Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS Interface East
Residential Program

May 23 - 24, 2019

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	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 & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 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	Satisfactory

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewer

Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Mike Marino, Regional Monitor, Department of Juvenile Justice

Christy Cheshire, Senior Case Manager, Youth and Family Alternatives

Jessica Bolenbaugh, Intensive Case Manager, Lutheran Services of Florida

Shante Cooper, Residential Shift Leader, Children's Home Society

Quality Improvement Review
CDS Interface East – May 23 – 24, 2019
Lead Reviewer: Ashley Davies

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

Persons Interviewed

- ☐ Chief Executive Officer
- ☐ Chief Financial Officer
- ☐ Program Coordinator
- ☐ Direct – Part time
- ☐ Volunteer
- ☒ Clinical Director
- ☒ Counselor Non-Licensed
- ☐ Advocate
- ☐ Nurse – Full time
- ☐ Executive Director
- ☒ Program Director
- ☒ Direct – Care Full time
- ☐ Direct – Care On-Call
- ☐ Intern
- ☒ Counselor Licensed
- ☒ Case Manager
- ☒ Human Resources
- ☒ Nurse – Part time
- ☐ Chief Operating Officer
- ☒ Program Manager
- **1** # Case Managers
- **1** # Program Supervisors
- _____ # Food Service Personnel
- **1** # Healthcare Staff
- _____ # Maintenance Personnel
- _____ # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Logbooks
- ☐ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☒ Fire Inspection Report
- ☐ Exposure Control Plan
- ☒ Table of Organization
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☐ Key Control Log
- ☒ Fire Drill Log
- ☒ Medical and Mental Health Alerts
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☐ Supplemental Contracts
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- **6** # Health Records
- **7** # MH/SA Records
- 12 # Personnel /Volunteer Records
- **9** # Training Records
- **5** # Youth Records (Closed)
- 5 # Youth Records (Open)
- _____ # Other: _____

Surveys

- **3** # Youth
- 4 # Direct Care Staff
- **0** # Other: _____

Observations During Review

- ☐ Intake
- ☐ Program Activities
- ☐ Recreation
- ☐ Searches
- ☒ Security Video Tapes
- ☒ Social Skill Modeling by Staff
- ☐ Medication Administration
- ☒ Census Board
- ☒ Posting of Abuse Hotline
- ☐ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Discharge
- ☐ Treatment Team Meetings
- ☐ Youth Movement and Counts
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☐ Group
- ☐ Meals
- ☒ Signage that all youth welcome

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

At the time of the review CDS East was fully staffed with no vacancies.

A new Residential Supervisor was hired in January 2019.

The shelter is currently in the final year of a three-year Basic Center Grant which extends through September 2019. The Basic Center grant allows us to fund two major positions: Safe Place/Outreach Specialist and Life Skills Instructor. The Safe Place/Outreach position affords the shelter the opportunity to participate in many community events and has enabled them to secure a total of 27 safe place sites and 33 mobile sites.

The shelter has participated and helped to organize many outreach events including Human Trafficking Awareness Walk, Homeless Coalition's Self-Care Day, Child Abuse Prevention month block party, and numerous other outreach events. The Life Skills Instructor position allows them to provide the youth with tutoring, and various life skills such as budgeting/finance, consumerism, employment skills, educational opportunities, and goal setting.

During the past year, the shelter has continued to focus on maintaining a trauma informed environment and have re-painted the girl's day room to brighten it and give it a fresh look. As far as building maintenance, they had to replace an air conditioning unit, complete a roofing repair, and install walk- way gutters.

Standard 1: Management Accountability

Overview

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, fourteen Youth Care Workers, one Senior Youth Care Worker, 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.

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.

1.01 Background Screening of Employees/Volunteers

☒Satisfactory ☐ Limited ☐Failed

The program has a policy titled: Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns. The policy states the program will comply with regulations and protocols defined by Florida's Department of Juvenile Justice (DJJ) and the Department of Children and Families (DCF). The review date for the policy was January 4, 2019.

