Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Capital City Youth Services

on 09/05/2012

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 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 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 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	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 D Carr, Principal Consultant, Forefront Consulting LLC

Sylvester Jones, Assistant Shelter Manager, Anchorage Childrens Home

Sherri Swann, Associate Director, LSF NW

Latrice Covington, DJJ Contract Manager

Jessica Fansler, Contract Management Specialist, FL Network

Persons Interviewed

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

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

0 Maintenance Personnel
3 Program Supervisors
0 Other

Documents Reviewed

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

0 Health Records
0 MH/SA Records
6 Personnel Records
6 Training Records/CORE
13 Youth Records (Closed)
29 Youth Records (Open)
0 Other

Surveys

4 Youth | 3 Direct Care Staff | 0 Other

Observations During Review

- [x] Admissions
- [ ] Confinement
- [ ] Facility and Grounds
- [ ] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] Medical Clinic
- [ ] Medication Administration
- [ ] Posting of Abuse Hotline
- [ ] Program Activities
- [ ] Recreation
- [x] Searches
- [ ] Security Video Tapes
- [x] Sick Call
- [ ] Social Skill Modeling by Staff
- [ ] Staff Interactions with Youth
- [ ] Staff Supervision of Youth
- [ ] 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

This review was conducted in accordance with Florida Administrative Code 63L-2 (Quality Assurance, 6/10/10 Hearing Draft), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and Mental Health/Health Services, which are

included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2012).

Capital City Youth Services (CCYS) provides both residential and non-residential Children In Need of Services and Families in Need of Services (CINS/FINS). The program serves youth and their families in eight (8) counties (Franklin, Gadsden, Jefferson, Leon, Liberty, Taylor, Madison and Wakulla) in the panhandle region of North Florida.The agency has also secured masters and doctoral interns to provide counseling services to the outlying counties Gadsden and Wakulla. Capital City Youth Services interns/counselors are currently providing and estimated to 10-12 counseling hours per county for those two counties.

The agency conducts its daily activities schedule as designed. The schedule includes a broad range of structured activities. The residents participate in school and education activities off campus. The agency also conducts group activities on a daily basis as listed on the schedule. The agency has also made several physical plant improvements throughout various areas of the shelter. The agency has numerous interagency agreements. Further, the agency has focused on enhancing their internal quality improvement efforts to assess, review and implement various interventions to address areas that require improvement. Services provided by CCYS are primarily provided in Tallahassee and the local Leon County area. Surveys completed by youth indicate that residents feel that they are well cared for and they feel safe during their shelter stay.

The agency hosted the CCYS Tally Awards and a five (5) Kilometer race fundraising event that resulted in approximately $40,000 in funds raised in 2012. Since 2010, the ageny's fundraising and grant-writing efforts have netted nearly $300,000 toward erecting a new residential facility. The agency continues to seek outside funding to support its programming and has applied for street outreach and other development projects.

The shelter and offices are beautifully decorated and kept clean and tidy. Staff interactions with youth were positive and the youth reported feeling safe here. Staff were welcoming to peer reviewers.

Strengths and Innovative Approaches

Rating Narrative

Capital City Youth Services (CCYS) has implemented several new strategies to enhance its current clinical and counseling services, in an effort to increase the quality of clinical supervision for both existing CCYS staff and for the agency's clinical internship programs. Capital City Youth Services invested in two (2) licensed clinicians to attend trainings provided by the Florida Department of Health's Qualified Clinical Supervisory Training. This training afforded the agency's 2 licensed clinicians the training to supervise post-graduate clinical interns who are attempting to become licensed in the state of Florida. This greatly benefits the agency's clinical internship program and also helps increase staff retention as it enables CCYS to offer free licensure supervision for clinical staff that are pursuing licensure. The agency has also enhanced this initiative by adding Video and Audio coverage of supervision of clinical services. Additionally, over the past year, CCYS has invested in the technology required to record and monitor their clinical services (e.g. individual and group counseling). These videos of individual and/or group counseling sessions are then reviewed by CCYS's licensed clinicians on a regular basis and feedback is provided to the counselors. This system is used with both agency interns and full-time employees.

