Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Capital City Youth Services

on 10/16/2014

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

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 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, FNYFS/FOREFRONT

Jessica Fansler, Contract Coordinator, FNYFS

Bruce Morton, Management Review Specialist, Department of Juvenile Justice

Sylvester Jones, Anchorage Children's Home of Bay County

Sherri Swann, LMHC, Lutheran Services Florida-Northwest

Persons Interviewed

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

4 Case Managers
2 Clinical Staff
0 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
2 Program Supervisors
8 Other

Documents Reviewed

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

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

Surveys

3 Youth | 7 Direct Care Staff | 0 Other

Observations During Review

- [x] Admissions
- [x] Confinement
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [x] Group
- [ ] Meals
- [ ] Medical Clinic
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Program Activities
- [x] Recreation
- [x] Searches
- [x] Security Video Tapes
- [ ] Sick Call
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Transition/Exit Conferences
- [ ] Treatment Team Meetings
- [ ] Use of Mechanical Restraints
- [x] Youth Movement and Counts

Comments

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

All documents requested of Capital City Youth Services (CCYS) prior to this joint on site Quality Improvement and Compliance Monitoring program review were provide as required.

Strengths and Innovative Approaches

Rating Narrative

The Capital City Youth Services (CCYS) agency has continued to progress towards implementing several staffing, program and operations change. Since its last Quality Improvement (QI) review in September 2013, the agency has established new programs and undergone some staff roster changes.

The CCYS secured space and opened offices in Taylor and Jefferson counties, while co-locating offices within schools in Madison, Wakulla, Gadsden, and Franklin counties. In early 2014, a CCYS standalone office was opened in Gadsden County.

In November 2013, the newly constructed Transitional Living facility obtained its Child Caring License. The program began operation with the first residents being admitted in December 2013.

In February 2014, CCYS held its annual signature fundraising event, “The Tally Awards”, which recognizes local businesses that are chosen as favorites by an online voting system. In addition to being a fundraiser, this event provides a prime opportunity to increase the agency’s name recognition of awareness of the services its programs provide.

In March 2014, the Street Outreach Program enhanced its services by opening a “Drop In Center” in downtown Tallahassee.

The agency is Council on Accreditation (COA) accredited, has a comprehensive Program Quality Improvement (PQI) process and has several examples of using this process to address trends, patterns and performance issues.

Standard 1: Management Accountability

Overview

Narrative

Capital City Youth Services (CCYS) is lead by Kevin Priest, Chief Executive Officer. Mr. Priest oversees a high capable team of educated professionals that includes Gina Dozier, Chief Operating Officer; Crystal Robinson, Human Resources Manager; and Patrick Minzie, Shelter Program Manager. The agency has hired Rachel Greene, Residential Clinical Director and promoted current staff member Jason Ishley to Non-Residential Clinical Director.

Since the last on site Quality Improvement (QI) program review conducted in September 2013, CCYS has restructured some of its managerial and leadership positions. The management structure in the CCYS Someplace Else (SPE) Youth Shelter previously consisted of a single Shelter Manager that supervised three (3) Team Leaders. In July 2012, the agency formalized the new management structure and changed the Team Leader titles to Residential Supervisor. The Residential Supervisors now work 10-hour shifts 4 days per week. Their typical schedule takes place from 10:30 am to 8:30 pm. This allows them increased time on the floor with direct care staff and residents, as well as increased interaction with the youth and the Youth Care Specialists during peak activity times for the SPE program.

The agency has a Human Resources Director that oversees all HR functions including background screening and training. The agency trains all new and on-going staff as required. The agency utilizes a combination of live instructor and online web-base training. In addition, the agency uses a training format that captures all training dates, topics, hours that is maintained on each staff member.

The agency has an annual performance evaluation process and executed administrative reporting and issuing necessary workplace suspension on an as need basis. The agency utilizes monthly data reports that consist inform executive and leadership staff on performance and risk management issue s on a monthly basis.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Capital City Youth Services agency has a background screening policy that encompasses and meets the major requirements of the of Background screening indicator. Since the last onsite program review, the agency had a total of twenty-two (22) background screenings since the completion of the last onsite program review in September 2013. The agency performs all require steps to for background screening in compliance with Department of Juvenile Justice (DJJ) policy.

The agency notes that in the policy for requirements are the following items that include: Background screening prior to hire date; Employees and/or volunteers are re-screened every five (5) years of the date of employment.