The procedure details steps to be taken to have potential employees and volunteers background screened, to include the completion of required forms, obtaining clear copies of the applicant’s driver’s license and social security card, obtaining fingerprints, and utilizing the Clearinghouse portal. The procedures states employees will be rescreened every five years, which is calculated from the “Retained Prints Expiration Date” posted on the Clearinghouse site.

Background screening for nine employees hired within the last year were reviewed. A background screening with an eligible rating was completed prior to hire for each employee. The program recently started a pre-employment assessment (the Check

Criteria) and provided documentation of completion of the assessment for the three most recent applicants. The program did not have any volunteers start during the review period. Three employees were applicable for a five-year rescreening. Documentation showed a rescreening was completed within a year of and prior to each applicable employee's anniversary of hire date. An Annual Affidavit of Compliance with Level 2 Screening was completed by the provider and submitted to the Department's Background Screening Unit on January 7, 2019.

Exceptions:

No exceptions are noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒Satisfactory ☐ Limited ☐Failed

The program has multiple policies to addressing an abuse free environment. These policies include Florida Abuse Reporting, Rule Violations, Behavioral Expectations for Staff, Standards of Conduct (for participants), and Complaint/ Grievance Process for Participants of Companions with Disabilities. The stated purpose of each policy reflects the intent of the program to ensure program participants and staff are provided with a safe environment with fair expectations and equal application of rules. The review date for these policies was January 4, 2019.

The procedures for abuse reporting states youth will be provided unimpeded access to report abuse. Staff are obligated to report any suspected abuse. A form to be completed to document abuse reporting is included with the procedure. The procedures for staff behavioral expectations along with the code of ethics in the employee handbook are acknowledged by staff upon hire. The procedures outline actions to be taken if staff violate the code of conduct. Procedures related to participants outline youth and parent/guardian rights, rules, and how rules will be applied in a fair and equitable manner. The grievance procedure outlines how participants may grieve and actions to be taken to address grievances in a fair and expeditious manner.

Program rules and standards of conduct are reviewed with youth during the orientation process and acknowledged by youth signature. Grievance forms are available to youth in the dayroom. There is a lockbox for youth to submit grievances. Only two grievances were filed by youth during the review period. Both grievances were resolved, with one noting coaching that was needed for staff. Youth may also complete a "Feelings Log Sheet" if they have an issue they would like to discuss with staff. None of the youth interviewed had filed a grievance, though all reported being aware of the process.

The number for the Florida Abuse Hotline is posted in common areas and covered with youth during upon admission to the shelter. A review of unusual event reports found there have not been any allegations of abuse made against staff. There were three

instances of staff reporting suspected abuse based upon reports made by youth regarding caretakers. All staff have received training on child abuse reporting. Three youth interviewed said they have not been denied a call to the Florida Abuse Hotline and reported they staff treat them with respect.

Exceptions:

No exceptions are noted for this indicator.

1.03 Incident Reporting

☒Satisfactory ☐ Limited ☐Failed

The program has policies related to incident reporting, which includes Unusual Event Reports – Internal and Incident Reporting Procedures. The purpose for the unusual report policy is to ensure events are recorded and shared up the chain of command. The purpose for incident reporting is to ensure governing agencies for the program are notified of incidents. The policies were reviewed on January 4, 2019.

The procedures detail the completion of forms to document events and incidents and the review of incidents. For DJJ incidents, the procedures reflect reporting incidents to the Department's Central Communication Center (CCC) within two hours of the program becoming aware of the incident. The phone number for the CCC and the types of incidents to be reported are included in the procedure. All unusual events and incidents are faxed to CDS administration for review.

The program had nine incidents reported to the Central Communications Center (CCC) during the past six months. All incidents were reported to the CCC within two hours of the program becoming aware of the incident. Internal reports were documented for each CCC incident, which were faxed to the corporate office for review. Management staff for CDS review all incidents monthly in order to address any actions needing to be taken. Logbooks reviewed found the reporting of all CCC incidents were noted in "Shift Leader Summary" section; an entry was made in the narrative section of the logbook for the shift for eight of nine of the CCC incidents.

Exceptions:

No exceptions are noted for this indicator.

1.04 Training Requirements

☒Satisfactory ☐ Limited ☐Failed

The training policy states all full-time and part-time personnel will receive training as required by contacts and applicable rules and regulations. The policy was reviewed on January 4, 2019.