The agency has several partnerhsips with credible local community-based organizations. Capital City Youth Services has officially adopted a local Meals on Wheels route to provide meals to elderly shut-ins. Agency staff members and shelter residents take meals to several dozen local families every Thursday. Additionally, the agency has partnered to provide pet therapy dogs in a partnership with the Delta Society of COMFORT Pets. Capital City Youth Services has weekly volunteers that bring their specially trained therapy dogs out to spend time with CCYS youth. The volunteers and their dogs take approximately 1 hour to spend time talking with the clients and allowing for positive interactions. The agency states that this has been a great benefit for helping CCYS clients demonstrate their newly learned social skills in a safe and controlled setting.

Capital City Youth Services also operates a Foster Grandparent Program through their partnership with local area Elder Care Services iniative. As part of the federal SeniorCorps program, CCYS will have a Foster Grandparent on site 22 hours per week starting October 1, 2012. This Grandparent will interact with the youth and help with teaching basic daily living skills such as cooking, gardening, cleaning, and washing clothes.

Group is conducted 7 days a week instead of the required 5 days. The flow of work from the identified issues on the screening form is easy to follow on all clinical documents, including the psycho-social assessment, plan of service, progress notes and the chronological.

Standard 1: Management Accountability

Overview

Narrative

CCYS has also implemented several management structure changes. The management structure in the CCYS Someplace Else (SPE) Youth Shelter previously consisted of a single Shelter Manager that supervised three (3) Team Leaders. The Team Leaders that were marginally responsible for the oversight of the Youth Care Specialists acted basically as a shift supervisor. Under this structure, Team Leaders did not have full management responsibility. In late 2011, CCYS terminated their Shelter Manager position and re-evaluated the management structure of the Someplace Else Youth shelter. In an effort to increase the quantity and quality of supervision provided to the agency's Youth Care Specialists, the agency experimented with utilizing their Team Leaders in a more senior supervisory role. The responsibilities of the Shelter Manager were evaluated and distributed among the 3 Team Leaders and each Team Leader was assigned specific areas of individual accountability (e.g. oversight of the Food and Nutrition Program, supply ordering, maintenance/repair).

Capitl City Youth Services monitored the overall performance of the SPE shelter throughout the first half of 2012. Having 3 Team Leaders afforded the agency the opportuntiy to have management staff on the floor seven (7) days per week during the busiest hours of the SPE program. This management format also allowed CCYS to provide immediate feedback to staff members regarding their use of the Behavior Management System in addition to allowing their supervisors to address youth grievances and other issues. 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 to be on the floor and interact with the youth and the Youth Care Specialists during peak activity times for the SPE program.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's background screening policy was reviewed onsite. The agency's current policy met all the policy requirements for this indcator. A total of seven (7) eligible staff members/intern files were selected to determine the agency's compliance to this indicator. Of the 7 staff member/intern files reviewed, all files were well organized in a standardized format with no exceptions found. All files reviewed had the required information and met all the requirements for this indicator. The agency has also demonstrated and provided evidence that the Annual Affidavit of Compliance with Good Moral Character Standards was completed and sent to the DJJ Background Screening Unit prior to the January 31 deadline. The agency provided a copy of the document that verifies that the Affidavit was completed on January 3, 2012.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a combination of three (3) policies that are related to addressing the Abuse Free Environment. These 3 policies include "Abuse Reporting; Aggressive Clients and Supevision of Client and Staff Responsibilities". Of the 3 policies, Supervision of Client and Staff Responsibilities are the most relevant to addressing issues related to aggressive clients. There is one (1) section in the Supervision of Clients and Staff Responsibilities policy named "Staff Conduct-Residential" that references staff behavioral expectations. Under this section there are ten (10) items that range from guaranteeing safety of all residents; not using any form of phsycial discipline; not leaving work during a scheduled shift; and not sleeping on shift. The Aggressive Client policy requires that the agency's Residential and Non-Residential staff maintain a safe, secure and humane environment for youth and staff. The policy also states that implementation of non-physical/non-violent crisis intervention techniques shall be utilized by all staff and at no time are staff members permitted to violate the provisions of this policy.

There were a total of eleven (11) incidents documented by the DJJ Central Communications Center (CCC) between March 2012 and September 2012. Of these 11 CCC incidents, none were related to behavior that violates the agency Code of Conduct or work performance requirements. The agency provided documented evidence of a total of forty-five (45) Grievances over the last six (6) months. A review of the documented grievances revealed that seven (7) youth grievances related to staff disrespect, attitude, being put off, being ignored. The agency provided copies of nine (9) documented internal written Corrective Action memorandums. These internal memos document the Dates of the Behavior, Nature of the Behavior and the Facts Leading up to this Corrective Action.

