



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface East

on 06/06/2018

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	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	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
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:100.00%
Percent of indicators rated Limited:0.00%
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, Lead Reviewer/Consultant, Forefront LLC

Amy Tyson, Regional Monitor, DJJ

Andrea Johnson, Quality Management Specialist, CHS West Palm Beach

Mark Shearon, Chief Compliance Officer/Shelter Program Manager, Arnette House

Jessica Szymczyk, Clinical Director of Residential Adolescent Services, Stewart Marchman

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input checked="" 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 checked="" 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 | 1 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 type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 10 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 5 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 4 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

4 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 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

CDS Behavioral and Health Service had their CARF survey on February 26 – 28, 2018. They received notice in early April 2018 that they have been approved and granted a full three-year CARF accreditation.

CDS-East is currently in their second year of a Basic Center Grant which funds two major positions in the East Region. They have a Safe Place/Outreach Specialist and a Life Skills Instructor. During the past year, they purchased additional Educational material with funds from the Basic Center grant also.

The Enhanced Summer Program will begin on May 28th. They are implementing an “Explore the World” program to include guest speakers, games, arts and crafts, and field trips with an emphasis on various countries and their cultures. The goal is to help youth broaden their horizons and learn research skills as well as work to build a understanding of various cultures and develop more empathy for others.

The shelter also received funding from the Challenge grant which allowed them to purchase twelve new mattresses and pillows for the shelter, audio equipment for their current video surveillance system, and provided funding to resurface the shelter parking lot.

Other substantial improvements made by the agency include a complete renovation of the front shelter bathroom and the purchase of a twelve passenger 2016 Ford Van.

Since the QI review last year, they have hired a former intern for the Residential Counselor position. They also hired two part-time Registered Nurses. They hired one Non-Residential Counselor in October 2017. At the time of the review CDS-East was fully staffed although they have experienced some turnover in new Youth Care staff during the past year.

Standard 1: Management Accountability

Overview

Narrative

The CDS Family and Behavioral Health Services, Inc. – Interface Youth Program East conducts background screenings prior to hiring and any five-year anniversary of all staff members through their centralized Human Resources offices located in Gainesville, Florida. The program complies with the requirements and procedures outlined in Florida Statute and Department Policy for Child Abuse reporting. Program staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. CDS is committed to maintaining compliance with the incident reporting policies of the Department of Juvenile Justice. The agency conducts outreach throughout their designated service regions to local youth, parents/guardians, local community organizations, partners and stakeholders.

The CDS-East shelter in Palatka, Florida is operated by one Regional Coordinator. The agency assigns the daily operation and direct responsibility of each shelter to the Residential Supervisor. The shelter also employs, one Residential Counselor, two Non-Residential Counselor/Case Managers, one Community Outreach/Safe Place Specialist, fifteen Youth Care Workers, one Life Skills Educator, an Administrative Assistant, and two Registered Nurses. The agency has Centralized Human Resources and fiscal departments that are responsible for all personnel and financial matters respectively. All CDS residential shelters and Non-Residential programs have implemented uniform operating protocols for all three service locations in their respective service areas. Other uniform protocols for all three locations include training and professional development exercises.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy regarding background check, reference check, fingerprinting for personnel, volunteers or interns which ensures they will comply with regulations and protocols defined by Florida's Department of Juvenile Justice and the Department of Children and Families. This policy was reviewed and signed on January 17, 2018.

When a supervisor or coordinator identifies a person not currently employed by CDS as a potential hire or volunteer/intern, they must facilitate the completion of a Background Screening packet to determine the applicant's eligibility for hire.

Five year re-screens should be conducted on employees, calculated from the "Retained Prints Expiration Date" posted on the Clearinghouse site.

The Annual Affidavit of Compliance with Good Moral Character Standards shall be submitted to the Department of Juvenile Justice's Background Screening Unit by January 31 of each year.

There were nine employees hired since the last annual compliance review. Each had a background screening completed prior to their date of hire. Each of the nine staff were rated "eligible".

There was one employee eligible for a five-year re-screen. The rescreening occurred within the appropriate time frames and the employee was rated "eligible".

The facility has one volunteer who was also background screened prior to volunteering at the facility.

The Annual Affidavit of Compliance with Good Moral Character Standards was completed and submitted to the Department of Juvenile Justice's Background Screening Unit on January 4, 2018.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The shelter has several policies to ensure an abuse free environment. These policies include Rule Violations, Behavioral Expectations for Staff, Standards of Conduct for Participants, Florida Abuse Reporting, and Complaint/ Grievance Process for Participants of Companions with

Disabilities. These policies were reviewed and signed on January 17, 2018.

Upon admission to the shelter, each youth is oriented to the Program Rules, the response/consequences of violating rules and the FACE system, which includes points and levels. Responses and consequences have been established for different types of rule violations. In situations where a youth has violated a program rule, the response applied should be consistent with identified consequences outlined in FACE system.

All employees are required to follow the behavioral guideline outlined in the CDS Family & Behavioral Health Services, INC. Employee Handbook section entitled, "Ethical Conduct and Employee Professionalism" which states: CDS is fundamentally concerned with the welfare, integrity, and human dignity of our employees, our staff members, and our participants. To accomplish its goals, CDS expects all of its employees to act in an ethical and professional manner. Accordingly, CDS has adopted guidelines for ethical conduct. The code of conduct prohibits the use of physical abuse, profanity, threats, or intimidation.

The Standards of Conduct for Participants outlines the orientation process and all rights afforded to participants.

The procedure regarding Florida Abuse Reporting states CDS employees who have been entrusted with the responsibility for a child's welfare and care, and those who are directly involved in providing services to protect children under eighteen years of age are legally obligated to report. It is recommended personnel consult with their supervisor prior to reporting suspected abuse and neglect; however, this should not impede the reporting process.

The procedure regarding the complaint and grievance process states each level of the process shall be addressed within seventy-two hours. The process shall include acknowledgement by the participant in writing that a written response from the program was received. A final response to the participant that includes the issue grieved. Programs generating written grievances shall turn them in monthly to the Data Systems Department as part of the Utilization and Risk Management process to ensure trends and issues are tracked and analyzed.

The agency has a code of conduct that is explained in depth in the employee handbook which is signed by the employee acknowledging they have read and understand the contents. Employee's job descriptions also address the program's code of conduct and the employee signs acknowledging that they are aware of what is expected of them.

There were no allegations of child abuse reported to the CCC since the last review. In the facility there are postings of the Florida Abuse Hotline.

Staff receive regular training on child abuse reporting.

There were five instances of abuse calls which were logged in the facilities internal Unusual Event Report binder.