The monitor reviewed a total of ten (10) randomly selected staff members hired by the agency within the last year. The files were comprised of both regular staff members and interns. The monitor reviewed personnel hire documents and official background screening results from the DJJ Background Screening Unit. All information reviewed in the personnel files indicated that the agency completed the background screening as required according to DJJ Background Screening requirements. At the time of this onsite QI review, the agency did not have any staff members that required a 5 year background rescreening.

The monitor requested the CCYS Annual Affidavit of Compliance with Good Moral Character document and found that it was completed by the agency and sent to the DJJ Background screening Unit on January 28, 2014.

No exceptions were noted for this indicator by the reviewer.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an Abuse Reporting policy that contains the provisions that require that all staff members reports any known or suspected case of child abuse or neglect immediately. The current policy was last reviewed and signed by the agency Chief Executive Officer on July 2013.

Staff members are informed during program orientation that a failure to report abuse may result in disciplinary action. Additionally, staff members are also required to report when they learn of any possible child abuse allegations, at any time from the referral process through aftercare or follow-up contacts, a report is to be made to the statewide toll-free Abuse Registry Hotline.

The agency also requires that all clients served by the agency be informed of their rights to reporting any known acts, events or occurrences related to abuse. Clients are also informed of their rights to report abuse and the abuse hotline number via a notice that is posted in notice that is posted in the day room of the youth shelter.

A similar advisory notice is placed on page twelve (12) of the Client Handbook. Clients are free at any time to file their own abuse reports and are not denied access to telephones to report abuse.

The agency provided a binder with all reported grievances over the last 6 months. All grievances indicate that the agency protocol for reviewing and addressing grievances in 3 days or less is generally being followed by staff.

The agency has a policy on Abuse Reporting that requires that all staff members report any known or suspected case of child abuse or neglect immediately. All staff members are informed during orientation that failure to report abuse may result in disciplinary action. The Abuse Reporting policy was last updated in July 2013.

A review of survey data completed during the QI Program Review indicates that in the past year staff report working conditions at this shelter have been Good (5) and Very Good (2). A total of seven (7) staff surveyed reported and described how youth are allowed to call the Abuse Hotline to report suspected abuse. In addition, 7 staff members completing the surveys reported that they have never observed a co-worker telling a youth that they could not call the Abuse Hotline; never observed a co-worker using profanity when speaking to youth; never observed a co-worker using threats, intimidation, or humiliation when interacting with the youth; and never witnessed youth ever being sent to their room or an isolation room for punishment. Additionally, staff members surveyed reported that room checks are conducted on youth (non-suicidal) youth placed in their room for sleeping or non-punishment reasons is ten (10) minutes.

A total of three (3) youth completed online resident/youth surveys. Of these youth, 2 stated that they did have knowledge of the availability of the Abuse Hotline number and that is it available for you to report abuse at this shelter. Of the 3 youth surveyed 2 stated that they had knowledge of where this number is located. None of the youth surveyed stated that they had made an attempt to call the abuse hotline. No youth had been stopped or delayed in making the call to the abuse hotline.

Of the 3 youth surveyed, all 3 reported that the adults here are respectful when talking with you and other youth. All 3 residents surveyed that they had not heard adults use curse words when speaking with you or other youth. All youth surveyed reported that they had heard any adults threaten you or other youth. All youth surveyed reported that they did feel safe at this shelter.

Of the 3 number of youth surveyed, 2 stated that they did know about the grievance process. None of the youth surveyed reported that they had ever been sent to your room for punishment. Also, youth surveyed that they have a designated counselor and that they reported that they were familiar with the current goals that they are working on. As of the date of this onsite review, there were a total of fourteen (14) grievances reported by residents between April 2014 and the date of this onsite review.

Exceptions are noted related to online survey results. One youth surveyed, reported that they did not know about the Grievance process.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The CCYS agency displays a standard policy for reporting incidents for internal and CCC type incidents. The policy contains organized processes for both internal and CCC reportable incidents. Furthermore, the Program's policy explains the documentation required for internal incidents and the protocol for reporting CCC reportable incident sto the Department of Juvenile of Justice. The current policy was last reviewed and signed by the agency's Chief Executive Officer in July 2013.

The QI Reviewer reviewed all current CCC reportable incidents during the time period of April 1, 2014, through September24, 2014. The Program had twelve (12) reportable incidents during the time period April 1, 2014, through September 24, 2014. The Program was compliant on 12 out of 13 DJJ CCC reportable incidents during said time period. Additionally, the assigned QI Reviewer reviewer the Program's internal incidents during the time period April 1, 2014, through September 24, 2014.