The agency's Management then lists Previous Corrective Action(s), Specific Plans for Improvement and Discipline to be Taken if Behavior Occurs Again. Of these Corrective Action Memos, 2 had evidence of staff engaging in verbal confrontations with residents and staff discussing issues concerning another resident in front of a current resident. The agency documented these 2 incidents, all related facts and the prescribed disciplinary measure to address the situation.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an Incident Reporting Policy that addresses incident reporting that coincides with the Florida Network and the DJJ CCC policies. The current policy was last reviewed on November 10, 2011. The agency's policy specifies that the agency notifies the Department's Central Communications Center (CCC) within two (2) hours of the incident, or within 2 hours of becoming aware of the incident.

According to the official report of documented incidents provided by the DJJ CCC database, a total of eleven (11) official incidents were accepted and documented in the system with in the last six (6) months. Of these reports five (5) were Medication Errors. Nine (9) out 11 were called into the DJJ CCC within the 2 hour reporting requirement. The agency provided all incidents reported to the DJJ CCC. However, 2 incidents were intially missing from the incident binder. These missing incidents were later located and provided on site during the program review.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency possesses a comprehensive training policy that addresses annual training requirements for first year and on-going staff members. All full time staff members are required to complete a total of 80 hours during the first year of employment and 40 hours of training every year thereafter. All training hours are tracked and recorded on an annual spreadsheet starting from the hire date and kept in an individual training file.

The reviewer assessed a total of nine (9) staff member training files. Of these files, three (3) were first year staff members and six (6) were on-going staff members. All 3 of the first year employees demonstrated evidence that they are well on their way of meeting the 80 hour first year training requirement.

Of the six (6) on-going staff members, five (5) met the 40 hour minimum annual total training hour requirement. All of the required refresher trainings by direct care staff are being met, which includes fire safety equipment, CPR, first aid and suicide prevention.

The agency is effectively monitoring staff member training hours and tracking their training requirements. This includes, but is not limited to, monthly email reminders, spot checking hours, training at monthly staff meetings and quarterly training schedule. There are also numerous webinars that are available to the staff members through the Florida Network and the Youth and Family Services Network website.

1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains Cooperative Service Agreements, Interagency Agreements and Memorandum of Understanding (MOUs) to ensure families receive medical, educational, therapeutic supports within the area. Some of the agreements include, but are not limited to, Bond Community Health Center, Patient's First, Camelot Community Care, Apalachee Center, Disc Village and many more. All of the agreements reviewed had current contract/agreement dates. Review of the agreements and outreach activities demonstrates a strong community partnership and collaboration.

The program also has a strong community presence. A few of the activities in the last year include the CCYS Tally Awards which have raised over $40,000 and a 5k Run/Walk event. In addition, Miller's Ale House hosted a charity "Bike Night"event and all proceeds from the event went to CCYS. The agency also worked with the FNYFS on the Disproportionate Minority Contact (DMC) project, We Come 2gether, in Gadsden County. The agency also conducted a Service Fair in Wakulla County that demonstrates CCYS outreach efforts across multiple counties in their services region. CCYS also oversees and maintains Safe Place as beneficial outreach and relationship tool.

NetMIS is being utilized by the agency to capture outreach activities conducted by the program, as required by the Florida Network. However, current information on outreach is delayed by 2 or more months. This observation was brought to the attention of the agency's Outreach Director during the onsite QI review.

1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency's current emergency disaster plan, approved March 15, 2012, revealed that it is in compliance with the all requirements

for the indicator. The plan includes various types of emergency/disaster situations such as youth disturbances, fire, severe weather, hurricanes, tornado, flooding, chemical spills, bomb threats, taking of hostages and/or shooting and terrorist acts.

The agency plan addresses procedures for severe weather warnings, necessary and secure transportation for evacuation, conditions under which an evacuation would occur and identifies two specific CINS/FINS shelters as alternative evacuation facilities. The agency is an active participant in the Universal Agreement for Emergency Disaster Shelter with all of the full service Florida Network Member Agencies.

The plan also includes a detailed evacuation plan that addresses bringing food, medications, log books, cell phones, radios and other necessities along with an evacuation checklist and return check list. In addition, this plan includes a phone tree with emergency contact numbers, including the Florida Network, DJJ CCC and Big Bend Community Based Care. Prior to hurricane season the Program Services Director will ensure that all emergency supplies are ready in the event of an evacuation.