The parent/guardian orientation packet and the orientation checklist explains the program's grievance procedures, each are signed by the youth and/or parent/guardian. The program has grievance forms and a locked box to submit the forms, located throughout the shelter. All grievances reviewed were resolved within the 72-hour time frame.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The facility has a policy regarding Incident Reporting Procedure and Internal Unusual Event Reporting. These policies were reviewed and signed on January 17, 2018

Incident reporting procedures common for all participants are legible and thorough documentation and internal notification of all incidents. The Department of Juvenile Justice's Central Communications Center will be contacted within two hours of any reportable incident or two hours of becoming aware of the incident. The policy defines reportable incidents.

Reports to the Central Communications Center were reviewed for the past six months. In the past six months there have been six incidents which required reporting to the Central Communications Center (CCC). Each was called in within the required two-hour time frame. Incidents were also documented on an incident reporting form. In one case there was an update to the CCC required which was completed. In this case the youth was transported to the hospital by his parents and the facility contacted the CCC again when the youth returned to include the youth's diagnosis and any restrictions required. Each report to the CCC was documented in the programs logs.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The Training Policy is in place to articulate CDS's commitment to providing training and development opportunities to personnel as required by contracts and applicable rules and regulations and as resources are available. This includes educational opportunities, which are appropriate to employees' present work and professional growth. The training plan covers the fiscal year July 1, 2017-June 30, 2018.

The agency has procedures that require a training plan be developed for each new employee. The agency requires the CDS employee to be trained on the required curriculum. The agency provides training sessions and topics which include: Orientation, CINS/FINS Core, Managing Aggressive Behavior, Suicide Prevention, Signs and Symptoms of Mental Health and Substance Abuse, CPR/First Aid, Behavior Management, Title IV-E, In-Service Training, Medication Distribution, Adolescent Development, Ethics and Civil Rights, Equal Employment Opportunity, Sexual Harassment, Confidentiality, Child Abuse Reporting, Trauma-Informed Care, Prison Rape Elimination Act, Fire Safety Equipment, Information Security Awareness, Serving LGBTQ Youth, and Cultural Humility.

Employees are also required to complete specific refresher trainings in the areas of safety equipment, crisis intervention, CPR/First Aid, and suicide prevention.

A random sample of eight training files were reviewed. Of these files, all were current employees with three representing recently hired staff and five representing staff that have been employed with the agency over two years. The three recently hired staff were all hired after February 2017. One employee completed all required training's within the required time-frames and has a total of 154 training hours. The other two employees completed the majority of the required training's within the required time frames.

Five staff training files were reviewed for annual training compliance. All five contained documentation that the staff received twenty-four hours of job-related training to include refresher training in the following topics: suicide prevention, CPR, First Aid, Managing Aggressive Behavior, Fire Safety Equipment, and Prison Rape Elimination Act.

The program maintains an individual training file for each staff, which includes an annual training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.

Two staff members did not complete all required training's within within the first 120 days of employment. Both of the staff members were missing two training's each. Both were missing Managing Aggressive Behavior and one was also missing Behavior Management and the other staff was missing Signs and Symptoms of Mental Health and Substance Abuse.

The employee responsible for conducting Managing Aggressive Behavior training abruptly quit prior to the two new employees receiving the training. The facility designated another employee to be certified to provide the training; however, his training was delayed due to hurricane Irma. The two staff were trained in Managing Aggressive Behavior outside of the 120 day window, but as quickly as possible due to lack of a trainer on site.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

It is the policy of CDS, to formally and routinely collect and analyze data for the purpose of quality improvement and to ensure compliance with Substance Abuse and Mental Health, Independent Living and CINS/FINS related Quality Assurance Standards and applicable licensure and accreditation requirements. The policy was reviewed and approved on January 17, 2018.

The program collects and reviews several sources of data to identify patterns and trends. This information includes quarterly peer reviewed CINS/FINS case management records, monthly review of incidents, accidents, and grievances, annual review of customer satisfaction, annual review of outcome data, and monthly review of NetMIS data reports.

The program prepares a detailed monthly report titled "CDS Performance and Risk Management Reports." This report includes performance analysis, CINS/FINS program-wide information, CINS/FINS non-residential items, residential lists, satisfaction survey results, an incident report summary for all discharges. This monthly report also includes a data report and analysis and projections of contractual requirements from NetMIS.

Additionally, there is an analysis of the residential and non-residential admissions, daily populations, average length of stay, and bed days for the last five fiscal years. The annual report also includes satisfaction survey result data. CDS conducts quarterly peer reviews on the files. The agency also reviews customer satisfaction data during their monthly management team meeting.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy (P-1013) entitled "Vehicle Use and Safety Inspection" which was last updated December 2015 and last approved by the Chief Executive Officer January 17, 2018. The policy clearly outlines the responsibilities and expectations for vehicle use and safety maintenance.

The policy is to provide guidance and best practice model to serve as a protection to avoid situations that place youth and/or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. In cases of Residential and Domestic Violence related transport s documentation that notes the name of the driver/second adult, date and time, mileage, number of passengers, purpose of trip will be documented and maintained. Additionally, in cases where a 3rd party is necessary for transport, the policy states the individual will be an approved volunteer, intern, agency staff, or another youth. In events where a 3rd party cannot be obtained there is a system in place which requires appropriate approval from management staff where consideration is given in regards to the client's history, evaluation, and recent behavior.

The CDS procedure outlines the parameters for which vehicles are to be used which is for conducting official CDS business unless otherwise authorized by the Chief Executive Officer or his/her designee. Only authorized employees may use CDS vehicles and/or drive participants in personal vehicles. Authorized drivers must be approved administration and on the approved drivers list. Drivers must have and maintain a valid

Florida Driver's License and valid Automobile Insurance.

The CDS Procedure states in cases of misuse or abuse CDS assumes no liability and holds the driver accountable for costs or damages that are incurred. In case of accident the agency holds the employee responsible for the proper notifications which includes their immediate supervisor and may be held responsible for repairs/deductibles which is at the discretion of the Chief Executive Officer.

Prior to CDS vehicle usage and providing transportation to participants, drivers receive driver training in an effort to achieve the safest environment for all involved parties. Each authorized driver is expected to participate in a driver in-service training program to become familiar with the vehicle use and safety inspection policy, their responsibilities, and the vehicles designated to their program.

The CDS Procedure also addresses other transportation and safety guidance which includes: Driver Training, Driver Selection, During the Use of CDS vehicles, Accident Procedures, Immediately following the Use of CDS vehicles, and Vehicle Safety Inspections.

Keys and Proof of Insurance is kept on file and in a secure area.

Vehicles insurance and safety inspections were on file and reviewed. Vehicle Annual Safety Inspections 2003 Ford Van dated 1/25/2018 and satisfactory. Safety Inspection for newly purchased 2016 Ford Van dated 12-6-2017 also satisfactory. Vehicle Insurance up to date for both vehicles and documentation on file. Transportation log book along with the Travel Log review shows the date of travel, destination and purpose of trip, trip details (i.e start/end time) driver, second adult, and approvals information.

