which provides much of the required information.

There were no exceptions for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were four residential files (two open and two closed) and four non-residential files (two open and two closed) reviewed. The Needs Assessments met time criteria and had appropriate signatures. There were no youth identified with an elevated risk of suicide based on the Needs Assessment.

There were no exceptions for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were four residential files (two open and two closed) and four non-residential files (two open and two closed) reviewed. All Case Plans were individualized and reflected needs and issues identified in the Needs Assessment. The recommended services identified the type, frequency, and location of services, the persons responsible, target dates, and had the required signatures. There were no residential case plans requiring a thirty day review as the youth were discharged prior to this. The three non-residential files eligible for a thirty day review had a review by the assigned counselor and a review done by telephone with the parent/guardian.

There were no exceptions for this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were four residential files reviewed (two open and two closed). Of the two closed files, only one was referred for other services. The other closed file was a client who turned eighteen years old. The client appeared to have serious mental health issues but there was no indication the client was referred to adult services for mental health or transitional services. All cases documented appropriate counseling and support for families.

There were four non-residential files reviewed (two open and two closed). Three of the cases had referrals for other community services. All cases documented appropriate counseling and support for families. There were case termination notes for the four closed cases.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

All families were offered individual, family, and group counseling. There is documentation of group counseling being held five days per week in the shelter. Youth's presenting problems were addressed in the Needs Assessment and Case/Service plans. Completed case notes indicate the services provided and sometimes the worker's thoughts on how things are going. Sometimes the counselor/case manager writes of the client's progress but not consistently. There is also no documentation of a clinical or supervisor's on-going review of specific case records and staff performance. There is a review of case work at opening and closing but no documentation of on-going review. The licensed clinician meets with the shelter case manager monthly and the non-residential counselor weekly, but the documentation is general and does not mention review of any specific cases.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policies for case staffing are in place and are consistent with FL Network policies.

It's clear that it is not always easy to get parents on board with the case staffing process, but all cases reviewed were eventually successful in this area. Quite a few attempts to reach parents were documented. In each case (after case staffing was held) a revised service plan was completed and signed. Parent(s) were notified of content of service plan and any revisions. Cases reviewed were those of a sibling group who had been court-ordered to come to CDS for services. As a result, there were several case staffings in this family's case. Represented at each case staffing was a mental health advocate (from CDS), representatives from the school district (including truancy counselor and guidance counselors), two DJJ staff (one being Assistant General Counsel), a representative from DCF, and a homeless specialist who was a liaison to the school board. All protocols from 2.06 (Adjudication and Petition Process) are being followed with generally successful outcomes. Parent participation appears to be the primary struggle.

There were no exceptions in this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Of the eight residential and non-residential and three CINS files reviewed, all were marked confidential except for three which were marked confidential during on-site visit. Open non-residential files are kept in an opaque container marked confidential and transported in this container. The container is reportedly kept in a locked car trunk but does not have its own locking mechanism. The LMHC indicated she would get a locking container. On the last day of the review, a locking opaque container was purchased to use to transport the files.

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 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 four (4) 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 addressed within twenty-four hours of being submitted to management.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

At the time of the review the program's fire safety inspection was current with no violations noted during the inspector's visit. There was no health inspection conducted for the current year, with the most recent being completed in January of 2015. When asked about the status of the current year's health inspection it was mentioned that the health inspector was currently on leave and it couldn't be scheduled until she returned. The program completes a minimum of one fire drill per shift per month. All fire drills are logged as well as documented on a monthly calendar and kept in a binder. The agency has a disaster plan that is updated annually. Plan includes all components consistent with FNYFS policy and procedure manual. The program completes one mock emergency drill per month on each shift. These drills are documented and logged in their own binder. The agency's mock emergency drills were reviewed for the past 6 months with all drills accounted for.

The facility is equipped with a knife for life and wire cutters that are located in the direct care staff office. Although the knife for life is kept in an unlocked drawer, the office doors are secure and locked. The knife for life is accessible by all staff members on shift.

The menus posted have been approved by a licensed dietician. The Kitchen and pantry areas are clean. The program has a current DCF License that is displayed in plain sight. The building is locked and secure and all visitors must be buzzed in at the front door. All visitors must also sign the visitors sign in sheet. The youth cannot access staff only areas. Key control is in compliance with regards to keys being secured in a locked box that only staff members can access. During the walk through, detailed maps with agency floor plans were seen in all areas of the facility. The Abuse Hotline information was posted throughout the facility in plain view as well as the DJJ Incident Reporting number. Cameras were seen throughout the facility. All cameras were operational and the facility had a camera feed which could be monitored in the staff office. Interior and exterior lighting appeared to be

in working condition.