The training procedures reflects training requirements in the indicator, identifying trainings to be completed within specified time frames. The procedure includes the development of a training plan for each employee annually and a quarterly training calendar.

A total of nine training records were reviewed, which included four new hires and five staff in subsequent years of employment. An individual training file is maintained for each staff, which includes a tracking log identifying all training completed and total training hours as well as certificates and/or sign-in sheets for training attended. The four new hires had completed well over eighty hours of training. The new hires completed training required within 120 days of hire with one exception, which was Child Abuse: Recognition, Reporting and Prevention reporting in SkillPro. All staff completed this training, but three of the staff completed the training outside the 120-day time frame. All four staff did complete an instructor-led training on child abuse within 120 days of hire. For the thirteen trainings to be completed within a year of hire, one staff did not complete one training and completed two other trainings just outside the annual time frame. The remaining three new hires have completed most of the required training and are still have time to complete the remaining required training. The five staff in subsequent years of employment all had completed over forty hours of training in fiscal year 2018-19. All seven required trainings had been completed by four of the five staff. One staff completed six of the seven required trainings and has time to complete the remaining one.

Exceptions:

No exceptions are noted for this indicator.

1.05 Analyzing and Reporting Information

☒Satisfactory ☐ Limited ☐Failed

The program has multiple polices for analyzing and reporting information, which are titled: Program Improvement Plan Policy; Risk Management Plan; and Quality Assurance Program. The polices outline reports to be completed and systems for review of the reports in order to identify opportunity for improvement. The policies were reviewed on January 4, 2019.

The procedures state how reports will be completed, to include forms the reports are to be completed on and the frequency for the reports to be completed. Procedures for the review of the reports and actions to be taken based on the reviews are outlined for the program and CDS administration.

A performance improvement and risk management report is developed every fiscal year. The data is captured using graphs, charts, spreadsheets, and in written form. This information is also captured and analyzed monthly. Monthly data is collected for participant performance based on contracted deliverables, incidents, accidents, and grievances.

The annual CDS performance and risk management report from the past fiscal year was reviewed. The report included performance analysis data from participant satisfaction surveys, demographics of all participants, performance and projections, monthly shelter utilization, outreach, risk, and issue distribution. Other areas addressed included annual data collection of screenings, admissions, discharges, emergency shelter participants, Net MIS data entry, medical emergencies, incident summary report, and personnel summaries.

All data collection is shared and reviewed with management and staff monthly as documented in meeting minutes and agendas reviewed for the past six months. Any improvements or corrective actions needed are implemented at this time.

The program also completes internal peer reviews of youth charts. Documentation showed that actions are taken to make improvements.

Exceptions:

No exceptions are noted for this indicator.

1.06 Client Transportation

☒Satisfactory ☐ Limited ☐Failed

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 regard to the client's history, evaluation, and recent behavior. The policies were reviewed on January 4, 2019.

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 for the 2003 Ford Van were dated 1/07/2019 and were satisfactory. Safety Inspection for the 2016 Ford Van were dated 11/06/2018 and were also satisfactory. Vehicle Insurance is up to date for both vehicles and documentation was on file.

The Transportation Logbook along with the Travel Log was reviewed for the last six months. The log documents the date of travel, destination and purpose of trip, trip details (i.e. start/end time) driver, second adult, and approvals information. These logs were consistently filled out in their entirety for the last six months. The Transportation Logbook was cross referenced with the Travel Log for single client transports. A sample of these transports were reviewed from the last six months and all documented the youth was approved for the transport prior to it taking place.

Exceptions:

No exceptions are noted for this indicator.

1.07 Outreach Services

☒Satisfactory ☐ Limited ☐Failed

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. The policies were reviewed on January 4, 2019.

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 2018 – May 2019 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 and other Informational and Educational Services, Alternative Services, and Community Development Services. CDS maintains relationships with its community partners including the school district, Department of Juvenile Justice, police officers, CareerSource, Public Defender's Office, educators, and over 60 other agency partners in an effort to address the needs of their clients.

Exceptions:

No exceptions are noted for this indicator.

