Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS-Interface NW

on 04/19/2018

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	Limited
1.07 Outreach Services	Satisfactory

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

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

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

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer/Consultant, Forefront LLC

Lauren Maldonado, Early Intervention Specialist, Florida Network of Youth and Family Services

Shad Renick, Residential Director, Sarasota YMCA

Erik Kline, Residential Supervisor, Family Resources Bradenton

Cindy Hoskins, LMHC, Anchorage Children's Home

Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Chief Financial Officer
- [x] Program Coordinator
- [ ] Direct-Care On- Call
- [x] Clinical Director
- [x] Case Manager
- [x] Nurse
- [ ] Executive Director
- [x] Program Director
- [x] Direct- Care Full time
- [ ] Volunteer
- [x] Counselor Licensed
- [ ] Advocate
- [ ] Chief Operating Officer
- [x] Program Manager
- [ ] Direct-Care Part Time
- [ ] Intern
- [x] Counselor Non- Licensed
- [x] Human Resources

1 Case Managers
1 Program Supervisors
1 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

2 Clinical Staff
0 Other

Documents Reviewed

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

5 # Health Records
5 # MH/SA Records
8 # Personnel Records
8 # Training Records
4 # Youth Records (Closed)
5 # Youth Records (Open)
0 # Other

Surveys

3 Youth 4 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating 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 program locations report to the agency's Chief Executive Officer and Chief Operations Officer that are located in the central office in Gainesville, Florida.

Since the last program quallity improvement visit, there has been several changes. They include:

-The Residential Counselor was recently promoted to the Residential Supervisor role. A new Residential Counselor was hired.

-The facility has been painted since the last on-site review.

-The shelter will be using Challenge Grant funds to re-do flooring in the building and to re-do the outside of the building.

-The security system has been upgraded. The shelter now has sixteen cameras, including two outside cameras.

-The tile in the youth bathrooms was recently replaced.

-The shelter just received their three year accreditation with CARF.

Standard 1: Management Accountability

Overview

Narrative

The CDS-NW in Lake City, Florida location is operated by a Regional Coordinator. The Regional Coordinator position is the highest-ranking position for the agency at this location. The agency assigns the daily operation and direct responsibility of each shelter to a Residential Supervisor. The shelter also employs a Senior Youth Care Worker, ten Youth Care Workers, an Administrative Assistant, a Registered Nurse, and a Residential Counselor.

The CDS-NW program agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, the agency consolidates trainings to simultaneously train its staff on various training topics across all work sites and to create better camaraderie amongst staff members assigned to various youth shelter locations.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency uses policy P-1025 to address background screening requirements. The policy titled Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns was last reviewed on4 January 17, 2018.

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

There were a total of six staff hired since the last review. All six staff received a background screening prior to their hire date. There were two staff eligible for a five-year screening to be conducted. One screening was completed prior to the staff’s initial date of hire as required. The remaining screening was completed approximately two months after the staffs initial hire date.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit on January 4, 2018.

Exception:

One five year re-screening was completed approximately two months late.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has comprehensive policies and procedures related to providing an abuse free environment. These include Florida Abuse Reporting with a quick reference guide, Standards of Conduct, Rule Violations, Complaint/Grievance for Participants or Companions with Disabilities, and Behavioral Expectations for Staff. These policies were last reviewed on January 17, 2018.

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

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

female and male day rooms.

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

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

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

The program has a tracking system for complaints/grievances. The tracking log for the review period showed two complaint/grievances. One complaint/grievance was completed by the youth on 3/31/2018, followed up by the Resident Supervisor on 4/2/2018 and resolved with the youth on 4/3/2018. The second complaint/grievance form was completed by the youth on 4/1/2018, followed up by the Resident Supervisor on 4/2/2018 and resolved with the youth on 4/4/2018.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has two policies related to this area: Incident Reporting Procedure and Unusual Event-Internal. Both policies were last reviewed on January 17, 2018.

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

The program has had three incidents reported to the CCC in the past six months. All three incidents were reported within two hours of staff becoming aware of the incident. Follow-up documentation was provided for all incidents. Questions from the CCC along with follow-up answers from the program, and any supporting documentation was provided for all three reports. There was documentation the reports were successfully closed.