A bedbug infestation in December caused the program to come up with a new protocol when admitting new intakes. To ensure over all cleanliness all new intakes must have their belongings washed immediately and shower right after intake. While their clothes are being washed and dried the agency provides the youth with “facility” sweats. If youth have extra belongings that need to be locked up they are placed in the outside shed until a guardian can pick them up. During the time of the review all areas were clean with no signs of infestation. Furniture was in good condition and made the atmosphere seem more homey and less like a residential facility. No graffiti was seen during the tour and artwork which was painted by one of the program administrators and the youth. They are displayed throughout the youth living rooms. There is one bedroom for the male youth and another for female youth. All youth have individual beds assigned and rooms were in a neat and orderly condition. All beds had numbers assigned for classification purposes. Interior areas (bedrooms, bathrooms and common areas) were all clean and organized. The youth are usually separated by gender and have assigned bathrooms and living room areas. Both the boy’s and girl’s areas were clean and organized.

Exterior areas are well maintained and litter free. The trash cans were covered. Agency vehicle was locked at the time of review. The reviewer was able to observe major safety equipment including a first aid kit, fire extinguisher, flash lights, and seatbelt cutter. The program has a posted grievance procedure that provides youth with clear, accessible, and fair avenues for resolving complaints and grievances within the required timeframe, including opportunity for appeal. The program has a grievance policy stating that grievances/complaints will be addressed within 72 hours. They maintain grievances for up to one year. The reviewer discussed grievance practices with a direct youth care staff and it was explained that the youth fill out the Grievance and it is then handed to a staff member or slid under counselor’s door. One recommendation would be that a small privacy box be placed next to the grievance box. Although there is a clear process to address grievances in place it might make the youth feel more comfortable to be able to place their grievance in the box immediately rather than waiting till the residential counselor arrives the next day or sliding it under her door.

The program has posted daily/weekly schedules as well as a calendar that is developed for summer months detailing the activities that are available for the youth each day. The program also has a list of approved activities that staff/youth can choose from for weekends during the school year. Activities include social, recreational and educational activities, as well as treatment related activities. Youth are also given the opportunity to participate in faith based activities on Sundays. If a youth didn’t want to participate in the faith based activity they would follow the normal weekend schedule.

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program orientation is initiated upon intake and completed within 24 hours. There is an Orientation Checklist which indicates information that must be addressed by staff at the time of intake. Youth are introduced to key staff members and their roles at the agency. Youth are given a tour of the facility and are given the opportunity to ask questions while staff reviews agency procedures. Staff reviews procedures to access medical, dental, mental health care and/or substance abuse. During orientation youth are informed of their rights, program rules, grievance process and access to the Florida Abuse Hotline. Visitation policy, telephone procedures, dress code, program goals and services are also addressed during intake/orientation. Youth are provided with an Orientation Packet for which they acknowledge receipt and understanding evidenced by signature page in the youth file. Youth are given their point books which they review and go over with day staff.

Of the five files review, four were open and one was closed. Files did contain all of the information that was provided to the youth at the time of intake. Parent and youth signatures were obtained and acknowledgement of orientation packet was documented by parent and youth.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy that meets the requirements of the indicator. The agency has a process in place in order to determine bed assignment. A total of four open files and one closed file were reviewed. Initial classification and room assignment are completed during the orientation process and within 24 hours. Areas considered include age, gender, youth's history and exposure to trauma as well as shelter population. A youth's Initial interactions (level of cooperation at the time of intake) as well as staff observation of the youth are all factors during the process of assigning a room/bed. The program gathers information with regards to gang affiliation and suicide risk.

No exceptions are noted for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy with regards to maintaining log books. The agency policy includes all areas as required by standard 3 (indicator 3.04 Logbooks). The log book is designed in a way to reflect all that is required of the indicator. The book had good examples of documenting specific facts that were helpful to minimize and/or eliminate errors on shifts. Program reminders were present in the front of the book and pages were designated to outline date, as well as shift times, and shift leads. Key exchange staff on duty and youth presently on census were also documented regularly. The program direct youth care workers as well as program administrators review the logbooks daily and weekly, indicating it has been read and documenting need to know information and program alerts are done. All direct youth care staff are required to review a minimum of two previous shifts before signing that they have reviewed the logbook. After making any entry in the logbook a staff member must sign their full name and position title and all entries are documented in black ink. A shift lead is also designated on each shift to ensure all shift responsibilities are covered.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written description of the behavioral management strategies utilized for their youth. The plan clearly explains how the youth are able to earn points and gain privileges. The BMS plan discusses the system and how each step is earned. Plan encourages staff to use positive feedback when addressing youth behaviors and applying successful interventions. The BMS encourages youth to demonstrate pro-social behavior and provides progressive levels for youth to achieve.