Standard 2: Intervention and Case Management

Overview

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 staffing's 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

The agency has a policy in place titled Screening Process. The policy was last reviewed on January 4, 2019 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 ten files were reviewed including five non-residential files and five residential files. Out of the five non-residential files, two were open and three were closed. Out of the five residential files, two were open and three were closed.

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

Exceptions:

No exceptions are noted for this indicator.

2.02 Needs Assessment

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Needs Assessment. The policy was last reviewed on January 4, 2019 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 ten files were reviewed including five non-residential files and five residential files. Out of the five non-residential files, two were open and three were closed. Out of the five residential files, two were open and three were closed.

All ten files reviewed documented the Needs Assessment was completed on the same day the youth was admitted to the program. All ten 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 one closed and one open residential file 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.

Exceptions:

No exceptions are noted for this indicator.

2.03 Case/Service Plan

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Individual Plan. The policy was last reviewed on January 4, 2019 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 Needs 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 ten files were reviewed including five non-residential files and five residential files. Out of the five non-residential files, two were open and three were closed. Out of the five residential files, two were open and three were closed.

In all ten of the files reviewed the Case/Service Plan was developed within seven working days of the Needs Assessment. In ten of the ten files reviewed the Case/Service Plan documented: individualized and prioritized need(s) and goal(s) identified by the Needs Assessment, the service type, frequency, and location, the person(s) responsible, the target date(s) for completion, and date the plan was initiated. All ten files had the youth, parent/guardian, counselor, and supervisor signatures.

All ten 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.

Exceptions:

No exceptions are noted for this indicator.

2.04 Case Management and Service Delivery

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Case Management, Counseling, and Service Delivery. The policy was last reviewed on January 4, 2019 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 ten files were reviewed including five non-residential files and five residential files. Out of the five non-residential files, two were open and three were closed. Out of the five residential files, two were open and three were closed.

All ten 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 ten 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 two court hearings. None of the ten files were applicable for referring the case to case staffing to address problems and needs of the youth/family.

All six closed files provided case termination notes. In the three closed non-residential files two were applicable for follow ups, and one had a thirty day follow up and the other one had a thirty- and sixty-day follow-up, as required.

Exceptions:

No exceptions are noted for this indicator.

2.05 Counseling Services

☒Satisfactory ☐ Limited ☐Failed

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 4, 2019 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 ten files were reviewed including five non-residential files and five residential files. Out of the five non-residential files, two were open and three were closed. Out of the five residential files, two were open and three were closed.

All ten files reviewed had the youth's presenting problems addressed in the needs 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 ten 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 five 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.

Exceptions:

No exceptions are noted for this indicator.

2.06 Adjudication / Petition Process

☒Satisfactory ☐ Limited ☐Failed

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 4, 2019 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 staffing's 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 one Student Intervention Team Meeting, which do 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 the 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.

Exceptions:

No exceptions are noted for this indicator.

2.07 Youth Records

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Youth Case Record. The policy was last reviewed on January 4, 2019 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 ten 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.

Exceptions:

No exceptions are noted for this indicator.

2.08 Sexual Orientation, Gender Identity, Gender Expression

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy titled Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of the indicator. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy. Areas in which youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

The shelter has signage located throughout the shelter including in the hallways, lobby, staff offices, and boys and girl's dayroom indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. The actual SOGIGE policy is hanging up in the staff office for staff to easily see and review. The residential counselor completes different groups with the youth on appreciation for diversity, sexual identity, same sex relationships, and awareness and acceptance. The groups include vocabulary terms, worksheets, and tests. The counselor also completes these same trainings, with the tests and worksheets, for all staff. The counselor also has copies of the Zine available for any youth who want it. In January 2019 there was documentation all staff received training on the SOGIGE policy. A review of three random training files and staff meeting minutes confirmed this. The youth are asked at intake what their preferred name and pronoun is.

Exceptions:

No exceptions are noted for this indicator.

Standard 3: Shelter Care and Special Populations

Overview

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 Need 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. The shelter follows a daily schedule to keep the active so there is minimal down time. 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 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

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 July 1, 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 is well kept, free of any insect infestation, hazards, and debris. The youth have created a garden which appears to be well kept and free of insects. At the time of the tour, the basketball court was being remodeled. However, there are other recreational activities available. The agency vans were locked and contained all mandatory safety equipment in both vans.