There were no exceptions to this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place Policy (P-1053) which was last updated September 2015, and most recently approved by the Chief Executive Officer on January 17, 2018. The policy is intended to provide the roles and responsibilities of staff as they relate to Outreach Services and contribute the implementation of DJJ objectives through participation in local and circuit level meetings.

The CDS Prevention Outreach Policy is implemented and administered by program staff and includes but is not limited to the following: responsibilities of staff, information services, community development services, and early intervention services. CDS maintains written cooperative agreements with community partners which continue to provide a system of services obtained by way of a comprehensive referral process. Some examples of the community partners include: but not limited to Department of Juvenile Justice, Police Officers, CareerSource, Public Defender's Office, and Educators to name a few.

CDS staff participate in local board and council meetings to ensure CINS/FINS services are represented in a coordinated approach to increase public safety by reducing juvenile delinquency through effective prevention, intervention, and treatment services.

The CEO/COO will designate lead staff members to attend local and circuit level meetings convened by the Department of Juvenile Justice.

The Regional Coordinator is responsible for coordinating Prevention Outreach efforts within each region and is responsible for providing training to the direct care service staff regarding documentation procedures. Direct care staff participate in Outreach initiatives based on ability and availability.

Staff that are assigned to Community Outreach activities should be available to provide support as well as Information materials (i.e. brochures, flyers, presentation materials, etc.). Activities are advertised via the CDS website and Facebook regularly and documented in accordance with the CDS Data Systems Department.

Outreach Program documentation was reviewed from June 2017 – May 2018 which detailed Council Meetings with included participants and Outreach agenda items. Each meeting contained a sign-in sheet complete with signature(s) of a CDS representative along with detailed agenda items list and other supporting documentation.

The Putnam County Council Meetings are comprised of several different community leaders/partners and as evidenced by reviewed Meeting Minutes provide in detail the comprehensive Outreach goals, efforts, and expectations of CDS and their partners.

The agency's Outreach Plan addresses Early Intervention Services other Informational and Educational Services, Alternatives Services, and Community Development Services. CDS maintains relationships with it's Community Partners including the Mc-Kinney-Vento school district and over 60 other agency partners in an effort to address the needs of their clients.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The CDS-East Non-Residential Counseling Program is contracted to provide non-residential services for youth and their families that are primarily in Putnam, Bradford and Union Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week to status offenders that include runaways, truants, ungovernable and lockout youth. Residential services include individual youth, family and group services. Case management and substance abuse prevention education are also offered.

The non-residential program consists of two Non-Residential Counselor/Case Managers. The program receives requests for services from parents/guardians, system partners and the general community. The agency's screening determines eligibility of CINS/FINS youth and families that are referred to the program to start the intake process. The program has the capability to offer both case management and substance abuse prevention education on an as needed basis.

The shelter does not routinely perform case staffings unless there is a written request by the parent or school. The shelter defers to the school district's truancy petition process reportedly under sections 1003.21 and 1003.24, Florida Statutes. The shelter participates in the school district's Student Intervention Team (SIT) and is named as part of the school district's Truancy Procedure. However, referral is made to the program only if there is a determination by the school's "RTI/Child Study Team" that the student "is in need of services at a higher level of care".

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place titled Screening Process. The policy was last reviewed on January 17, 2018 by the Chief Operations Officer.

The procedures require trained staff to complete the intake screening process, upon receiving the referral, within twenty-four hours, but no later than seven calendar days. The procedures also state that upon completion of the intake screening, the intake/assessment process needs to be initiated within seven days along with necessary assessments.

A total of eight files were reviewed including four Non-Residential files and four Residential files. Out of the four Non-Residential files, two were open and two were closed. Out of the four Residential files, two were open and two were closed.

Of the eight files reviewed all eight were contacted and/or screened within seven days of the referral. All files indicated that service options, clients rights, potential CINS/FINS actions, and grievance procedures were reviewed and the parent brochure was provided during the screening/intake process.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place titled Needs Assessment. The policy was last reviewed on January 17, 2018 by the Chief Operations Officer.

The procedures require a Bachelor's or Master's level staff member to initiate or attempt the Needs Assessment within 72 hours of admission. The Needs Assessment is to be completed within two to three face-to-face contacts following the initial intake. The provider requires the counselor/case manager to sign and date the Needs Assessment form corresponding to the date of completion. The supervisor is then required to review and sign the completed document.

A total of eight files were reviewed including four Non-Residential files and four Residential files. Out of the four Non-Residential files, two were open and two were closed. Out of the four Residential files, two were open and two were closed.

All eight files reviewed documented the Needs Assessment was completed on the same day the youth was admitted to the program. All eight files documented the Needs Assessment was completed by a Bachelor's or Master's level staff member. All Needs Assessments were also reviewed and signed by a supervisor.

In the two closed residential files reviewed the youth were identified as having an elevated risk of suicide as a result of the Needs Assessment.

These files had a completed assessment of suicide risk which was conducted by a licensed mental health professional.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place titled Individual Plan. The policy was last reviewed on January 17, 2018 by the Chief Operations Officer.

The procedures require an Individual Plan to be developed with the youth and family within seven working days, following completion of the assessment. The procedures outline all the requirements for each Individual Plan that needs to be included, which corresponds to the requirements outlined in the CQI Indicator. The Case/Service Plan includes the following: individualized and prioritized need(s) and goal(s) identified by the Psychosocial Assessment, service type, frequency, location, person(s) responsible, target date(s) for completion, actual completion date(s), signature of youth, parent/guardian, counselor and supervisor, date the plan was initiated, and reviewed for progress/revised by counselor and parent (if available) every thirty days for the first three months and every six months after.

A total of eight files were reviewed including four Non-Residential files and four Residential files. Out of the four Non-Residential files, two were open and two were closed. Out of the four Residential files, two were open and two were closed.

In all eight of the files reviewed the Case/Service Plan was developed within seven working days of the Psychosocial Assessment. In seven of the eight files reviewed the Case/Service Plan documented: individualized and prioritized need(s) and goal(s) identified by the Psychosocial Assessment, the service type, frequency, and location, the person(s) responsible, the target date(s) for completion, and date the plan was initiated. In one open Non-Residential file the frequency, location, and person(s) responsible was not identified on the Case/Service Plan. All eight files had the youth, parent/guardian, counselor, and supervisor signatures.

All eight files documented the Case/Service Plans were reviewed for progress/revised by the counselor and parent every thirty days for the first three months, if applicable, and every six months thereafter, if applicable.

In one open Non-Residential file the frequency, location, and person(s) responsible was not identified on the Case/Service Plan.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place titled Case Management, Counseling, and Service Delivery. The policy was last reviewed on January 17, 2018 by the Chief Operations Officer.