The program also keeps Unusual Incident Reports for any other incidents occurring in the program not requiring notification to the CCC. These reports are kept in a binder and separated by month. These reports were reviewed as well, and there were no incidents within those reports requiring notification to the CCC.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Training Plan in place that is effective from July 1, 2017 – June 30, 2018.

The plan states that the Program/Regional Coordinator at the program will maintain training files that include documentation of training and

certifications on each employee. A position-specific annual training plan, which indicates completed training as well as projected training topics for the remainder of the year, is also maintained in each employee's training file. The training outlined in the plan meets the requirements outlined in the Florida Network's CINS/FINS Policy and Procedure Manual.

There were two staff training files reviewed only for training completed during the staff's first 120 days of employment. One staff was missing CINS/FINS Core Training and Managing Aggressive Behavior. One staff received CPR, First Aid, and Understanding Youth Development outside the 120-day requirement. All other training's were completed as required.

There was one staff file applicable for first year training requirements. This staff received 85 hours training hours during the first year of employment. This staff received all required trainings.

There were five staff training files reviewed for annual training requirements. All five staff documented more than the required forty hours of training annually with: 77, 62, 47.5, 77, and 90 hours respectively. All staff documented all required trainings were completed with the exception of one staff who did not receive PREA training, and one staff who did not receive PREA training and Managing Aggressive Behavior training.

Exceptions:

One staff was missing CINS/FINS Core Training and Managing Aggressive Behavior in the first 120 days of employment.

One staff received CPR, First Aid, and Understanding Youth Development outside the 120-day requirement.

Out of the five staff training files reviewed for annual training, one staff did not receive PREA training, and one staff did not receive PREA training and Managing Aggressive Behavior training.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy for this area called Quality Assurance Program which was last reviewed on January 17, 2018.

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

The program collects and reviews data from several different sources of information to identify patterns and trends. The program reviews a monthly report, which also becomes a yearly cumulative report, as it builds throughout the year which is called the CDS Performance and Risk Management Report. This allows staff not to only look at the monthly trends but how the data compares to prior months.

The program holds monthly meetings with staff; this is documented in the Staff Meeting binder and includes minutes and a sign-in sheet. Based on the meeting notes there was a meeting for all months of the review period. According to the documentation, Risk Management is discussed at all staff meetings.

Peer case reviews are completed quarterly. There was documentation of these reviews for the last two quarters. Incidents, accidents, and grievances are reviewed quarterly in the CDS Performance and Risk Management Report. A description and action taken for each report was documented. The Performance and Risk Management Report also includes a monthly review of NetMIS data reports.

There were no exceptions to this indicator.

1.06 Client Transportation

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has policies and procedures regarding Vehicle Use and Safety Inspection (P-1013). The policy was last reviewed by the COO in January 2018.

Procedures in P-1013 indicate that it is best practice to have a third party present in the vehicle while transporting a service participant. According to this document a third party can be an approved volunteer, intern, agency staff, or other participant. The agency requires that Approved Drivers have a valid driver's license, and have automobile insurance in addition to the automobile insurance provided by the agency. Procedures also include an initial review of employee driving records and annual follow up reviews, as well as minimum standards for driving eligibility. The policy notes that as a last resort when a third party cannot be utilized the participant's history, evaluation, and recent behavior will be considered prior to transport and evidence that the program supervisor is aware of this and provided consent (prior to transport) will be documented. The policy notes that the Mileage Log should be filled out after the use of the vehicle.

The agency uses the Travel Log/Van document to note the required information including name of driver, name of other adult, date and time, mileage, number of passengers, purpose of travel and location. The agency utilizes the Transportation Exceptions Approval Log (Single/Third Party) to coordinate which youth and staff are approved to travel without third party companion. The supervisor signs and approves this log weekly. There are multiple youth names listed for each week and the supervisor signs approving all those youth for single client transports for that week.

The Transportation Exceptions Approval Logs and the Travel Log for the last six months were reviewed. Some of the entries in the Travel Log were compared with the Program Log Book. Out of 473 entries, 468 included all the needed data as required in Indicator 1.06.

Exceptions:

Out of 473 entries in the Travel Log, four entries did not list the drivers' names and one entry did not list the date and purpose of the travel.