A copy of the DCF childcare license was found on display in the main lobby and throughout the facility in multiple places. Upon inspection, both the male and female youth rooms and bathrooms were found to be well clean and without graffiti and hazards.

A review of fire inspection reports indicate that the facility is in compliance with the local fire marshal. In addition, staff complete one mock emergency drill each shift, within one minute or less, for each quarter the last drill was completed on 5/18/19.

The youths schedule was made available throughout the facility. A youth schedule was reviewed which outlined education, recreation, counseling, and social skills activities youth are involved in during their stay. The logbook was reviewed and confirmed the schedule was consistently followed.

Exceptions:

No exceptions are noted for this indicator.

3.02 Program Orientation

☒Satisfactory ☐ Limited ☐Failed

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 July 1, 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 and mental health procedures, Review of program rules, and Disciplinary action.

There were seven files reviewed, four 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 documentation indicating that program orientation was completed by staff with each youth. The program orientation was signed off by staff, youth, and parent/guardian.

Exceptions:

No exceptions are noted for this indicator.

3.03 Room Assignment

☒Satisfactory ☐ Limited ☐Failed

The agency has two policies and procedures in place outlining room assignments. The policies were reviewed and signed by the Chief Operations Officer on January 4, 2019

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 six youth files reviewed, two closed files and four open files. All six 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 verses 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.

Exceptions:

No exceptions are noted for this indicator.

3.04 Log Books

☒Satisfactory ☐ Limited ☐Failed

The agency has a policy in place titled Log Books that addresses the requirements of this indicator. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

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 follow UPS that shall be documented.

The shelter uses a paper logbook created by the agency to be utilized each shift by staff to document daily program activities, events, and any incidents occurring at the shelter during one's shift. The logbook has highlight codes for general reviews, suicide, and medications. The highlight codes were used properly throughout each shift viewed. The logbook consists of key sections filled out by staff including staff on duty, shift leader assignments/review, informal count, and medications issued. Also, any assignments that were completed by both staff and youth. Staff communicated any alerts, counts, and medications for the previous/next shift clearly in the logbook. 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 log in and review the past three shifts when coming on duty. At the end of the shift, the shift leader summarizes the events of the day/shift and makes appropriate comments as needed. Shift leaders review the logbook daily and provide oversight and instruction in the logbook each shift. The residential supervisor reviews the logbook weekly. All errors are struck through with a single line and initialed. All entries were entered clear and legible for staff to read.

Exceptions:

No exceptions are noted for this indicator.

3.05 Behavior Management Strategies

☒Satisfactory ☐ Limited ☐Failed

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 policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

The agency uses FACE (Facilitating Activity & Communication Effectively) System with the intent to persuade the youth to make positive choices and increase personal & 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 the last resort. In the event that the verbal de-escalation or physical intervention to control aggressive behavior aren't successful or raises concerns of safety to staff or youth, staff will contact law enforcement to de-escalate and protect the facility. Youth who are on Achievement are allowed to purchase items such as snacks, sweets or candy.

Youth are provided with an orientation packet at intake explaining in detail the Behavior Management System (FACE). There were six residential files reviewed and there was documentation in each file in the form of a signature indicating that each youth was given this information.

Initial training for all staff on the FACE system occurs within one month of hire. There is a protocol for providing feedback to staff regarding their use of the FACE system rewards and consequences. A 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.

Exceptions:

No exceptions are noted for this indicator.

3.06 Staffing and Youth Supervision

☒Satisfactory ☐ Limited ☐Failed

The CDS policy for staffing and youth supervision requires that adequate staffing is provided to ensure the safety and security of youth and staff. The policy was last reviewed on January 4, 2019 by the Chief Operations Officer.

The procedures designate the Regional Coordinator/Designee as being responsible for scheduling and assuring all coverage requirements are in accordance with Florida Administrative Code and Contract. The residential programs shall maintain the minimum following staffing ratio: one staff to six youth during awake hours and community activities and one staff to twelve youth during the sleep period, with at least one staff on duty of the same gender as the youth. There is always at least one male staff and one female staff scheduled. Volunteers, practicums, and interns may not be used in calculating ratios. The staff is expected to cooperate in the event of rescheduling due to unforeseen circumstances i.e. absence of other staff members, illness, etc.