The procedures require the assigned counselor/case manager/residential counselor to be responsible for providing the individual and family counseling based on the Individual Plan. The counselor/case managers are responsible for following the youth's case and to ensure youth/family receive the necessary services and/or referrals needed based on their Individual Plan. The process includes the following: establish referral needs and coordinate referrals based on the ongoing assessment of the youth/family problems and needs identified in the Individual Plan, coordinate Individual Plan implementations, monitoring youth's/family's progress in services and providing support for the families, monitoring out-of-home placement, if necessary, making referrals to the case staffing committee, as needed to address the problems and needs of the youth/family, recommending and pursuing judicial intervention in cases as appropriate, accompanying youth and parent/guardian to court hearings and related appointments (if applicable), make referrals to additional services, if needed, continued case monitoring and review of court orders and case termination with a follow-up.

A total of eight files were reviewed including four Non-Residential files and four Residential files. Out of the four Non-Residential files, two were open and two were closed. Out of the four Residential files, two were open and two were closed.

All eight files reviewed had a Counselor/Case Manager assigned, established referral needs, coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in services, and provided support for families. None of the Non-Residential files were applicable for monitoring out-of-home placement.

In all eight files there was documentation the youth/family were referred for additional services when appropriate, provided case monitoring, and reviewed court orders. In one of the closed Non-Residential files there was documentation of staff accompanying the youth and parent/guardian to court hearings. None of the eight files were applicable for referring the case to case staffing to address problems and needs of the youth/family.

All four closed files provided case termination notes. In the two closed Non-Residential files, one had a thirty day follow-up as required and the other had a thirty and sixty day follow-up as required.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has three policies in place to address counseling services titled Case Management, Counseling, and Service Delivery, Youth Case Record, and Clinical Supervision. All three policies were last reviewed on January 17, 2018 by the Chief Operations Officer.

The procedures require counselor/case managers to be responsible for documenting all contacts in progress notes and maintaining them in the participant's file which includes regular contact with the youth and family as well as any outside service providers that may be applicable. Counselor/case manager is to ensure continuity of care along with monitor delivery of services.

Residential counselors are to give individual counseling based on the Individual Plan, group counseling sessions based on established group process procedures; which are to be conducted a minimum of five days per week focusing on clear and relevant topics (informational/developmental/educational). Group sessions are to have a clear leader or facilitator and be at least thirty minutes in length. Group sessions should be an opportunity for youth to engage. Non-residential counselors provide services through a therapeutic community based service designed to provide the intervention necessary to: stabilize the family in the event of a crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services and prevent the involvement of families in the delinquency and dependency systems.

A total of eight files were reviewed including four Non-Residential files and four Residential files. Out of the four Non-Residential files, two were open and two were closed. Out of the four Residential files, two were open and two were closed.

All eight files reviewed had the youth's presenting problems addressed in the Psychosocial Assessment, had youth's presenting problems addressed in the initial case/service plan, youth's presenting problems addressed in the case/service plan reviews, case notes maintained for all counseling services provided, and documented the youth's progress.

All eight files had an on-going internal process that ensures clinical reviews of case records and staff performance, that youth and families receive counseling services in accordance with the case/service plan, and that the program provides individual/family counseling.

All four Residential files indicated that group counseling sessions were provided at least five days a week. The counseling sessions consisted of the following: length of at least thirty minutes, clear leader or facilitator, clear and relevant topic (informational/developmental/educational), and opportunity for youth engagement.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has three policies in place to address the adjudication/petition process titled Case Staffing Committee: Review and Committee Composition, Case Staffing Committee: Parent/Guardian Request, and Case Staffing Committee: Plan of Service. All three policies were last reviewed on January 17, 2018 by the Chief Operations Officer.

The procedures state that a Case Staffing Committee meeting is to be held to review cases determined in need of services or treatment if: the family or youth is not in agreement with the services or treatment offered, the family or youth will not participate in the services or treatment selected, the counselor/case manager needs assistance in developing an appropriate Individual Plan, the parent or guardian, or any member of the committee requests that a Case Staffing Committee meeting be arranged (If requested by a parent, a Case Staffing Committee meeting must be held within seven days, excluding weekends and holidays, of written request). The counselor/case manager is responsible for implementing and monitoring the Plan of Services. A copy is required to be sent to the parent/guardian within seven days of the meeting to provide a written report outlining reasons for or against a petition being filed and the recommendations. The Case Staffing Committee must

include, but not limited to, the following: a representative from the Department of Juvenile Justice or designee in accordance with the CINS/FINS Operations Manual, a representative of the CINS/FINS provider and a representative of the youth's school district.

The shelter does not routinely perform case staffings unless there is a written request by the parent or school. The shelter defers to the school district's truancy petition process reportedly under sections 1003.21 and 1003.24, Florida Statutes. The shelter participates in the school district's Student Intervention Team (SIT) and is named as part of the school district's Truancy Procedure. However, referral is made to the program only if there is a determination by the school's "RTI/Child Study Team" that the student " is in need of services at a higher level of care".

Documentation was provided for two Student Intervention Team Meetings which occur on a monthly basis at the shelter. During this meeting, all truancy cases slated for court the following day are reviewed by the team consisting of: Counselors/Case Managers from CDS East, the Regional Coordinator for CDS East, representatives from the Putnam County School District, representatives from the Putnam County Juvenile Probation Office, and representatives from a partnering agency that provides substance abuse counseling. Further documentation was provided that consisted of notes on the docket paperwork for each youth seen the following day in truancy court. This system demonstrates a high level of involvement by the CINS/FINS program regarding all truancy cases in the county in which the shelter resides.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place titled Youth Case Record. The policy was last reviewed on January 17, 2018 by the Chief Operations Officer.

The procedures require that an official record shall be maintained for each youth receiving services upon Intake. Case records are to be kept in a neat, orderly manner. All records are to be marked as "confidential" and stored in a secure room or locked in a file cabinet that is marked "confidential." When in transport, all records are to be locked in an opaque container marked "confidential."

All eight files reviewed were marked "confidential." All files are securely maintained in locked cabinets in controlled rooms. All files were neat and maintained in a consistent and orderly manner. The program maintains an opaque, lockable container, for transporting files, that is marked confidential.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The CDS Family and Behavioral Health Services-Interface Youth Program East is located in Palatka, Florida. The agency operates twenty- four hours a day, seven days a week. The agency provides the services to the Department of Children and Families (DCF) and Children In Needs of Services (CINS) youth. The Residential Supervisor oversees whether the Youth Care Workers are orienting the new youth and introducing them to the Behavioral Management Strategies-FACE (Facilitating Activity & Communication Effectively). In the absence of supervisor on duty, a shift lead oversees and maintains the shift.