In comparing the Transportation Exceptions Approval Log with the travel entries on the Travel Log, there were twenty-nine cases in which the single driver listed in the Travel Log was not approved in the Transportation Exceptions Approval Log. Furthermore, in neither the Travel Log nor Program Log Book youth names were not listed for travel. As a result, verification that the youth listed in the Transportation Exceptions Approval Log were the same youth travelling with a single staff member could not be confirmed. This lack of youth names left unable to determine the exact youth on the transport so we were unable to verify if the youth had been approved.

Lastly, in comparing the Travel Log with the Program Log Book there were some discrepancies related to travel time/occurrence.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has two policies related to outreach: Roles and Responsibilities - Prevention Outreach and Outreach Plan for Targeting Youth for Program Services. Both polices were last reviewed on January 17, 2018.

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

The program has a binder in which they keep the meeting agendas from Circuit 13 Juvenile Justice Advisory Board Meetings. Based on the documentation in the binder, the program attended both quarterly meetings during the review period, one in October 2017 and another in January 2018.

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

The agency has a Cooperative Service Agreement dated 2/21/2018, which list forty-six other community agencies.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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

The agency also leads and coordinates the local Case Staffing Committee, a statutorily-mandated committee that develops treatment plans for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court if needed.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy 1112 addresses the screening process to ensure that consistent and pertinent health, safety, and other relevant information is gathered during this process to identify a youth's immediate needs and determine eligibility. If it is determined that a youth is at risk of harming himself or others, the screener should contact 911 to ensure the youth receives emergency services. If no imminent danger is identified, normal screening procedures should be followed. A Screening/Referral form should be completed for each youth considered for Residential Services to assess eligibility. The purpose of the policy is to ensure youth and families have access to services 24 hours a day, seven days a week with the intention of making sure that the youth are adequately screened upon admission and provided with all necessary program information during intake.

Policy 1151 addresses the Intake/Assessment process that occurs once a screening has been completed. The intake/assessment process shall be initiated within seven days. The assessment process may include but is not limited to: Screening, PAT (Non-Residential only), Needs Assessment, Medical History, Suicide Assessment (when needed)

The purpose of this policy is to ensure that the assessment process is initiated in a timely manner after receipt of a referral for services. The assessment should serve to develop a thorough picture of the problems faced by the youth and/or family.

The program has a phone number for youth and families to call at any time if in need of services. Youth are screened to determine eligibility and assessed for any critical risks. Once a youth is determined eligible for services, an Informed Consent and Participation Agreement Parent/Guardian Orientation packet is reviewed, signed, and a copy is made available for residential youth and Participant Rights and Responsibilities are completed with a residential youth. An Informed Consent and Participation Agreement Participant Rights and Responsibilities is reviewed, signed, and a copy is made available for non-residential youth and families. This covers agency practices related to confidentiality, grievance procedures and all other program expectations. All families served are also provided with a CINS FINS brochure that details possible actions available through involvement with CINS/FINS services.

There were four non-residential files (two open, two closed) and four residential files (two open, two closed) reviewed. Initial screenings were completed upon intake in each file to determine youth eligibility well within seven days of the initial referral. Each file has documentation youth were provided with a participant agreement and packet. The review of the participant agreement was acknowledged by youth signature.

There were no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy 1019 address the needs assessment. The purpose of this policy is to outline the process involved in completing the Needs Assessment and PAT for CINS/FINS youth.

Each youth admitted to the program should participate in an assessment process with staff to gather pertinent information regarding the participant and their family that can be used to assist the youth and family in developing an Individual Plan to address their unique situation and

needs.

Needs Assessments must be initiated (or attempted) within 72 hours of admission and mpleted within two to three face-to-face contacts following the initial intake if the youth is receiving non-residential services

Needs assessments are completed by Bachelor's or Master's level staff and signed by a supervisor. If the suicide risk component of the assessment is required, it must be reviewed, signed, and dated by a licensed clinical supervisor or written by licensed clinical staff.

A review of four non-residential files (two open, two closed) found needs assessments were completed on the date of admission in each case.

A review of four residential files (two open, two closed) found needs assessments were completed within 72 hours, with most being completed on the date of admission, except for one file where a needs assessment was completed outside of the 72 hour time frame. This Needs Assessment was completed one day late due to the 72 hour time frame falling on Christmas Day.

Needs assessments for non-residential youth were either completed by a LMHC and/or a supervisor reviewed and signed each completed needs assessment.