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. With the exception of March 2019, where there was an inconsistent male to female ratio on the overnight shifts. There were

approximately eight shifts during the month of March with no male staff on the over-night shift. Upon interviewing the regional coordinator on site, documents were provided that showed a male staff member had corrective action against him, and the staff member was moved to day shift, and reduced to part time. The incident in staffing has since been resolved in the ongoing months. The program staff schedule is posted in a place visible to all staff. There is a holdover overtime rotation roaster 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.

Exceptions:

No exceptions are noted for this indicator.

3.07 Special Populations

☒Satisfactory ☐ Limited ☐Failed

CDS policy for staff secure populations are as follows, staff secure services provide more intensive staffing and individualized services than the short-term shelter services but provided in the same un-locked, living environment, and facility as temporary and voluntary shelter services.

CDS policy for domestic minor sex trafficking shall provide placement for eligible youth who are suspected or confirmed to be victimized by sexual exploitation for the financial or material benefit of a third person as determined on a case by case basis by the Florida Network. Services are designed to serve these youth who may require additional supervision for the safety of the youth or the program. The intent is to provide for quick deployment of additional staff when required to maintain the safety of all youth in the shelter and to provide one to one supervision to the identified youth.

CDS policy for the domestic violence respite population is as follows, CDS shall provide a safe alternative to secure detention for youth ages 10 to up to 18 years of age who have been charged with a domestic violence offence. Youth ages 8 and 9 can be referred on a case by case basis. These services are short term and are designated to facilitate services and supports for the safe return of the youth to his/her home minimizing the risk to reoffend. If the Interface Supervisor determines a referred youth is not appropriate for services, Interface shall decline the referral and shall immediately contact the referral source.

CDS has a policy for probation respite for youth from ages 10 up to 18 years of age. DJJ probation may refer eligible youth. Prior to accepting this population, all factors shall be considered, seriousness of past charges/history, behavior history, current

population and bed availability. Eligible youth must be on probation with adjudication withheld.

CDS has a policy for FYRAC population. CDS shall provide FYRAC services to youth who meet the following criteria, youth is referred by DJJ and must have been approved by the Florida Network. All intake and case files must adhere to the network policy. Deliverables can be verified by one or a combination of the following: intake management session, individual sessions, or group sessions.

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.

CDS also has a Family/Youth Respite Aftercare Services or FYRAC population, and the procedure is as follows, all referrals must adhere to the eligibility criteria outlined and have a documented approval from the Florida Network.

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

Exceptions:

No exceptions are noted for this indicator.

3.08 Video Surveillance System

☒Satisfactory ☐ Limited ☐Failed

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-weekly reviews using a random sample of shelter activities of weekly shelter activities are conducted and documented in the logbook. These reviews should be authorized by a supervisor and in accordance with all professional, ethical and legal standards. Cameras should have back up capabilities that allow for operation during a power outage. While video surveillance is not an acceptable alternative to direct sight and sound supervision, it is a compliment to the process and is 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. If a request for video recordings are made from program quality improvement visits or when an investigation is pursued after an allegation of an incident, it will be made available within 24-72 hours.

The program was able to show a document displaying a backup system for the cameras in case of a power outage. The program also has a sign displaying that there are surveillance cameras up for the purpose of safety. 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 meets the fourteen day minimum requirement and was evidenced through analysis of program logbooks, and by interviewing staff. There was one occasion where it exceeded the 14-day minimum by a few days but it was documented. There were verified surveillance reviews by a supervisor dating from 12/25/18 – 5/9/19. Although no request was 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.