1.07 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency does not have a policy on analyzing and reporting information. However, the agency does have an operating protocol named Performance Quality Improvement that provides the agency with information in which to assess key areas of agency performance and risk management issues. The agency references several resources to assist them with assessing areas of performance and risks that include Florida Network of Youth and Family Services (FNYFS) NetMIS data extracts, incident, accidents and medication errors reports. The aforementioned information is provided on a monthly and quarterly basis. The agency also tracks training topics and hours completed by staff members on a quarterly basis.

The agency is a current active member of the Council On Accreditation (COA) and the 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. The agency did have concrete examples to demonstrate how internal oversight measures lead to actual examples of them implementing an intervention to address a problem. One example demonstrates the internal process that the agency utilizes to identify address medication errors. In this instance the agency identified medication errors as an issue and analyzed the contributing factors or root causes. The agency developed a plan to address the problem and set a goal that 95% of all medications distributed in the shelter would be delivered without error. The agency documented some of the measures it implemented to reach this goal that included changing the medication distribution form and conducting reviews of medication distribution over the next few months to test whether the intervention was effective.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

All youth admitted into Capital City Youth Services are provided residential and non-residential case management and intervention services for both troubled youth and families. The non-residential program offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for the youth and their family. The youth along with their family, a representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another service plan is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with treatment services.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. The agency provided documentation that new staff members are trained on Screening and Intake.

A total of eight (8) youth case files were reviewed for this indicator that included four (4) residential and 4 non-residential. Seven (7) of the eight (8) files reviewed documented the eligibility screening was completed within seven (7) days of the referral. All 8 files had documentation of available service options, rights and responsibilities of youth and parents/guardians, and grievance procedures. Six (6) of the 8 files had documentation that the parent/guardian brochure was received and the possible actions occurring through involvement with CINS/FINS.

One (1) of the 8 files did not complete the eligibility screening within seven calendar days of the referral. Two (2) of the 8 files document the parent/guardian brochure was not received.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is an updated and approved policy for indicator 2.02 Psychosocial Assessment. There is documentation that new staff members are trained on conducting and completing psychosocial assessments. A total of eight (8) client files were reviewed for this indicator – 4 residential and 4 non-residential client files. All residential client files reviewed onsite document that psychosocial assessments were initiated within 72 hours. Three (3) non-residential files document that the psychosocial assessment was completed within 2-3 face-to-face contacts. All psychosocial assessments are completed by bachelor's or master's level staff and include supervisor review and signature.

One (1) of the eight (8) files did not complete the addendum to the psychosocial assessment within 2-3 face-to-face contacts.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. There is documentation that new staff members are trained on developing and completing case/service plans for a youth admitted to the program. Eight (8) client files were reviewed for this indicator, four (4) residential and 4 non-residential client files. A review of seven (7) client files documents that case plans reviewed onsite were developed within 7 working days. All case/service plans include individualized and prioritized need(s) and goal(s); service type, frequency, location; person responsible; target completion dates; actual completion dates; and signatures of youth, parent/guardian, counselor, and supervisor. Four (4) of the eight (8) case plans have a date initiated.

One (1) of the 8 client files revealed that the case service plan was developed before the addendum to the psychosocial assessment. In addition, the non-residential service plans do not include the date initiated.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. A total of eight (8) client files were reviewed for this indicator. Of these files, four (4) were residential and four (4) non-residential client files. All 8 client files reviewed contained the required elements for this indicator. The agency has a comprehensive policy and procedure for client assignment and caseload that indicates cases are assigned to a counseling staff person at, or prior to Intake.

Interviews results with Youth and Family Advocate (YFA) staff support agency case management and service delivery procedure and all files reviewed showed consistent work with the assigned staff person. Files reviewed showed evidence of service coordination with community resources, such as interpreters, school personnel, DCF and non-residential service providers.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained in this indicator. A total of five (5) residential and four (4) non-residential client files were reviewed onsite. All files reviewed contained the required counseling elements, when applicable. All files reviewed showed good case service delivery and flow of addressing problems identified at screening and intake, throughout the development of the Psychosocial Assessment and Plan of Service. Each file contains progress notes and Service Plan updates that specifically addressed issues as identified on Plans of Service. All residential client files indicated coordination of services with parents was noted on the chronological notes following telephone conversations about the Plan of Service. Group Counseling is provided to shelter youth seven (7) days a week, which exceeds the five (5) day requirement.