The program also utilizes the point sheets to enhance the youth's personal accountability and social responsibility. At the time of the Quality Improvement Review, youth were not in school. However, the specific schedule of each day of the week was posted for youth to be engaged. The program promotes youth to be active during the summer. Therefore, CDS developed a 2018 IYP-E Enhanced Summer Residential Program. Youth are offered to participate with a variety of activities such as gardening, baking, journaling, painting, and attend to guest speakers. The youth's sleeping arrangement was made based on gender, age, history of aggression, mental health, suicide risk, etc. The youth information such as his/her referral behaviors, alerts, allergies, monitoring status, medications could be found in the files, alert board, and the log book.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place which indicates the program will provide a safe clean, neat and well maintained environment for the youth that they serve. In addition the program will provide structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development. The policy was reviewed and signed by the Chief Operations Officer on January 17, 2018.

The agency has procedures in place for ensuring the facility is well maintained and is a safe environment for the youth served. There are procedures in place for daily activities and programming, for all monthly, quarterly, and annual safety and fire inspections to be completed, for completing drills, and for maintaining agency vehicles.

A tour of the facility was provided and the facility was found to be in good repair, free of any insect infestation/debris and was clean. Agency vans were found to be locked and contained all mandatory safety equipment.

A copy of the DCF child care license was found on display in multiple places throughout the facility. Upon inspection, both the male and female youth rooms/bathrooms were found to be well kept and without visible graffiti.

A review of fire inspection reports indicate that the facility is in compliance with the local fire marshal. In addition documentation was found corroborating that staff complete one mock emergency drill per shift each quarter.

A youth schedule was provided for review which outlined education, recreation, counseling and social skills activities youth are involved in during their stay. The log book was reviewed and confirmed the schedule was consistently followed. The youth schedule was also found to be posted publicly in multiple locations.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place outlining admission/intake and participant orientation which is provided within twenty-four hours of intake. The policy was reviewed and signed by the Chief Operations Officer on January 17, 2018.

At intake each youth is provided a detailed orientation by program staff informing the youth (but not limited) to the following: Key staff and their roles, Program dress code, List of prohibited contraband, Grievance procedures, Tour/Physical layout of the facility, Dress code, Access to medical & mental health procedure, Review of program rules, and Disciplinary action.

There were five youth files reviewed, two closed files and three open files. The program provides a detailed orientation to each youth entering the facility upon the youth completing the intake process. Each file contained necessary documentation indicating that program orientation was completed by program staff with each youth. Each youth and staff member signed off on the program orientation as well as the youth's parent/guardian.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place outlining room assignments. The policy was reviewed and signed by the Chief Operations Officer on January 17, 2018.

During the intake process, each youth is assigned a room or bed based on the information provided by the youth, parent or guardian, and outside related sources that may have knowledge of the youth's history. Several factors are taken into consideration when assigning a youth to a room including: suicide risk, physical characteristics, mental or physical disability, gang affiliation, and aggressive/violent behavior.

There were five youth files reviewed, two closed files and three open files. All five files confirmed that staff make bed assignments based on the above mentioned information provided by the youth, their parent/guardian, and outside sources when appropriate. The facility has dorm style rooms, one for males and one for females, with multiple bunk beds in each. Staff were able to articulate how bed assignments are made and what factors are taken into account to determine if a youth is placed on a top vs. bottom bunk. Youth who are placed on sight and sound during sleeping hours sleep in the living room to allow for a direct line of sight supervision by a staff member.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place which outlines that "a permanent, bound program logbook" will be used to record daily events in the program. The policy provides guidelines for its use and dictates that logbooks will be retained for a period of three years. The policy was reviewed and signed by the Chief Operations Officer on January 17, 2018.

The policy of the program states that it is the responsibility of the shift leader to ensure that appropriate documentation occurs on each shift. It also states that the program Log Book shall document, but is not limited to, the following: All incidents when physical intervention used, Intakes and Dispositions of youth, The staff on duty, That the security of the building has been checked, All incidents including when youth leave and return to the general population, and Any current deficiencies in the program. A review of the program log by the incoming shift leader and staff of the previous three shifts in order to be familiar with activity on prior shifts, unusual occurrences, or problems must be conducted by all staff coming onto shift. A weekly review by the Program Manager, Supervisor, or designee with corrections, recommendations, directives or followup shall be documented.

The shelter uses a paper log book that was created by the agency. The log book is a bound notebook utilized each shift to document daily program activities and occurrences at the shelter. The pages of the log book consist of key sections filled out by staff including staff on duty, Shift Leader Assignments, participant count, Shift Leader Review, Pass on Information Chronological Shift Events, Shift Leader Summary and Shift Leader Comments. The Shift Leader fills out the first sections with staff on duty and participant count at the beginning of the shift along with the previous dates and shifts reviewed. Staff sign in, in a separate log from the program log book. Staff are logged in on duty all at one time in the program log book. An excellent practice of documenting pass on information is completed next giving staff on duty important information about current or future shifts. The next part of the log book is the shift events that document daily occurrences. Finally, the Shift Leader summarizes the events of the day/shift and makes comments based on events or needs. Significant events and incidents are highlighted in the log book. Shift leaders review the log book daily and provide oversight and instruction in the log book each shift. The Residential Supervisor reviews the log book weekly. All errors are struck through with a single line and initialed. All entries were clear and legible.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy to ensure that a consistent and fair system of privileges and consequences are used. The agency uses the Behavior Management System (BMS) to provide rewards, consequences, and ongoing feedback in order for youth to fulfill program expectations.

The provider uses the FACE system (Facilitating Activity & Communication Effectively) with the intent to influence the youth to make positive choices and increase personal accountability and social responsibility. The FACE system consists at three different phases (Assessment, Daily and Achievement). The provider has a written procedure explaining the importance of using verbal de-escalation as a first approach and discourages verbal threats to youth when youth becomes unruly. Physical restraints are used as a last resort. In the case the verbal de-escalation or physical intervention to control aggressive behavior are unsuccessful or raises concerns of safety of other participants, law enforcement is contacted to protect the participants and staff.

Youth who are on Achievement can purchase extra, sweet, snacks

All staff initial training upon hire is within 1 month. There is a protocol for providing feedback of staff regarding their use of BMS rewards and consequences. Supervisor completes a record of action form and the feedback is discussed with the Youth Care Worker. Youth are encouraged to make positive decisions and staff are not to use punishment as a tool.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy titled Staffing and Youth Supervision. The policy was last reviewed by the Chief Operations Officer on January 17, 2018.

The procedures require the Regional Coordinator/Designee is responsible for scheduling and assuring all coverage requirements are in accordance with Florida Administrative Code and Contract. The program shall maintain the minimum staffing ratio: one staff to six youth during awake hours, one staff to twelve youth during the sleep period with at least one staff on duty of the same gender as the youth, one male staff and one female staff scheduled all times.