Exceptions:

No exceptions are noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

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

The agency uses policies titled P-1117 Residential Admission: Preliminary Physical Health Screening, and P-1118 Residential Admission: Medical Follow-Up to address the requirements of this indicator. These policies were last reviewed on January 4, 2019 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 six files were reviewed to assess requirements of this indicator. Of the six files reviewed, all contained the Intake Assessment form with all health screening sections completed. In four of the seven files reviewed, it was documented the youth were on multiple medications. The medications were listed, as well as, the reasons for each medication. In three of the files reviewed, it was documented the youth had seasonal allergies. In file the youth was also documented as being lactose intolerant. In two of the files it was documented the youth had asthma, however one youth has not had an episode since three years of age and did not require any medication or inhaler. The other youth had medication for asthma. The Registered Nurse (RN) documented a health assessment in each file on the Intake Assessment form. This assessment a long with a review of the form by the RN was documented within one to two days of the youth being admitted. None of the youth had any type of chronic medical condition requiring follow-up medical care, however; there are procedures in place if needed.

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 six 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, two of those files also had a follow-up sheet for Asthma. In the fourth file, 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.

Exceptions:

No exceptions are noted for this indicator.

4.02 Suicide Prevention

☒Satisfactory ☐ Limited ☐Failed

The agency utilizes policy number P-1247 to address suicide screening and assessments. The policy titled Suicide Assessment (Residential) was last reviewed on January 4, 2019 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.

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 two open and five closed files were reviewed of youth that had been placed on suicide precautions in the last six months. In all seven 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 seven files. All seven youth were assessed by the non-licensed professional (master's level) residential counselor, under the direct supervision of a licensed professional (LMHC) within the agency, within twenty-four hours. All seven assessments were faxed to the LMHC to be further assessed and reviewed. All seven youth were appropriately placed on constant sight and sound supervision until the LMHC reviewed the assessment, signed it, made notes, and faxed it back to the program. All seven youth were placed on standard supervision and did not require a further assessment. Observation logs in all seven 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 seven 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 documented in the progress notes in the youth's file and highlighted in blue. Three of these instances were randomly reviewed for logbook documentation and all three 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.

Exceptions:

No exceptions are noted for this indicator.

4.03 Medications

☒Satisfactory ☐ Limited ☐Failed

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 4, 2019 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 eighteen staff who are trained to supervise the self-administration of medications. Out of the eighteen 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 over 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 which covers the medication policy, documentation, Pyxis training, Epi-Pen training, the episodic care policy, the medical and mental health alert system, and three medication pass observations. 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 ten discrepancies documented in the last six months. 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. The RN prints and reviews the Discrepancy Audit Report weekly. There were no open discrepancies at the time of the review.

The RN prints four different reports from the Knowledge Portal, three reports are printed monthly and one report is printed weekly. The monthly reports include: All Profile Overrides, User Summary by Transaction Type, and Summary by Transaction Type. 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 revealed 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.

The shelter has a medication board in the staff office that documents all youth on medication and the times they are to be given. If the youth is on controlled medication, the medication name is written in blue on the board and also has a “C” next to it circled. The total number of controlled medications in the shelter is written at the top of the board for staff to quickly and easily see for inventory purposes. In addition to the medication alert board, a Medication Verification Log is filled out at the beginning of each shift by the shift leader. This Log documents staff assigned to give the medication, the youths name, the medication and dosage, the scheduled time, and then a place to circle yes or no if the medication was given yes or no if both initials were on the MRL. There is also a medication clock in the staff office that is programed for every time a medication is to be given. When the alarm on the clock goes off staff must hit the button on top to acknowledge that the medication was given.

There were two youth in the shelter on medications and both files were reviewed, along with two 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.

Exceptions:

No exceptions are noted for this indicator.

4.04 Medical/Mental Health Alert Process

☒Satisfactory ☐ Limited ☐Failed

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 4, 2019 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 four 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 two applicable files. In these two files, both youth had allergies and one youth also had asthma. The forms 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 four 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 two youth in the shelter on medication, all medications the youth were taking, and the times they are to be given.

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 were no youth in the shelter with a food allergy or special diet.

Exceptions:

No exceptions are noted for this indicator.

4.05 Episodic/Emergency Care

☒Satisfactory ☐ Limited ☐Failed

The agency uses policy number P-1166 for Episodic/Emergency Care. The policy was last reviewed on January 4, 2019 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.

There were six incidents in the last six months 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. A review of training files revealed all staff have a current CPR and first aid certification.

Exceptions:

No exceptions are noted for this indicator.