The needs assessments addressed all areas required by program and procedure.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy 1162 addresses Individual Service Plans. The stated purpose of the policy is to ensure each youth is provided with an individualized service plan to best address his/her identified needs.

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

Four non-residential files (two open, two closed) were reviewed. An individual plan was developed after the completion of the needs assessment and on the date of admission in each case.

Four residential files (two open, two closed) were reviewed. An individual plan was developed within seven days of completion of the Needs Assessment in all four cases.

All eight individual plans included objectives to address needs identified in the Needs Assessment. Page one of the plans had standard service provisions (i.e. individual
counseling, family counseling, case management).

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

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy 1163 addresses Case Management, Counseling, and Service Delivery. It states that staff shall maintain direct and ongoing contact with agencies active with the youth/family to ensure case coordination, case management, and continuity of care. All contacts shall be appropriately documented.

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

Four non-residential files (two open, two closed) and four residential files (two open, two closed) were reviewed. Documentation of referrals to outside agencies for services were documented in the youth's files. Documentation on individual plans and progress notes documented coordination of services and monitoring of youth and family progress.

Support for families in each case was evident in the progress notes as well. In the four closed files, documentation showed the programs followed up with the family within thirty days of release and again within sixty days of release. The program's Administrative Assistant maintains records for the thirty and sixty day follow-ups.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policies 1163, 1199, and 1046 address Counseling Services. The stated purpose of these policies is to ensure each youth is provided counseling based on identified needs.

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

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

Counseling services and other services were provided in accordance with objectives listed in case plans, though page one of each case plan included standard service provisions, to include the frequency of services, such as weekly individual counseling and monthly family sessions.

Group counseling was documented five days a week for youth in their files.

A review of the supervision binder over the last six months indicates that monthly staffing/supervision meetings occur and a quarterly Peer Participant Review was documented as well.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policies 1160, 1157 and 1159 address the Adjudication/Petition Process. The stated purpose of the policy is to ensure a case staffing committee meeting is appropriately convened if a youth and/or family is determined to be in need of services and a staffing is needed to ensure services.

The procedures detail when a case staffing committee meeting is required, what participants must be included, and other participants who may be included. The procedure provides an outline of time frames for scheduling and notifications to be completed prior to and following the completion of a case staffing committee meeting. It was reported that there is regular and ongoing contact with a new staff member at the local

school board office who is familiar with the Adjudication/Petition Process and will refer as needed.

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

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy 1046 addresses maintenance of youth files. The stated purpose of the policy is to ensure files are maintained in an orderly manner, to maintain the confidentiality of youth files, and ensure that files are kept in an area with limited access.

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

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

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

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

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

The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis. The medication and first aid supplies are stored in the staff office in a locked desk behind a locked door near the dining/office area. The Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The residential shelter also includes administrative offices for Regional Coordinators, Counselors and Case Managers, and the Administrative Specialist.

Residential services—including individual, family, and group services—are provided to youth and families. Case management and substance abuse prevention education are also offered. The program also has an effective grievance process. When submitted grievances are reported, they are generally addressed within seventy-two hours of being submitted to management.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy reflects the Quality Improvement Standards outlined by the Florida Network. The intent of this policy describes the key components of Facility Standards that are necessary to maintain the safety of participants, employees, volunteers and visitors and to ensure compliance with licensure rules, Florida Statute, funding sources and accreditation requirements. In addition to the facility standards there are also policies for Leisure and Education and Faith Based Activities. While the policy and procedure has not been individually signed, the policy and procedure was reviewed by the COO on 1/17/18, as indicated on a program memorandum.

The program follows the requirements for annual fire and safety inspections as well as completes the necessary fire and emergency drills. The grounds and facility are well maintained by the program. The youth are engaged in meaningful activities and the environment is safe and structured.

CDS Northwest is a twelve bed facility in Lake City, Florida. The programs facility and grounds are well maintained and safe for the youth residing in the Shelter. There are two dorm rooms, one for the male residents and one for the female residents. Both dorm rooms house six residents and are clean and well organized with the youth having their own bunk and a storage bin that is unlocked in the dorm room. If the youth is in need to store valuable personal belongings there are two separate locked storage closets where those valuables may be stored. Both male and female residents have a living space that is just outside the dorm rooms that is equipped with a TV that they can watch TV or read in and it is separate from the other gender.