The CCYS agency as a whole documented a total of one hundred seventy-four (174) internal incidents during the time period April 2014, through September 2014. The type of internal incidents reports included the following: Abuse report; Medication; Runaway; Client injury/illness; and Drug/Alcohol possession, Contraband. Staff members consistently document all DJJ CCC reportable incidents and internal incidents. Agency internal reports describe specific events across all three (3) programs that include CINS/FINS, Emergency Shelter-DCF, and the Transition Living Program.

There is an exception documented by the reviewer for this indicator. The agency had twelve (12) reportable incidents during the time period April 1, 2014, through September 24, 2014. The Program was non-compliance with one (1) DJJ CCC incident that was reported to the CCC outside of the 2 hour incident reportind period.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This reviewer indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

The reviewer conducted an assessment on a total of eleven (11) training files were pulled and reviewed. A random sample of first year and on-going client files was conducted on site. The reviewer assessed a random sample of staff member training files. The file conducted by the reviewer included a review for all first year direct care staff received the required trainings and had more than 80 hours. The reviewer found first year trainings to consist of program orientation, CPR, first aid, Crisis Intervention, Suicide Prevention, CINS/FINS Core, Title-IVE, fire safety, subsance abuse and mental health, universal precautions, cultural compentency and several other topics.

Upon the initial review, the reviewer did not find evidence and documentation of training completed by some staff members. However, CCYS staff were able to locate and address some of the items that werre not found. Current staff all had evidence of completing over 40 hours and had taken the required refresher trainings. The reviewer found on-going trainings to include CPR, first aid, Crisis Intervention, Suicide Prevention, CINS/FINS Core, Title-IVE, fire safety, subsance abuse and mental health, universal precautions, cultural compentency and several elective topics that are offerred directly by the agency.

The organiation of training files were consistent across all files reviewed. The agency's files use a quarterly roll-up form that is review-friendly and that made easier for the review to track evidence of file information.

No exceptions were documented for this quarter.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy that includes requirements on Analyzing and Reporting Information. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator. As part of their Performance and Quality Improvement efforts, they have Program Quality Improvement (PQI) sub-committees to evaluate efficacy or to identify areas where modification is needed. Agency procedures in the policy include how the agency reviews various sources of information, monthly, quarterly and annually. These ongoing reviews include: case records, incidents, accidents and grievances, customer satisfaction data, outcome data and monthly NetMIS data reports.

The examples provided by the agency include the agency's leadership team includes the review of meeting minutes, sample reports of aggregated data, and committee meeting minutes showing the discussion of the pertinent information. In addition, the agency also provided evidence of emails verifying that the agency disseminates information to managaement regarding its performance and risk management issues.

The agency’s CEO is a current active member of the Council On Accreditation (COA). In addition, the CCYS Executive Director is an active COA Reviewer. The agency utilizes COA information and assessment tools and applies these self-assessment measures into their own strategies. This tool lists an array of reports and data that the agency uses to assess program trends and various risk management issues.

No exceptions were noted for this indicator by the reviewer.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Capital City Youth Services has two (2) Clinical Directors who have been in their positions for about one month. The Non-Res Clinical Director was previously a Non-Res YFA who has experience with the agency and procedures. The Res Clinical Director is completely new to CINS/FINS but has experience with mental health crisis intervention and has transitioned nicely to the program. Given these significant recent changes, both Clinical Directors seem to have a good understanding of the program expectations and requirements and are very conscientious about service provision and meeting DJJ standard requirements.

The agency conducted a series of program staffing changes since the last QI review. Last fall, the Outreach and Development Director resigned. The decision was made not to immediately fill the vacated director position. However, all nonresidential counseling positions for outlying/rural counties were filled. These positions were a result of a new CINS/FINS designated funds for FY 2013-2014.

Throughout the year, there were a few organizational management changes implemented by the agency. In early 2014, a Clinical Supervisor position was created to assist with Program Services Director and Clinical Services Director with the increased work demand brought on by the significant agency growth. The licensed person in this position resigned in March 2014. At the end of April 2014, after being vacant for several months, the Outreach and Development Director position was filled. In early May 2014, the management team conducted a agency retreat and restructured the management team. The Program Services Director positon was eliminated and replaced with a Clinical Director of Residential Services. Program Managers (shelter and TLP) were given more leadership responsibility and began reporting directly to the COO. The vacant Clinical Supervisor position was eliminated. To offset that support, supervision of the Street Outreach Program was moved from the Clinical Services Director to the CEO. A part time Program Services Specialist Positon was created for the non-residential program and a full time Program Services Specialist position was developed for the shelter.