It is important to note that the agency's policy and procedure regarding Groups indicates documentation is maintained in the Activity Log and the Youth's chronological. In the files reviewed, this was not the practice. Documentation was only found in the Activity Log. Overall, the Psychosocial Assessment is thorough and contains a completed summary at the end. In addition, Plans of Services are varied and include all required elements.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency policy related to this indicator was conducted. The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained for the Adjudication/Petition process indicator.

There is Policy and Procedure in place that specifically outlines the reasons for convening a Case Staffing Committee (CSC) meeting and the parties to be involved. This policy further states that a CSC will be held within seven (7) days of a parent's written request and that parents will be given a copy of the completed CSC Recommendation Form at the end of the meeting, or mailed to them within 7 days of the meeting if they did not attend.

Three (3) Case Staffing files were reviewed and all were initiated by verbal requests made by parents. The files were neatly organized and easy to follow by using the chronological.

In all 3 cases the Youth and Family Advocate (YFA) initiated the process of convening the CSC very quickly. One (1) case was convened within three (3) days of admission, one the same day of admission, and the last one actually five (5) days prior to admission (based on the screening).

Review of all three (3) cases supports the diligent efforts on the part of the YFAs to communicate with CSC Committee Members using email, fax and postal letters. In all three (3) cases the appropriate parties were represented, including the DJJ attorney. In all three (3) cases the youth and family were provided a new or revised plan for services. One of the three (3) cases proceeded to the petition process and the YFA worked with the DJJ attorney to submit a Predisposition Report to the court. Interview with the Clinical Director and YFA confirmed this practice.

While the program has polices and procedures regarding the practice of giving parents a copy of the completed CSC Recommendation Form at the end of meetings, and interviews with staff support this practice, two of the three files failed to document this practice. In the third file, there was a notation written in at the bottom of the CSC Recommendation Form acknowledging that a copy was provided to all parties at the end of the meeting.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a client case file format the requires that all client files be organized in a uniform manner. Each file must contain the same set of core documents that include, screening, assessment, parent client consent, service/treatment plan, risk factor form, and NETMIS.

A total of 8 files were reviewed to assess the agency's adherence to this performance indicator. All files reviewed were stamped confidential and were organized in a standard format. All files contained all the the aforementioned core documents requirements.

All closed client files are stored onsite behind a locked door in a secure area in metal cabinets with locking mechnisms.

Standard 3: Shelter Care

Overview

Rating Narrative

The CCYS CEO and agency leadership have made a strong effort to enhance the physical environment of the youth shelter. The agency has completed upgrades for 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). The program is designated a Staff Secure Shelter. Staff Secure youth are court ordered for extended shelter stays. The CCYS Staff Secure component provides increased levels of supervision across all work shifts and weekly counseling sessions from agency counseling staff. Per the agency's daily schedule, youth required to attend school, are assigned chores, and are provided groups on a daily basis.

3.01 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy in place that clearly states the procedure to support the indicators for this standard. The policy states how a youth would be assigned a room using the following criteria including age, gender, gang affiliation, sibling or not, youth's history with the program, as well as a youth's exposure to trauma. The policy also gave steps for assigning a room if a youth admitted to the program during sleeping hours in an effort not to disrupt the others until the next day.

A total of Eight (8) files where reviewed for this indicator, six (6) open flies and two (2) closed files. Each file has evidence of items on forms that include age, gender, disabilities physical size, gang affiliation could be helpful to staff. All required items were identified on the youth's screening form or the youth's intake form. All 8 files all area of indicators where filled out completely. These are helpful when assigning a youth to a room or roommate.

In the progress notes there was information that was helpful when pertaining to sexually aggressive or youth with sexual behavior or those that pose a suicide risk.

Additionally, there is a "Hot Dot" (alert system) which was also helpful to staff members to ensure that they are aware of youth with certain risks and conditions. This information is also placed in the progress notes and passed on across staff member work shifts.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy in place that clearly outlines the orientation process and procedures that staff members utilize with all youth admitted to the program. The policy has information for the parent and youth and they both sign that they agree to what is listed. The policy also has the opportunity for residents to assist youth incoming to transition into the facility.

The items required to meet the requirements of this indicator are listed in the policy and in the youth's handbook. The youth handbook lists the mission statement in bold lettering. The youth is given a hand book within 24hours of intake. The client handbook it clearly lists and explains the disciplinary actions, grievance procedure contraband and room assignment. The handbook also gives the youth a daily schedule, explains the behavior management system, youth rights, daily schedule and chores and youth safety agreement.