In addition there is a common living room where the youth may congregate together both male and female. They can watch TV, play games, groups are run there, as well as, arts and crafts. Outside there is a parking lot where there is a basketball hoop and chairs. Youth can go outside for recreation time. The daily schedule is posted in each separate living area so that youth know daily program activities. In each gender's living area there is a bathroom with a single shower. The bathrooms are well maintained. There is a counseling office where individual and family sessions occur as well as a conference room. There is a kitchen with a pantry that stores all of the chemicals that are maintained and counted regularly. There is a dining room where the youth eat. There is also a nurse's station with access to both the living room and conference room. There is also a calming room which is accessible from the common living room.

The Shelter has one, twelve passenger van that is well maintained and has all of the required safety equipment. Egress plans are posted throughout the facility. All appropriate notices are posted including abuse hotline numbers, grievance forms, DCF license, and client rules. All Fire and Safety inspections are completed within the required time frames. The schedule provides the youth with the opportunity to engage in structured activities including education, recreation, physical activity, homework, and faith based services (if requested).

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy reflects the Quality Improvement Standards outlined by the Florida Network. The purpose of this policy is stated to be to ensure that youth receive a comprehensive intake and orientation to the program in a timely manner. While the policy and procedure has not been individually signed, the policy and procedure was reviewed by the COO on 1/17/18, as indicated on a program memorandum.

The program utilizes several key forms and documents to ensure that the policy is implemented. Upon entry to the program the youth and parent sign for a Participation Orientation Packet that includes the handbook. This packet also includes the rights and responsibilities of the youth during their stay. In addition the youth sign an Orientation Checklist that is reviewed with the youth and signed off by staff. In addition there is a MOTHER SHEET that is completed by the Shift Leader to verify completion of intake information.

There were five files reviewed for compliance for this standard. All five files had documentation that a comprehensive orientation was complete and handbook provided within twenty-foyur hours. All five files had the required youth and parent/guardian signatures. A tour of the facility and program expectations was documented for each youth.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy reflects the Quality Improvement Standards outlined by the Florida Network. The purpose of this policy is stated to be to ensure that each youth is protected from harm and that safety and order is maintained. The youth's room assignment and reasons for those assignments is discussed in the policy. There is also an additional policy that addresses the medical/mental health alert process. While the policy and procedure has not been individually signed, the policy and procedure was reviewed by the COO on 1/17/18, as indicated on a program memorandum.

Upon admission into the program each youth is interviewed to determine what the most appropriate bed assignment/sleeping arrangements that need to be made to increase safety and staff awareness. This information is documented on the second page of the intake assessment in a box marked Participant Room Assignment. This box contains information on the history of the youth as well as physical information, religious affiliation, attitude/cooperation, sight and sound supervision and special instructions. Due to the dorm style arrangement of the Shelter, youth are assigned beds and bunks based upon the assessment at intake. When a youth is placed on sight and sound, a mattress is taken out of the dorm room and the youth will sleep on a mattress in the day room.

There were five files reviewed for this standard. All five files reviewed had a bed assignment. All relevant factors were addressed when making bed assignments including age, gender, history, build, behavior, and observations. The program has a comprehensive alert system on a blue sheet in the file that includes risk factors and a mental health alert system that gives instructions to staff on how to classify youth when they answer yes to any of the risk screening questions.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy reflects the Quality Improvement Standards outlined by the Florida Network. The purpose of this policy is to ensure that daily program occurrences are captured in a permanent, bound book. While the policy and procedure has not been individually signed, the policy and procedure was reviewed by the COO on 1/17/18, as indicated on a program memorandum.

The log book is utilized each shift to document daily program activities and occurrences at the facility. 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 facility utilizes a bound notebook that records the program activities on a shift by shift basis. 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. 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 summaries the events of the day/shift and makes comments based on events or needs.

Staff are consistently filling out the shift events which documents the daily program activities. The Shift Leader reviews the log book daily and provides oversight and instruction for each shift. 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. The shift count is completed by the Shift Leader at the beginning of the shift. Youth movements in and out the facility are documented in the shift events only and are not indicated on the count. While staff do document when school runs and visits are made there is no documentation of which youth are going on those runs. In addition there is no documentation of the groups completed in the program log book. Documentation for groups is in the youth's file.