In June 2014, the Clinical Director of Residential Services resigned. That licensed position was filled in August 2014. The Clinical Services Director (non-residential) resigned in August and that position was filled quickly by the agency with an internal candidate. There were also changes in the nonresidential staff, due to promotions, resignations and transfers, as well as additional funding for rural counties. At the time of the 2014 review, 4 of 8 nonresidential counselors have been in their current position (or location) less than 2 months. There is also one vacant counselor position in both the residential and residential.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The written policy and procedure manual indicates procedures to conduct screenings 24 hours per day and within 7 days of a youth being referred for services. A review of program documentation indicates that screening and intake information is well organized and addresses all the required elements in required forms (Youth Contract, Program Overview & Guidelines, Informed Consent & Guidelines, Family Rights & Responsibilities) and therefore, all 8 files reviewed met the indicator. In addition, the reviewer eternined that the agency provides available service options when applicable; rights and responsibilities information available to youth and parents/guardians; parent/guardian brochure; possible actions occurring through involvement with CINS/FINS; and services (case staffing committee, CINS petition, CINS adjudication); and grievance procedures.

Interviews with the YFA, and both clinical directors support this practice, indicating referrals come from Law Enforcement, Schools, Parents/Guardians and other system partners.

The agency reviewer noted no exeptions to this indicator.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator. The written policy in place indicates that the Needs Assessment will be initiated within 72 hours of a youth's intake. The PSA is considered initiated when the SPE Intake & Assessment Form has been cmpleted. A total of four (4) randomly selected residential files were used to assess this indicator. All 4 residential files reviewed met this timeframe. Additionally, in all but one of the residential files, the full PSA was completed within the 72 hours. The PSA is thorough and the summary comprehensive, including input from youth, parent, DJJ and referral source.

A total of four (4) randomly selected non-residential files were used to assess this indicator. All non-residential client files reviewed met the

identified requirements. Specifically, the Psychosocial Assessment was determined to be initiated within 72 hrs of admission for youth in shelter care. All Psychosocial Assessment s are done w/in 2 to 3 face-to-face contacts after the initial intake. When applicable, recent assessments are updated it is over 6 months old (non-residential care). All assessments have evidence of being completed by Bachelor's or Master's level staff. All assessments includes a supervisor review signature upon completion. Also when applicable youth are identified with an elevated risk of suicide as a result of the Psychosocial Assessment. When applicable the youth are referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional. In addition, all files reviewed were neat, organized and well written.

Interviews with two (2) YFAs, and both clinical directors further support the procedure and documentation of the accuracy and coompletion of assessments. It is clearly the practice of the program to coordinate with the families to identify youth needs and plan services accordingly.

Reviewer noted no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator. There written policy and procedure explains how the agency executes Plans of Service (POS), indicating they are completed within 7 calendar days of a youth's intake. All eight (8) files reviewed met this requirement, as well as the other indicators of this standard.

The need(s) and goal(s) identified are identified by the Assessment. In addition, the service type, frequency, location are documented. The person responsible, target date(s) for completion, actual completion date, signature of youth, parent/guardian, signature of counselor and signature of supervisor are also documented. The date the plan was also initiated accordingly to the agency policy. The review of this indicator also reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after.

In general, the plan of service form is well written and includes all the required elements. The POS reviewed were individualized and had all the required signatures. None of the residential files were open long enough to be reviewed however, the non res files opened long enough for review had appropriate reviews. The only issue to note is that none of the four residential files reviewed had actual completion dates.

Capital City Youth Services YFA staff and Clinical Directors report involving youth and parents in the case planning process. Three (3) out of 3 youth surveyed, reported that they were asked what they wanted to do while in shelter and also acknowledged knowing at least one of the goals.

The reviewer of this indicator noted no exceptions.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator. A total of eight (8) randomly selected client files were used to determine the agency's adherence to this indicator. All 8 files reviewed had a counselor assigned. The chronologicals in the files documented numerous efforts and contacts by staff and counselors, to coordinate services, including communication with parents, schools, and potential placements. The chronologicals also documented referrals for other services, including non-res counseling, substance abuse treatment, Case Staffing Committee, Transitional Living Program, and other long term placements.

Capital City Youth Services YFA staff and Residential Clinical Director reported the practice of contacting a youth's parent within the first 24 hours to explain s the program and to get information for the Psychsocial Assessment and Plan of Service(POS). A follow up call is made to confirm POS and to further discuss case. Documentation in all 4 res files reviewed supported this practice.