Achievement of different milestones results in extra privileges for the youth. Each level of the programs BMS system promotes skill building and encourages the youth to advance to the next level. Points are documented by each shift daily in the youth Point Book. As points are assessed (positive and/or negative), staff are to provide feedback to each participant on why points are earned and ways to improve when youth has earned negative points. The BMS indicates that there will be no group punishment for the actions of an individual. The BMS provides staff with examples of inappropriate consequences, which may subject staff to corrective action up to and

including termination. The BMS does not allow for youth to impose disciplinary sanctions on other youth.

Youth are introduced to the BMS during the orientation process. This introduction includes the program rules, the response/consequences to violating rules and the FACE System (which includes points and level). Each youth is provided with a copy of the BMS to keep in their possession. While onsite the reviewer was able to witness three youth participate in group which explained and demonstrated how the BMS works. The BMS encourages focusing on targeted skills that include life and social skills development. These skills as well as the steps to complete them could be seen posted in the youth rec room. Both youth and staff seemed well versed in the BMS and were able to give the reviewer examples of how it is utilized on a daily basis.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CDS Interface NW has a comprehensive policy on staffing and supervision which includes staffing ratios consistent with FL Network contract and with Florida Administrative Codes. There is a designated staff person who is responsible for scheduling and assuring adequate coverage at all times. There is evidence of a posted staff schedule, extending 6 weeks out, which I observed. There is also a final printed schedule (after the fact) which documents exactly which staff worked which shift.

There is a system that contacts personnel in order to relieve staff when extra coverage is needed. There is a scanning system for staff that documents the occurrence of bed checks at appropriate intervals (15 minutes). The scanner identifies the shift and gender of staff completing the check as well as the time of each check. There is a written policy on bed checks and supervision (which outlines gender specific bed checks) and explains process of sight and sound supervision at CDS Interface NW. Building security is exceptional.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Written policies and procedures are in place for special population clients. Staff secure procedures include in-depth orientation at admission, assessment and service planning, enhanced supervision and security, mechanisms for parental involvement, as well as collaborative aftercare. Elevated supervision (to include constant sight and sound monitoring) are outlined in policy. During the past year, since the 2015 Quality Improvement Review, there has been no Staff Secure, Probation Respite, or identified victims of domestic sex trafficking. Therefore, no files could be reviewed for any of those types of clients. Four files were reviewed for Domestic Violence Respite cases (which represented the total number of DV cases for the year), and they met the guidelines for DV populations. For example, the DV charge was noted in file, no stay exceeded the 21-day limit, and documentation was available when client transferred to CINS/FINS program. Case plans in files reviewed noted intent to work on anger and aggression in the therapeutic process.

There were no exceptions to this indicator.

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 agency has two (2) Counselors that are Licensed Mental Health Clinicians (LMHC). In addition, the agency's Chief Operation Officer is also a Licensed Mental Health Counselor.

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 at least five 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 is 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 policies state each youth will be provided a preliminary physical health screening and also staff will complete the Intake/Assessment Form. Information obtained from the youth’s initial screening is recorded on the Intake/Assessment form and the staff person completing the form will note on page 6 if there are any areas of concern or needed follow-up and will initiate the Medical/Mental Health Alert System. 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 72 hours. 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. Three of the five files reviewed documented the youth were on medications. The medications were listed, as well as, the reasons for the medications. Two of the files documented the youth had some type of allergies. One youth was a pre-diabetic; however, was not taking medication. There was a very detailed note from the RN in the file documenting her concerns with this youth and the conversation with the parent concerning the importance of the medication. Another youth documented a medical condition of Scoliosis and Spinal Stenosis. Again, a detailed note was in the file from the RN documenting conversations with the parent about the youth’s condition and also with the staff regarding the youth’s sleeping arrangements and chores. The RN documented detailed intake notes in all five files reviewed regarding the youth’s medical history and interview with the parent/guardian.