Exception:

As per Florida Network policy 4.14, one of the minimum requirements that a log book should contain are transports away from the facility, including the names of staff and youth involved and the destination plus expected time of return. The program does not provide documentation on which youth are going being transported to school.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy reflects the Quality Improvement Standards outlined by the Florida Network. The purpose of this policy is to ensure that a consistent and fair system of privileges and consequences exist. In addition to the Behavior Management System the program also has policies on rules violations, participant/staff interactions and interventions and seclusion and restraint and aggression control. While the policy and procedure has not been individually signed, the policy and procedure was reviewed by the COO on 1/17/18, as indicated on a program memorandum.

The program provides the youth with a Facilitating Activity and Communication Effectively, "FACE BOOK," at orientation. The booklet outlines the behavior management system utilized by the program. This booklet contains general information about the behavior management system, program rules, point sheet guide, behavior expectations, program schedule, curriculum/social skills and the point sheets themselves.

The youth receive a FACE BOOK at orientation that they keep with them during their stay at the program. There are three phases to the behavior management system. The youth begin on the Assessment phase and are on this phase for 72 hours. Provided they receive their points for appropriate behavior they are then moved to the Daily phase. If their behavior is not appropriate they are re-evaluated after 72 hours and given another opportunity to reach the second phase.

On the second phase, Daily, the youth are evaluated with the same point sheet as the Assessment phase. The expectations are the same on the first two phases. In order to move to the third phase, Achievement, youth must receive a total of 400 points. The youth is issued a separate FACE BOOK upon entering this phase and the point sheets are different and the youth are held to a higher standard.

There are different privileges afforded the youth as they move through the phases. Assessment privileges include TV, on-site movies, on-site recreation time and 10 minutes phone calls. Daily privileges include group outings, recreational outings, daily special snacks and extra cup of juice. Achievement privileges include 15 minute phone call, outside dinner, extra cup of juice, Achievement Area time, extended bed time, extended wake up time and Achievement store. The point sheets are reviewed with the youth every night. The Supervisors review the point sheets weekly, however this is an informal review and not documented. The behavior management system is posted in both the boys and girls living area.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedures (P-1121, P-1132, P-1133) that addresses all the key requirements of Indicator 3.06.

Policy 1121: Supervision and Staffing Ratio/Scheduling requires a minimum ratio of one staff to every six clients during awake hours, one staff to every twelve clients during overnight, and one male/one female staff on all shifts.

Policy 1132: Participant Supervision ensures that Interface residential programs shall maintain 24-hour awake supervision of participants while on the facility premises and/or directly under the care of our staff.

Policy 1133: Bed Time Supervision & Bed Checks is to ensure the safety of all participants and staff throughout the bed time hours.

The agency has a protocol in place ensuring coverage when a staff member is unable to report to work.

Overnight staff are required to do gender specific bed checks every fifteen minutes with verification by way of a bar code scanning system.

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

In reviewing the Youth Care Worker Schedules binder and random samples from the Program Logs of the last six months it was clear that the minimum staffing ratios were in compliance for both awake time and sleep time. There were some periods from 2pm-3pm during the weekdays when one of the two needed staff members were not scheduled to work. For further clarification the Residential Supervisor was interviewed and stated that during the 2pm-3pm hour most participants are at school and other staff (Administrative and Supervisory staff) are also present. While the agency has not been able to be in continuous compliance with having staff of both genders present for all shifts, the Residential Supervisor did show proof of a job posting to remediate this issue. In touring the facility this reviewer was shown the Important Numbers binder in the staff office which is used to contact other staff when additional coverage is needed.

In touring the facility it was clear that surveillance cameras were adequately positioned in the facility and in reviewing video camera coverage it can be confirmed that the surveillance system can backup tapes for at least thirty days. The bed check logs for the female room were reviewed for the nights of April 14-15th, March 12-13th, and January 19th-20th. The bed check logs for the male room were reviewed for the nights of April 14-15th and April 7th-8th. In reviewing this data the fifteen minute bed checks were consistently completed.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policies in place (P-1248, P-1249, P-1267, and P-1279) addressing Special Populations. These policies address the necessary aspects of Indicator 3.07 with the exception of any written policy related to Domestic Minor Sex Trafficking. The aforementioned policies related to Special Populations were all last reviewed by the COO in January 2018.