The YFA and Non-Residential Clinical Director reported the case management practice of contacting the parent within 48 hours of the referral to complete the screening and to schedule an intake appointment within five days.

The reviewer assessing this indicator indicated did not document any exceptions for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator. The written policy and procedures indicates that individual, group, and family counseling services are employed by the program. Agency documentation of presenting problems included addressing psychosocial Assessment; initial Case/Service Plan; and case/Service Plan reviews.All eight (8) files reviewed held documentation, including chronological entries and SOAP progress notes to support the practice. The agency also captures case notes maintained for all counseling services provided and documents youth's progress. Review of the Group Log showed documentation to support youth attendance in group on a daily basis.

In all eight (8) files reviewed, the youth's presenting problems were addressed in the Assessment, the Plan of Service and in the case notes. Additionally, all of the files supported the practice of regular supervision and had the required supervision signatures. The reviewer of this indicator found that youth and families receive counseling services in accordance with the Case/Service Plan; the program provides individual/family counseling (shelter care); and group counseling is provided at least 5 days/week (shelter care).

Interview with Residential YFA and Clinical Director revealed practice of meeting with the youth weekly after the PSA has been completed and attempting at least one family session prior to discharge, typically at discharge. Interview with Non-Residential YFA and Clinical Director revealed practice of meeting weekly with families after the PSA has been completed or more frequently in high risk situations.

The reviewer noted no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator. One file was reviewed for the Adjudication/Petition Process. While it did not meet the required timeframes for notification of the Case Staffing Meeting, it was clearly not due to the fault of the program. The counselor immediately notified the DJJ attorney of the request for the meeting, however the attorney did not respond in a timely manner and set a meeting date that did not allow for sufficient notification. Because the counselor had maintained on-going communication with the parent and committee, the meeting was held with one day notice.

Additionally, the school representative was not present for any of the meetings, however he had been invited.

The case did not go to petition so a summary was not completed. At each of the meetings, a copy of the revised Plan of Service was provided to the families, surpassing the seven day requirement.

Both YFA and Clinical Director explained the Case Staffing procedure in accordance with DJJ Standard and expressed frustration with the lack of involvement from the school representative.

Reviewer noted no exeptions in this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

A total of six (6) files were reviewed for this indicator, three (3) residential and three (3) non-residential. Three (3) open files were obtained from a locked file cabinet marked confidential in the staff area. All records reviewed were all marked confidential, contained the SPE file check sheet in the beginning and all of the corresponding documents filed behind in order. The 3 closed cases, which are kept in locked file cabinets, in a locked room, were all marked confidential and complete. All were in order according to the file check sheet with the exception of one.

No exception were documented for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The CCYS Some Place Else youth shelter provides residential services 24 hours a day, seven days a week. The residential stay at the shelter is specifically designed as a respite or cooling off period in order to reduce an existing crisis situation. General services provided by CCYS include supervision of youth, meals, clothing and limited healthcare as needed and permitted by the parent/guardian. The CCYS residential program also has the capacity to provide individual, family and groups counseling. Group counseling is still being provided a minimum of five (5) days per week or more for all youth served. Per the agency's daily schedule, youth required to attend school, are assigned chores, and are provided groups on a daily basis. The program also provides case management services to all residents as needed to make certain that all efforts implemented to return all shelter residents home, maintaining school involvement and other activities.

The agency has a three (3) building structures on the campus. One houses a multi-bed shelter that is licensed to serve up to eighteen (18) shelter residents. The second building houses the administration and staff and offices and includes meeting/conference rooms. The third building is a recently constructed structure that is to designed to house the agency's new Transitional Living Program.

The agency has clean and well appointed resident bed rooms, bathrooms and common areas. The day-to-day operations and management of the youth shelter manager is the responsibility of the agency's Chief Operation Officer and a Program Services Director, who is also a Licensed Mental Health Counselor. Shelter residents admitted to the CINS/FINS SPE program must be status offenders that meet eligibility requirement that include having either been a runaway, experiencing problems with their family such as being ungovernable, truant or lockout.