In reviewing the staff schedules, the program maintains staff ratios as required by the Florida Administrative Code. Over-night shifts consistently maintain a minimum of two staff (one female and one male) present. The program staff schedule is posted in a place visible to staff. There is a holdover overtime rotation roster that includes contact numbers to reach these staff when additional coverage is needed

The Overnight Bed Check Log was reviewed and documented that all bed checks were completed within the required fifteen minute time frame for the last six months. There were three days of video surveillance reviewed to verify bed checks were being completed. The review of the video confirmed the bed checks were being completed as documented for those three days.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Special Populations. The policy was last reviewed January 17, 2018 by the Chief Operations Officer.

CDS policy includes several different components designed to provide safe and secure placement services and protocols for youth, families, and staff. There are five areas of primary concern with respect to the Staff Secure Shelter Services and they include:

1. In-depth Orientation and Admission
2. Assessment and Service Planning
3. Enhanced Supervision and Security
4. Parental Involvement
5. Collaborative Aftercare

The agency's Staff Secure Shelter Procedure details referral and eligibility requirements which state that ALL youth receiving services will receive the same living arrangements as specified in temporary shelter placement.

Each shift will monitor the secure staff youth at all times and should be documented in the Program Log Book.

Youth are referred to the facility however, they must meet specific criteria outlined in the policy. Referral information should be received by the staff local provider within 3 business days prior to the scheduled court hearing and potential transfer of the youth to the facility. Youth who meet the criteria and deemed eligible for staff secure placement must be adjudicated as a CINS/FINS youth. Youth may receive shelter services for up to 90 days with a possible 30 day extension of services.

CDS has Domestic Violence Respite for youth ages 10-18 years of age and who have been charged with a Domestic Violence offense in an

effort to provide a safe and secure alternative to secure detention. Eligible youth must meet specific program eligibility criteria outlined in the agency's policy which is determined through its screening process.

CDS also has a Probation Respite Program for youth between the ages of 10 and 18 years of age and referred by DJJ Probation. Eligible youth must be on Probation with adjudication withheld. Before approving a Probation Respite admission the Florida Network must be contacted for approval. Length of Stay will be determined after admitted into the program which typically varies from fourteen to thirty days.

The program has a Domestic Minor Sex Trafficking Program. Referrals must be approved by the Florida Network for access to funding to provide additional supervision. All request may be approved for a maximum of seven days. Approval for support in excess of seven days will be determined on a case by case basis. Youth must be entered into the NETMIS system as a "special populations" admission.

This program reports that there have not been any inquiries of Special Populations in the last six months to review

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place titled Video Surveillance System. The policy was last reviewed on January 17, 2018 by the Chief Operations Officer. The policy is intended to serve as a protection to youth, staff, and visitors through the use of video surveillance.

The written policy states the shelter shall maintain a video surveillance system that is operational 24 hours a day, 7 days a week and only be accessible to appropriate and trained staff.

A written notice should be posted and visible and conspicuously posted at shelter entrance noting that cameras are in use for security purposes.

Supervisory bi-reviews using a random sample of shelter activities of weekly shelter activities are conducted and documented in the log book. These reviews should be authorized by a supervisor and in accordance with all professional, ethical and legal standards.

Cameras should be able to record date, time, and location and maintain resolution that enables facial recognition.

While video surveillance is not an acceptable alternative to direct sight and sound supervision it is a compliment to the process and seen as secondary to sight and sound.

Cameras are mounted in visible locations and the system has the capability to store video for a minimum of thirty days as required. The program also maintains a back-up system in place in case of an unexpected power outage.

There is a written notice posted in the interior entrance hallway notifying visitors of surveillance for the purpose of security. All cameras are visible and strategically placed both inside and outside of the facility with facial recognition capability and can capture and retain images.

The program Director and the Program Supervisor are on the Camera Access- Approved Personnel List for both on and off-site permissions.

The program has sixteen operational cameras. No cameras were placed in bathrooms or youth sleeping quarters.

The program conducts a random sample review, by a Supervisor, of video which includes overnight shifts. The agency's procedure exceeds the fourteen day minimum requirement and was evidenced through staff interviews and analysis of Program Log books. There were eighteen verified surveillance reviews by a Supervisor dating from 11/10/17 – 6/3/18. There were two instances 5/5/18 and 5/11/18 when the surveillance camera was inoperable; however, it was accessed and reviewed via the Supervisor's cell phone.

Although no request were made there is a procedure in place for request for video recordings for QI visits or when an investigation is launched

after an allegation of an incident which states the video will be made available within 24-72 hours.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CDS-East program has specific policies and procedures addressing new admissions, screening, assessment, health/mental health conditions and training to ensure safety and appropriate supervision of youth admitted to the residential program. Upon admission, program staff conduct a full intake interview with the youth and their parent/guardian. An initial assessment helps to determine the most appropriate room assignment, what health/mental health conditions the youth is experiencing, how the youth may integrate with the current population, the staff's assessment of the youth's ability and capacity to function within the program rules and expectations, history of criminal involvement, the maturity level of the youth, school functioning and performance and family dynamics. Staff on duty at admission immediately identify special needs, conditions and risks of the youth. This may include risk of suicide, other mental health concerns, psychiatric medication, behavioral health, substance use/abuse, physical health including current issues as well as chronic issues and other potential security and safety risk factors.

There is regular and healthy communication and collaboration between the program shelter supervisor, coordinator and licensed mental health counselor with suicide risk assessments. When a youth is positive on a suicide risk screening, they are immediately placed on Constant Sight and Sound Supervision or One-to-One Supervision until a licensed mental health counselor is able to further clinically assess the youth for any further supervision needs. The agency uses an observation log system in the client file, reviewed by a supervisor, and a daily logbook documentation system as well as an alert white board as part of its internal medical/mental health alert system. The agency operates and utilizes a medication distribution system using a Med-Station Medication Cabinet. The program utilizes a Registered Nurse (RN) on-site several days a week. The RN monitors the youth's physical health and medication distribution as well as provides training to staff on various physical health issues. Staff are trained to provide CPR and First Aid as well as suicide prevention and assessment, and signs and symptoms of mental illness and substance abuse.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency utilizes policy P-1117, Residential Admission: Preliminary Physical Health Screening, and P-1118, Residential Admission: Medical Follow-Up, to address screening for all past or current medical conditions. These policies were last reviewed on January 17, 2018 by the Chief Operations Officer.

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. Any health concerns that require a follow-up are assessed at that time through consultation with the parent/guardian and documented on a Medical Health Follow-Up Form. If the parent/guardian is unavailable attempts are made to contact the youth's physician. In the case of an emergency, 911 is contacted for assistance.