P-1248 Staff Secure Shelter Services indicates that in-depth orientation at admission, assessment and service planning, enhanced supervision and security, parental involvement, and a collaborative aftercare are all included in agency policy. P-1249 indicates that youth referred for Staff Secure Shelter must meet the eligibility requirements of Florida Statute 984.225, that each shift should have specific staff assigned to monitor the movement and location of staff secure youth at all times, and that assigned staff members are noted in the Program Log Book. P-1248 lists under Collaborative Aftercare that the agency will work with the court, parents, youth, and referring CINS/FINS provider to discuss follow up services. This process included transferring all pertinent documentation to the referring local provider.

P-1267 Domestic Violence Respite indicates that a youth eligible for domestic violence respite services must have a pending Domestic Violence (DV) charge, and be screened by the JAC/Detention or Screening Unit, but must not meet the criteria for secure detention. This same policy document states that DV services must not exceed twenty-one days. No specific procedure was listed related to the transfer of DV youth to CINS/FINS or Probation Respite placement. P-1267 indicates that the Individual Plan for DV respite youth should include: anger/aggression management, family coping skills, or other interventions designed to reduce propensity for violence in the home; and notes that services provided to DV respite youth should be consistent with all other CINS/FINS program requirements.

P-1279 indicates that Probation Respite youth shall be referred by DJJ Probation, must be on Probation with Adjudication Withheld, and must be approved by the Florida Network with a time of stay determined at the time of admission. Furthermore, this policy states that the length of stay should be anticipated for fourteen to thirty days with placements beyond thirty days requiring JPO, Chief Probation Officer, and Florida Network approval. Finally, this policy notes that services for these youth should be consistent with all other CINS/FINS program requirements.

The agency has not had any staff secure youth or domestic minor sex trafficking youth within this review period.

The agency has had four DV Respite youth and one Probation Respite youth within this review period.

The four DV Respite files were reviewed. All four files included a Domestic Violence Respite Referral form showing that the youth were screened appropriately, had a length of stay that did not exceed twenty-one days, and had an Individual Plan (case plan) that included either aggression management, family coping skills, or other interventions to decrease domestic violence in the home. When applicable documentation showing that the youth transitioned to CINS/FINS placement was found in the files. This was applicable and noted in three files. All of the files reviewed were consistent with general CINS/FINS program requirements.

The single Probation Respite file was reviewed. Documentation in the file, the DJJ Referral, showed that this youth was referred by a JPO and other documentation in the file showed that this placement was approved by the Florida Network. The length of stay was determined with the parent at intake; as noted on the Intake Assessment form. The actual length of stay was less than fourteen days. As evidenced in the counseling progress notes, intake paperwork, Needs Assessment, Individual Plan, and Discharge Summary case management/counseling

needs and general CINS/FINS program requirements were appropriately noted.

Exception:

The agency did not have a policy and procedure for the Domestic Minor Sex Trafficking special population.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy 1280 is the Video Surveillance System. It was last reviewed by the COO in January 2018.

Each residential shelter shall maintain a video surveillance system that operates twenty-four hours a day, seven days a week to monitor and capture a recording of agency happenings. A written notice shall be conspicuously posted at the shelter entrance noting that cameras are in use for the purpose of security. The video surveillance system should only be accessible to staff trained to handle the equipment and is only accessible to designated personnel (a list is maintained which also includes off-site capability per personnel).

Supervisory reviews of the weekly activities on video is conducted bi-weekly and noted in the logbook. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts.

Review of any footage should be authorized by a supervisor and handled in a professional, ethical, and legal manner.

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

Cameras shall have back up capabilities that allow for operation during a power outage.

It is the primary responsibility of youth care workers to provide direct participant supervision. Video surveillance is not an acceptable alternative to direct sight and sound supervision. All other routine tasks are secondary to the priority of supervising youth,

The intention of this policy is to ensure, to the fullest extent possible, that the safety of all youth, staff, and visitors is enhanced through the use of a video surveillance system in the residential shelters.

Cameras shall not be placed in bathrooms or sleeping quarters. Cameras shall not be covert. Cameras should be visible to persons in the area. Cameras should be placed in interior and exterior general locations of the shelter to include hallways for sleeping rooms and where youth and staff congregate and where visitors enter and exit. Requests for video recordings from program quality improvement visits and when an investigation is pursued after an allegation of an incident shall be made available within 24-72 hours. Video and images shall be retained in a hard drive or designated secured network storage and access shall be restricted to personnel determined by the program administrator(s).