The shelter also admits non-Department of Juvenile Justice youth that are in crisis or in need of respite from their families. Youth can receive services from both the shelter facility and outpatient counselor at the same time. The CCYS program serves youth that are primarily ten (10) to seventeen (17) years of age. The agency does serve other special populations. The agency provides services to Staff Secure youth that are court ordered for extended shelter stays. The CCYS Staff Secure program component provides increased levels of supervision across all work shifts and weekly counseling sessions from agency counseling staff. In addition, the agency also serves youth referred to the agency as Domestic Violence Respite referrals. These youth are admitted to Domestic Violence (DV) Respite placement have a pending DV charge and have evidence of being screened by Junvenial Assessment Center/Detention, but do not meet criteria for secure detention. These residents and their families are provided temporary respite for limited time up to 2 weeks as a result of an active DV incident that occurred in the home. in general it is the CCYS program's strategy and service approach to to work with the youth and family to reach goals that focus on aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home. The agency also provides a functional work environment for staff to work with residents admitted to the program.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer of this indicator reviewed the Facility Disaster Plan and determined that it meets the requirements of this indicator. The assessment of the indicator also includes a full review of the agency's policy. The policy contains clear step-by-step procedures of how the plan will work. Their is a point of contact listed in the disater plan in the event of a emergency as well. The facility has an updated annual inspection from the local fire marshal. In addition, there is a record of two (2) Department of Health Inspector reports that both received a Satisfactory rating.

There is a knife for life located in the first aid tackle box located in the YCW station. The YCW station is a semi-secure area with no door, but is off limits to non-YCW staff. All First aid kits are full and secured with a plastic zip tie.

Facility and Site inspection: DCF License is posted and in clear view. A egress plan is posted in every area and in the resident sleeping rooms. The abuse hotline number is posted in clear view. The agency has a surveillance camera system that is backed up for 30 days as required.

At the time of this onsite program review, all agency vehicles are locked and equipped with major safety features. The agency reported that one month ago a youth displaying negative behavior vandalized agency property. This youth wrote excessive graffiti throughout the interior and a

sleeping rooms in interior areas of youth shelter property with writing on the walls and that writing still remains on the wall. The vandalized sleeping room was not in service and the agency was not placing any new residents in the aforementioned room. The agency noted that the facility is gathering quotes and about to have some remodeling done in those areas.

All other bedrooms and select restrooms smell odor free and are visibly clean. All chemicals have a MSDS sheet on each chemical and it was located in a binder at the desk of the direct care staff. Washer and dryer are working and in use at the time of the observation. Youth have easy access to the youth Grievance box and form. The Grievance procedure is explained to each youth and the steps for resolving a grievance on the youth handbook. A Daily Schedule is posted in the common area and provides youth the opportunity for educational, social, recreational and faith based activities.

The reviewer of this indicator documented exceptions for this indicator. The reviewer did find documentation to support fire drills are being conducted on a regular basis. Fire drill records indicate that drills are being conducted on every shift. There are several fire drills conducted and are as follows: 4/26: 12a - 8a (3 minutes), 5/17: 12a-7a (3minutes), 6/26: 12a-8a (4 minutes), 6/27: 8a-4p (no completion time), 8/14: 3p-11p (5 minutes).

The reviewer assessed all documentation concerrning Mock Emergency drills and counted a total of 5 drills conduted on the AM shift, 1 drill conducted on the evening shift, and 0 drills conducted on the overnight shift.

Several rooms have graffiti on the walls and head board. The reviewer also observed graffiti in the common area and other areas of facility also have writing on the walls. One (1) client room is out of order. This room is a bedroom that is unable to serve clients due to the room having graffti all over the entire room. The second room is a bathroom that is out of order because of a broken toliet. Copy of the work orders was produced on site, and bids are secured and in the process of starting repairs.

The area between the dryrer and rear wall in the laundry room has clutter including socks, wash cloths and dryer sheets. In general the aforementioned area is not clean and has excess lint build-up accumulating around the interior floor area behind the dryer, in the dryer exhaust vents and outside on top of the gas meter. The acculumation of lint is significant and poses a significant risk management issue related to a potential fire safety hazard. On September 25, 2014, the program did show where they had cleaned the areas of concern around the interior and exterior dryer area, dryer exhaust vents and the gas meter. The program also reported to this reviewer that they now added checking behind dryers and the exhaust vent area on to the facility cleaning checklist.

There is also dust accumulation on and in the exhaust vents in resident restrooms. At the time of this on site program review, there is a broken window at the back door of the facility. The agency has documentation of an active work order for the repair. A copy of the work order was produced on site.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy and procedure in place to support the Program Orientation. The reviewer assessed a total of eight (8) client files 6 closed and 2 open. The reviewer found that all of the files reviewed have a checklist. The checklist include a place where staff and youth sign off confirming that she/he has received a full review of the Program Orientation. The handbook is given to all clients and provides a brief explaination of the behavior management, grieveance procedure, emergency procedure, contraband and a sample of the daily schedule. A daily schedule is being posted in the commom area. The files reviewed contained the general alert dots located on several forms. Additionally, the information for the Abuse Hotline is signed by the youth. The Abuse Hotline information is also posted in the common area. Several forms document that the parent and the youth confirm that they accepted placement here.