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

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policy on Suicide Assessment addressing the requirements of this indicator. 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 (one open and two closed). In two of the three files the youth were placed on suicide precautions at intake due to issues identified during the screening process. Both youth remained on sight and sound supervision until assessed by a qualified professional. Both youth were seen and assessed by a Master's level counselor (using a suicide risk assessment) within twenty-four hours; however, none of the suicide risk assessments contained documentation of consultation with the LMHC prior to removing the youth from precautions. The LMHC signed the suicide risk assessments two days later. The youth were placed on normal supervision levels upon completion of the assessment. Both youth had thirty minute observations documented the entire time they were on suicide precautions.

The third file documented the youth was placed on suicide precautions while in the shelter. The youth was placed on precautions on the evening shift by staff and was assessed the following day by the Master’s level counselor. Consultation with the LMHC was documented and the LMHC signed the assessment immediately after it was completed. The decision was made to have the youth Baker Acted. There were thirty minute observations of the youth up to that point. The youth was assessed by the Counselor upon returning from the Baker Act (as the youth did not meet the criteria for a Baker Act) and was placed on standard supervision. All suicide precaution events were documented in the logbook.

Exceptions: Two suicide risk assessments reviewed (completed by a Master's level counselor) did not contain documentation of consultation with the LMHC prior to removing the youth from precautions.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a very detailed policy on Medication Provision, Storage, Access, Inventory, and Disposal. The policy has detailed procedures for Prescription Medication, Verification of Medication, First Aid and Over-the-Counter Medication, Utilization of the Pyxis Med-Station 4000, Medication Provision, Supervision, and Monitoring, Medication Errors and Refusals, Medication Storage, Access to Medication, Inventory Procedures, Medication Counting Procedures, Discharge of Youth with Medication, and Disposal.

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

The shelter has hired a Registered Nurse (RN) who has been employed at the shelter since October 2015. The RN is on-site seven days a week. She is on-call 24/7 to help staff through any issues they run into when she is not there. At the time of the on-site Quality Improvement Review the RN was the only person who was loading medications into the Pyxis Med-Station and also the only person administering medications to the youth. The RN reported staff are still intimidated by the machine. As a result, they have had very few discrepancies from the Pyxis Med-Station. The RN reported only minor discrepancies that were easily fixed and usually due to staff pressing the wrong buttons while doing inventories. 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 need a re-fresher on how to use the machine. There have been no new staff hired, since the shelter began using the Pyxis Med-Station, that have need of any type of new hire training the RN would be expected to provide.

If the RN is not on-site when a new youth enters the shelter with medication, then the medication is stored in a locked box in the same room as the Pyxis Med-Station. The RN reported since she is on-site seven days a week, twice a day, she is always able to ensure the medication is loaded into the Med-Station prior to the youth’s next scheduled dose.

All youth medication is stored in the Pyxis Med-Station. After the youth’s information is entered into the Pyxis Med-Station, a bin within the machine is assigned to the youth. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. The youth’s medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Pyxis Med-Station have to enter a password as well as their finger print to gain access. 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 Friday, by the RN. All medications are also inventoried at admission, when given, by maintaining a perpetual inventory with running balances, and at discharge. For the most part, controlled medications were being inventoried shift-to-shift also. There were occasions when these inventories were not completed. The RN reported she is currently working with the staff to ensure they are completed every shift and making sure staff are comfortable with the Med-Station to perform the inventories.

There were three youth currently in the shelter on medication. 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 MRL’s reviewed documented the youth's name, a picture of the youth, allergies, side effects, 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 MRL’s reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MRL’s 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 since the implementation of the Pyxis Med-Station in October 2015.

Exceptions: There was not consistent documentation of shift-to-shift inventories of controlled medications.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process. 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 beginning of each shift.

There were four open youth files reviewed. Two of the four 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 both files. One youth had asthma and this was also documented on the alert board in the staff office. One youth had allergy to shellfish, this was not documented on the alert board in the kitchen; however, staff did update the alert board in the kitchen immediately to include this allergy. It was also noted that the program does not serve shellfish. All medical related information was documented on the Intake/Assessment Form inside all four 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.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an Emergency Care Policy in place. There are procedures in place for staff to follow in different types of medical emergency situations.

The shelter has had one instance of off-site episodic emergency care since the last Quality Improvement Review. It was a youth having an allergic reaction and was transported to the Emergency Room. The youth’s parent was notified and the event was documented in an incident report and reported to the CCC.

All staff are trained in CPR, first aid, and AED. Also the shelter completes emergency medical drills in order to better prepare staff for actual events. Drills have been conducted in November 2015 on all three shifts and in May 2015 on all three shifts. The shelter has first aid kits located throughout the building and a knife-for-life and wire cutters.

There were no exceptions to this indicator.