A total of seven files were reviewed to assess requirements of this indicator. Of the seven files reviewed, all contained the Intake Assessment form with all health screening sections completed. In one of the seven files reviewed, it was documented the youth was on multiple medications. The medications were listed, as well as, the reasons for each medication. The remaining six files documented the youth was not on any type of medications. In three of the files reviewed, it was documented the youth had some type of allergies. In the four remaining files, it was documented the youth did not have any allergies. In two of the seven files reviewed, it was documented the youth had some type of existing (acute or chronic) medical condition. The remaining did not document any medical conditions. The RN documented an intake note in each file, documenting a review of the youth's medication and medical history. The Intake Assessment form was reviewed by the RN the same day of completion in all five files. In all seven files reviewed, a Registered Nurse reviewed all physical health screenings, including the youth's current medication, within five calendar days. In two files the RN reviewed the screening on the same day as admission. In three of the files reviewed the RN reviewed the screening the next day. In one file reviewed, the RN reviewed the screening two days after admission. In the last file reviewed, the RN reviewed the screening four days after admission.

The agency utilizes a Medical Health Follow Up sheet. This sheet 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 sheet with information on the health issue is placed in the youth's file. The sheet 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. In the seven files reviewed, four of the files contained this sheet. In three of the files reviewed, the youth had a follow-up sheet for an Allergic Reaction for the allergies identified. In one of the files reviewed, the youth had a follow-up sheet for ADHD. The sheets include Tips to Remember, a brief health education concerning these

conditions, the youth's name, date, medical instructions, and other information/instructions per the parent/guardian.

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 reviewed on January 17, 2018 by the Chief Operations Officer.

The agency has two levels of supervision, one-to-one supervision and constant sight and sound 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 of the same gender as the youth, unless it is documented in the case file and/or log book why it is not clinically appropriate) will remain within arm's length, not to exceed 5 feet, of the youth at all times. 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. For both levels of supervision, the staff assigned to monitor the youth must document his/her observations of the youth's behavior at intervals of thirty minutes or less.

The policy states all admissions to the program are screened for suicide risk using the Florida Network approved six suicide risk questions. Youth screened indicates a suicide risk are placed on one-to-one supervision or constant sight and sound supervision dictated by need until a clinical assessment is completed by a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional. Additionally, if at any time from when the point when a youth arrives at the shelter and any staff observes or believes a youth presents as an immediate threat to themselves or others, the youth will be placed on one-to-one supervision and staff will immediately call 911 and request assistance from law enforcement for a Baker Act and/or transportation for additional assessment. Furthermore, when staff observes any indicators (behaviors, actions, youth demeanor, conversations, etc.) subsequent to the youth's admission into the program that may reflect an increased risk of suicide, a suicide risk screening may be performed. At any time the youth has made suicide gestures or attempted suicide, the program supervisor shall be notified and informed what procedures have been put in place to insure the youth's protection. Any time there is a suicide attempt the agency CEO/COO, the Florida Network and DJJ shall be notified in accordance with DJJ Incident Reporting Policy.

Upon admission to the residential facility, there are six questions that are asked to each youth via the Interface Intake Assessment form: 1. Have you ever attempted to kill yourself; 2. Are you thinking about killing yourself now; 3. Do you have a plan (specific method) to kill yourself; 4. Do you feel that life is not worth living or wish you were dead; 5. Have you recently been in a situation where you did not care whether you lived or died; 6. Have you felt continuously sad or helpless?

If the youth answers yes to any of these six questions, an assessment must be completed by a licensed professional or an unlicensed professional under the supervision of a licensed professional. An assessment must be accomplished within 24 hours after the screening unless the screening occurs on the weekend (from Friday 5 pm to Monday 9am). Then, the assessment must be completed within 72 hours. If the youth answers yes to question 2 or 3 (with an immediate method to enact the Plan), one-to-one supervision shall be provided until an assessment is completed. If a youth answers yes to question 1, 3 (with no immediate method available to enact the Plan), 4, 5 or 6 the youth shall be placed on constant sight and sound supervision until an assessment can be completed. Staff should initial the following actions when it is completed on the Intake Assessment NetMIS form and note any other actions taken in the designated area: place the participant on one-to-one supervision and constant sight and sound supervision as indicated; begin observation log; complete youth safety agreement; alert a supervisor of participant's status; alert the licensed professional or unlicensed professional of the need for an assessment to occur within 24 hours; contact parent/legal guardian and inform them of the participant's status; document in the program log book; document in the participant file.

When a youth returns from a Baker Act facility, the youth will be placed on constant sight and sound supervision until an assessment of suicide risk can be completed by a licensed professional or an unlicensed professional under the supervision of a licensed professional to determine further supervision needs within 24 hrs. After the youth's return to the shelter, unless the screening occurs on the weekend (from Friday 5 pm to Monday 9am), then, the assessment must be completed within 72 hours.

A total of four closed residential files, randomly chosen by the reviewer, that had completed a suicide assessment in the last six months, were pulled to assess the agency's suicide precaution procedures. In all four files reviewed, the suicide screening occurred during the initial intake and screening process. The suicide screening results were reviewed and signed by the residential supervisor and documented in all four files. All four youth were assessed by a non-licensed professional (master's level) residential counselor under the direct supervision of a licensed professional (LMHC) within the agency. All four assessments were faxed to the LMHC to be further assessed and reviewed. All four youth were appropriately placed on constant sight and sound supervision until the LMHC reviewed the assessment, signed it, and faxed it back to the program.

In all four files, it was documented that the youth's parent/guardian and residential supervisor were notified once the youth was placed on

constant sight and sound supervision level. This was easy to find in the file since it was highlighted in blue in the progress notes. Observation logs in all four files documented thirty minute (or less) behavioral observations of the youth, by a staff assigned to monitor the youth, until the LMHC was able to further assess and review the assessment. In all four files the suicide assessment was completed by the counselor, and faxed and reviewed by the LMHC, within twenty-four hours. All four youth were placed on standard supervision and did not require a further assessment. All four of these instances of suicide precautions were found documented in the program logbook. There was documentation when the youth was placed on suicide precautions and there was documentation when the youth was removed.

There is one residential counselor who completes the suicide risk assessments. This is a master's level counselor who is not licensed. This counselor works under the supervision of the Regional Coordinator, who is a LMHC. Documentation was provided and reviewed to show this counselor had completed twenty hours of training with the LMHC, including conducting five, supervised suicide risk assessments.

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 reviewed on January 17, 2018 by the Chief Operations Officer.

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 nineteen staff who are trained to supervise the self-administration of medications. Out of the nineteen staff on that list three were listed as "Super Users" for the Pyxis Med-Station, they are the two Registered Nurses (RN) and a Senior Youth Care Worker.

The shelter has two RN's who have both been employed at the shelter for less than a year. The RN's split the twenty work hours that are required weekly. One RN works weekdays and is usually on-site three weekdays each week, for a total of at least ten hours. The other RN works mainly weekends and is usually on-site Saturday and Sunday, totaling another ten hours. The RN's will adjust their schedule each week depending on the needs of the shelter and the youth in the shelter.