The client file Check List is a an effective and functional check and balance to all of the paperwork that the youth and staff complete during the intake process.

One exception is documented for this indcator. One of the open files has a checklist date showing 7 days behind the intake date of completing paperwork.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The reviewer assessed the facility policy and procedure manual. The curren policy contains all the major provisions and steps involved in assigning residents to a room Their is also a policy for alerts, concerning what the description of each colored dot means. The policy clearly takes in the fact, the residents age, gender, disabilities, physical size, gender identification. The reviewer assessed a total of 10 (7 closed and 3 open) client files. These files show the detail on the intake assessment form and room assignment for each resident. The process allows for

a picture of the youth's day-to-day behavior and interaction in shelter. The Contact Authorization form contains a list of people that the youth is permitted to talk to over the phone, receive mail from and on site visits. This form along with the medical form displays the general alert dots.

Progress notes gives the reader a picture of the youth and the activities and events for the day. The contact form shows who and when the contact was made. The form also contains a picture and is a clear reference source for identification of the youth. The review also noted that one of the open files has a 2000 in take year.

No major expceptions are noted for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's Logbook policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

A review of the program logbooks for May 2014 through July 2014. A sample of the logbook content for July for 2014 found all of the required documentation present including highlighting that corresponded with the colors in the front of the logbook. Errors are documented clearly and were struck through with the signature of the staff person making the correction and the date of the correction. All entries were legible and written in ink. There was documentation of reviews of the logbook at least weekly. There was no evidence of the use of white-out as required. In general the agency is documenting major events, activities, incidents and routine operations, staff and program related information.

However, there was limited evidence found regarding documentation of all staff on each shift conistently documenting their individual review of the two (2) previous work shifts.

Rating Narrative

The facility has a policy in place for the Behavior Management System. The policy states clear direction and expectation of the Behavior Management System and meets the requirements for this indicator. During the youth intake process, all residents receive a full explanation of the Behavior Management System (BMS). Information about the BMS is present in the client hand book. The process requires that the youth review and sign it in the orientation stage of intake. The skill cards for the BMS are located in the classroom. The skill posted lists all the steps for each skill. The levels and rewards of the BMS are posted in the main hall and provide clear and detailed information pertaining to each level. The point card requires that the resident be responible for recording points earned (negative or positive) and to ensue that a staff supervision sign off on them. Certain behaviors resulted in each youth automaticly earning points and that information is displayed in the common area. The reviewer assessed a total of four (4) staff files to verfiy that they are trained in the BMS. Records show by the attendance log for the BMS training session that they are trained. Their are opportunities for corrective teaching for the resident when negative points are earned. During the corrective teaching phase the youth and the staff sit down one on one and talk about other options for the behavior that would have been more appropriate. Following one on one meetings, the resident and staff person work on a Behavior Chain Analysis worksheet together as part of the Behavior Management System.

No major expceptions are noted for this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a clear policy that states the general staffing ratio and requirements. The staff schedule is posted in the Youth Care Worker station/area of the program and they are also emailed a copy. The schedule is posted and emailed out a week in advance. The schedule does show that the agency is operating in compliance with the reqiurements of the Administrative Code. The agency schedule reflects 1 staff to 6 residents during awake hours and 1 staff to 12 residents during sleep hours. When there is a need for a holdover of staff the supervisor is covering the shift or staff members are asked to assist in picking up extra hours. In some instances, staff are asked to cover an extra shift or splitting the shift with a co-worker. The reviewer assessed the surveillance cameras and they are operational and the program has a 30 day play back of all surveillacne footage. Bed checks are observed being conducte every ten minutes during the overnight and all documentation is maintained in a seperate log. If the program can't meet the requirements for male and female guidelines they are to notify the supervisor and document this information in a logbook.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

A review of one (1) staff secure youth record, three (3) domestic violence respite, and two (2) probation respite youth records found documentation of single staff assigned to supervise the youth, a court order into Staff Secure Services, all services meet the requirements of F.S. 984, and a written discharge plan that can be given to the court for further legal proceedings. A review of 3 domestic violence respite and 2 probation respite youth records found each youth record had documentation of a DJJ JJIS face page that identified the youth's legal status and charges that verified domestic violence charges and placement on probation. One of the probation respite youth records did not have a case plan due to the youth absconded from the shelter the day after placement.