Recorded video shall be stored for a minimum of 30 days (90 days preferred) unless video is associated with a specific incident that is requested for review. In that case, video shall be stored for the length of time needed to complete investigation. Video clips which could become evidence in civil or criminal proceedings shall be kept indefinitely unless otherwise directed by the Department.

In touring the facility, this reviewer confirmed that the agency has a written notice regarding the surveillance camera system in the front lobby. The agency has cameras placed in the general locations of congregation and the visitor entrance/exit. All cameras are visible and no cameras are placed in the bathrooms or sleeping quarters. In reviewing the surveillance system and in speaking with the Residential Supervisor this reviewer confirmed that that video surveillance system can retain photographic images and facial recognition and is able to save data for up to 45 days. As confirmed by the Shelter Supervisor the agency has a backup system and generator that can be used to power the cameras during a power outage. In talking with the Regional Coordinator this reviewer confirmed that only the Residential Supervisor and Regional Coordinator have permission to access the video surveillance system. In reviewing the Program Log from Dec. 8 2017 to Jan. 4th 2018, this reviewer confirms that the Residential Supervisor reviews the video surveillance at least every fourteen days. The Shelter Supervisor confirmed that these reviews include a random sampling of overnight shifts.

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 shelter has one Counselor that is a Licensed Mental Health Clinician (LMHC).

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

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency utilizes policy P-1117 to address screening for all past or current medical conditions. The policy titled Residential Admission: Preliminary Physical Health Screening was last revised in January 2018.

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

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

A total of five files, three open and two closed, were reviewed to assess requirements of this indicator. Of the five files reviewed, all contained the Intake/Assessment form with all health screening sections completed. Four of the five files reviewed documented the youth were on medications. The medications were listed, as well as, the reasons for the medications. Three of the files documented the youth had asthma and one file documented the youth had kidney disease. The youth with kidney disease affected to the youth's blood pressure. This was monitored by the RN and any concerns were communicated to the parent and documented in the file. The RN documented detailed intake notes in all five files reviewed regarding the youth's medical history and interview with the parent/guardian. The Intake/Assessment form was reviewed by the RN the same day of completion in all five files.

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

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency utilizes policy number P-1247 to address suicide screening and assessments. The policy titled Suicide Assessment (Residential) was last revised in January 2018.

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

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency uses policy P-1120 to address the medication administration process. The policy titled Medication Provision, Storage, Access, Inventory, and Disposal was last revised on January 17, 2018.

The policy has detailed procedures for Prescription Medication, Verification of Medication, Medication Provision, Supervision, and Monitoring, Utilization of the Pyxis Med-Station 4000, Proper Storage of Medication, Medication Inventory, Medication Counting Procedures, Medication Errors and Refusals, Discharge of Youth with Medication, and Disposal.

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

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

The RN conducts training with all new hires on using the Pyxis Med-Station and distributing medications. The RN also does an annual refresher training with all staff.

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

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

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

times.

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

Exception:

There was no thermometer in the refrigerator to determine if the temperature inside the refrigerator was between 36 to 42 degrees.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency uses policy P-1119 to address the alert process. The policy titled Medical and Mental Health Alert Process was last revised in January 2018.

Upon admission to the shelter, each youth receives a preliminary medical, mental health, suicide risk, and substance abuse screening. Any conditions are noted on the Intake/Assessment Form. All medication the youth is taking is listed on the Intake/Assessment Form and the Medication Record Log. Medication allergies, food allergies, and any other allergies are noted on the Intake/Assessment Form, the medical record log, and on the outside cover of the youth's file with either an "Allergy" or a "Medical/Mental Health Alert" label. In addition, youth issues, concerns, conditions, or physical restrictions are noted on the youth board using appropriate codes. All incoming staff review the youth board at the beginning of each shift.

There were five open youth files reviewed. Three of the five of the youth were on medications and an alert was documented on the alert board in the staff office and also on the medication board in the staff office. A “Health Alert” sticker was on the spine of all three files. One youth had a medical condition and one youth had allergies. These alerts were documented with the applicable code on the alert board. These files also had a “Health Alert” sticker on the spine of the files.

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

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 revised in January 2018.

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

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

The shelter has had no instances of emergency off-site care in the last six months.

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

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

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

There were no exceptions to this indicator.