Trained staff, who are authorized, will distribute medications when the RN is not on-site. The RN does complete trainings with the staff, including a thorough training at hire on using the Pyxis MedStation and administering medication. The RN also completes refresher training for any staff who they feel may need it or ask for it, and also any staff who have a medication error.

There have been twenty-two discrepancies documented since the last on-site review. The Discrepancy Report was reviewed and documented all discrepancies were resolved before the end of the staff's shift. Most of the discrepancies were staff entering the wrong count. On one discrepancy a pill was dropped on the floor. On another discrepancy staff did not give the youth right amount of medication. This error was reported to the CCC. For the past three months, there were no discrepancies in May, there was one discrepancy in April and there were five discrepancies in March. There were no open discrepancies at the time of the review.

The RN prints five different reports from the Knowledge Portal, four reports are printed monthly and one report is printed weekly. The monthly report include: All Profile Overrides, User Summary by Transaction Type, Summary by Transaction Type, and Summary of all Treatment Activity. The report printed weekly is the Discrepancy Audit.

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. At the time of the review, only drawer two of the Pyxis Med-Station was being used. All other drawers were empty. The shelter has a system in place for refrigeration of medication if needed. The temperature of the refrigerator is checked weekly by the RN and documented on a chart located on the side of the refrigerator. The chart reveal the refrigerator stays at a constant 36 degrees. There were no medications requiring refrigeration at the time of the review.

All medications in the shelter are inventoried once per week, by the RN or a trained staff member. This inventory is documented on the back of each individual Medication Record Log (MRL). All medications are also inventoried at admission with the parent present, when given, by maintaining a perpetual inventory with running balances, and at discharge also with the parent present. Controlled medications are inventoried shift-to-shift also. The shelter does not have any over-the-counter medications.

There was one youth in the shelter on medications and that file was reviewed, along with four additional closed files, for medication administration. The agency still maintains hard copies of all documents relating to the medication process and enters all information into the Pyxis Med-Station, as required. The youth's MRL is maintained in a medication binder until the youth is discharged and then the MRL is filed in the youth's 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. The back of the MRL documented all daily and weekly inventories and the verification of the medication with the pharmacist or by the RN. All files reviewed documented medications were given at the prescribed times.

The agency has a medication process for notifying the parent/guardian when a medication supply is low. This notification is activated and parents are contacted at two weeks of remaining medication, and if not brought in, the notifications continue every couple of days until the parent brings the refill in.

There has been one medication error in the last six months. This was due to a youth only receiving one pill instead of the prescribed two pills. The agency provided full documentation of the measures taken to address the root cause and the remedial training provided to the staff involved in the error. The staff person was re-trained by the RN.

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 reviewed on January 17, 2018 by the Chief Operations Officer.

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 are to review the youth board and program logbook the beginning of each shift. All direct care staff are to receive training in signs and symptoms of mental illness and substance abuse, suicide risk assessment and prevention, and CPR/First Aid.

The agency has a coding system that includes twenty-one codes for various alerts that can occur in the residential setting. The staff places the appropriate number code(s) on the youth board in the youth care worker office for all staff to see at a glance. A medication board is also in the youth care worker office, that is used as an additional tool for staff to quickly see who is on medication and times it is to be given. A code definition sheet is taped to the work desk in a highly visible location in the youth care worker office. In the files, medication administration/management is documented in the progress notes and is highlighted in pink. Suicide assessments are completed on blue sheets. The agency also places the appropriate number code(s) on the spine of the youth's file. And if the youth has any allergies a form is printed out, in big, bold letters, that states the youth's allergy and the youth's reaction. This document is then placed on the front of the youth's file so that it is immediately visible to staff whenever the file is pulled. All alerts are updated as needed.

A review of seven open youth files was conducted to verify the shelter's alert process. A review of the files, and all screenings and assessments completed inside the files, revealed all alerts identified for each youth were appropriately documented on the spine of the youth's file with the corresponding code. In addition, A Medical Health Follow-Up form was found in the four applicable files. In these four files, three of the youth had allergies and one youth had ADHD. The form documented the symptoms for staff to watch for, first aid to give if needed, tips, things not to do, and when to call for emergency medical assistance. At the end of each form the youth's actual medical/mental health/allergy is documented by staff along with other information/instructions per parent/guardian.

A review of the youth board in the youth care worker office revealed all alerts, for all seven youth, were appropriately documented with all the applicable codes. The medication board was also observed, located under the youth board, and it also appropriately documented the one youth in the shelter on medication, all four of the medications this youth was taking, and the times they are to be given.

An interview with the Residential Supervisor revealed a firm understanding of the program's alert system. This individual was able to properly articulate the process used, explain the screening process and how alerts are identified, explain the different codes used, explain all places where the alerts are documented, and explain how the Medical Health Follow-Up form is used.

Any dietary alerts are documented on a dry erase board in the kitchen and also documented on a form kept in a binder in the kitchen. The form documents the youth's food allergy and what happens to the youth if they come in contact with that food. At the time of the review there was one youth in the shelter with a food allergy and this youth was documented on the dry erase and also on the form in the binder. The information reviewed in the binder revealed it was the same information documented in the youth's file.

There were no exceptions to this indicator.

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 reviewed on January 17, 2018 by the Chief Operations Officer.

The policy includes measures to ensure the provision of emergency medical and dental care. The policy includes a specific focus on collecting off-site emergency services; parental notification regarding emergencies; incident reporting to the DJJ CCC and FNYFS; daily logging of events/activities; and returns to the shelter, verification of medical clearances, discharge instructions and follow-up care. In addition, the policy addresses the provision of emergency equipment (first aid kits, knife for life, breathing barriers and blood borne pathogen kits); incident reports to DJJ CCC; critique of off-site emergency care; root cause analysis and emergency situations.

A review of on-site emergency events was conducted. A review of all incidents in the last six months was conducted from January 2018 to June 2018. There was a total of two actual incidents that resulted in off-site emergency care. Each incident was reported to the CCC and documented in the Medical and Dental Referrals Daily Log. An incident report was completed for each one as well, that documented what happened, notifications to the parents and supervisory staff, the treatment the youth received, and if any follow-up care was needed. The agency has completed an emergency medical drill on each shift for this last quarter.

There are four first aid kits located throughout the shelter. The kits are checked monthly by a youth care worker. A detailed report is completed when the kits are checked documenting an inventory, all expiration dates, and what was replenished. These reports were reviewed for the last six months. The shelter has both a knife for life and wire cutters located in the top drawer of a filing cabinet in the youth care worker office.

The agency has a broad range of emergency related training including CPR/First Aid, Fire Safety, Blood Borne Pathogens, and Disaster Training. The agency has access to two Registered Nurse's.

There were no exceptions to this indicator.