A case plan was missing from 1 of the Domestic Violence youth records. One of the probation respite youth records documented the youth being in a DV placement in the shelter 22 days instead of the maximum of fourteen (14) days.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Capital City Youth Services (CCYS) CINS/FINS program utilizes several program methods to ensure that staff members are properly trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to CCYS residential and non-residential programs. The agency uses a process that identifies mental health and health related risks system in the youth shelter. Specifically, the agency utilizes a general alert board and colored dot system that uses colors to inform all staff members of the status of each resident across all shifts. In addition, the agency has an effective health screening process that screens all youth for acute medical and mental health conditions.

The agency maintains a secure and detailed medication distribution system that provides training on assisting in the delivery of providing medication to all residents admitted to the youth shelter with prescribed medications. The agency also has practices in place in the shelter that address first aid assistance, suicide prevention and intervention techniques. The agency specifically designates and does post a list all staff members that have been identified to assist distribute medication.

The agency has the benefit of two (2) licensed clinicians on staff. The agency has strategically placed licensed clinicians to directly oversee both the residential and non-residential counseling components. The agency has a full complement of staff members across all three (3) work shifts. Staff member training files indicate staff members receive universal precautions, crisis intervention, first aid, CPR, suicide prevention and medication distribution training.

The agency also documents all real and mock emergency events. All events are documented and filed accordingly. The agency also uses a general alert colored dot identification systeme that uses a colore code specific to the results of the health admission screening process.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

The assigned reviewer conducted an assessment of a total of nine (9) youth shelter records. As a result of this, the review found that each youth was screened at intake as required. Additional task that were confirmed as being conducted by the agency included the identification for any physical healthcare issues including current medications, existing medications, allergies, recent injuries, and the presence of pain. In addition, the screening also addressed observations that are made during the intake process to determine if the youth has gotten into a physical altercation within the prior two weeks.

No exceptions were noted for this indicator by the reviewer.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

A review nine (9) youth shelter records found each youth was screened at intake to determine their level of risk for suicide. Each of the screenings had documentation of being reviewed and signed by a licensed mental health professional. Two (2) of the nine (9) youth records identified the youth as being at risk for suicide and were placed on sight-and-sound supervision. There was also a suicide risk assessment completed on each of the youth by a licensed mental health professional. Each youth was maintained on sight-and-sound supervision until being determined to no longer being at risk for suicide and being returned to standard supervision by a licensed mental health professional.

No exceptions were noted for this indicator by the reviewer.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addresses the major components required for meeting the requirements of this indicator.

Observation of the medication storage area found it to be clean and with a minimal amount of clutter around the refrigerator. The reviewer noted that given the location of the refrigerator, it would be difficult to use and store medications. Prescription and narcotic medications are stored on the same shelf behind two (2) locked doors. These medications have limited access and can only be accessed by an authorized staff person and with 2 keys. Topical medication is stored on a separate shelf. The sharps (razors) are stored on the bottom shelf. A check of the inventory of the sharps found it matched the number on the inventory. There is a list of youth who are restricted from using razors. There are separate medication logs for O-T-C and prescription medications. Each log documented the name of the youth and medication (frequency and dosage), the starting date and ending date of the medication inventories, initials of the youth and staff, and the date of the individual administrations. There was documentation of shift to shift inventories for all controlled medications. There was no documentation of lapse in administration of medications.

No exceptions were noted for this indicator by the reviewer.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

The shelter uses a colored "dot" system to alert staff members to specific conditions of all residents admitted to the youth shelter. Any youth that possesses a significant medical, mental health, sex offender, and behavioral condition is identified by a corresponding colored dot. The colored dots have the first letter of the colors to assist in determining the exact color of the "dot". An interview with a youth care worker intern found he did not initially know the type of the alert based on the color. However, he quickly found the legend that identifies the type of alert for each of the dots. A review of nine (9) youth shelter records found the use of the dot system to be consistent throughout each record.

No exceptions were noted for this indicator by the reviewer.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's policy was conducted by the lead reviewer. This review indicates that the agency has a satisfactory policy that addressses the major components required for meeting the standards of this indicator.

Review of the May 2014 through July 2014 program logbook found an entry of a youth jumping out of one of the program vehicles while moving. The youth was taken to the hospital and given medical treatment. The youth returned to the shelter on discharge instructions and continued medical treatment/rehabilitation. The day of the incident the youth became a DCF youth and did not meet the requirements for calling the DJJ CCC.

No exceptions were noted for this indicator by the reviewer.