The parent is given a program overview and guideline of the facility and is asked to sign and date it. A map that displays the floor plan of the residential shelter is posted on the walls of the shelter. The shelter floor plan uses red stars to indicate evacuation route. In addition, each resident's bed room includes a floor plan that shows the evacuation route as it pertains to that room.

3.03 Shelter Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are several policies listed in the agency's comprehensive policy manual related to all major areas of the Shelter Environment indicator. All shelter residents are informed of the program rules and requirements at intake (in the resident Contract). All shelter residents are assigned daily chores that are monitored by direct care staff personnel. The indicator for graffiti is addressed by the agency painting the backside of each resident's bedroom door with chalkboard paint. This provides a designated space that youth are allowed to draw or write on. All rooms in the shelter have adequate lighting. According to the indicator the furnishing is in good condition and there are no signs of disrepair.

The agency has a linen policy that supports for all youth's rooms. All youths are given linen at intake and it is changed twice a week. Towels are given to youth daily and on an as needed basis.

There is a policy that supports the maintenance of the building and grounds keeping. According to the indicator the grounds are in good condition and free of debris and safe. Maintenance checks are conducted weekly by the Program Services Director or Residential Supervisor and records are kept on the findings.

There is a policy in place that states how the handling of youth personal belongings for safe keeping will be stored and secured. This indicator requires that all youth personal belongings are to be secured in a lockable place. They are labeled in a zip lock bag and secured in a locked file cabinet behind staff desk and anything of expensive value is secured in a lock cabinet in the admininstration building.

The agency made several renovations to the physical plant in 2011. All painting, flooring, carpet, storage and furniture upgrades remain in excellent condition. The agency is currently working towards expanding the open field space adjacent to the facility to increase the current amount of open field space residents have for physical activity.

The agency conducts safety inspections on a monthly basis. A review of inspection was conducted onsite. All agency safety inspection documented from January 2012 through August 2012 and all were accounted for except for June 2012.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy in place that clearly states the procedure to support the documentation requirements for this standard. The policy states documentation procedures required by staff members to complete when utilizing the agency program logbook. The program logbook is color-coded to single out events through the day from Medical, Contacts, Behavior, Safety, Baker Acted and Messages to staff. A review of six (6) months of logbook documentation was conducted. There is evidence where safety indicators where highlighted. Several entries where doubled highlighted in various colors to identify multiple areas of concerns. All entries reviewed included hand writing that was legible and written in black ink. Staff members consistently document that they have reviewed all entries dating back to the last time they were last on duty. In addition, it was noted that the Supervisor reviewed the logbook and documented his reviews.

Several logbook entries were not stricken through as required. A line should strike through an unintended or incorrect entry with the writer's initials and date of entry. Some bed check entries were not documented every 10 minutes and voids did not follow the required strike through, dated with an initial. The reviewer also noted a couple of late entries related to the documentation of incidents. One of the late entries was two (2) hrs late being documented into the logbook and another one was four (4) hours late being documented in the logbook.

Rating Narrative

There is a policy in place that supports that shelter residents will be engaged in activities that promote health, social development, education and intellectual development. A daily schedule is posted in two (2) areas of the facility which is assessable to all shelter residents. This is noted in the agency's policy and procedure. One (1) schedule is in the Youth Specialist office and on the kitchen door. There is a policy in place to support this on the indicator. A general review of six (6) months of logbook documentation and daily schedules were completed by this reviewer. Youth are engaged in meaningful activities of education, recreation, counseling services 5 out 7 days a week. When weather permits youth are engaged in recreational activity onsite or at the local park as noted in the logbook. When the weather is inclimate, outside activity is limited and youth are engaged in inside activities. Residents also have the opportunity to attend church service on a weekly basis.

3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Behavior Management System (BMS) policy. The policy is recent and was last signed by the agency's Chief Executive Officer and President on 03/15/2012. The agency BMS policy describes the policy and procedure. In addition, the policy includes the explanations of the BMS that include Skills, Target Skills, Teaching, Points & Point Cards, Levels, Consequences and IOU's. Agency staff members are provided training during the Orientation training process. The agency provides an explanation of the BMS to all residents in the 4 pages of the CCYS Residential Handbook. The agency has a detailed written description of the BMS program's strategies.

The current program approach uses various stages that include Safety, Rookie, All Star and Captain level systems. The monitor observed that due to the short length of stay of residents, the BMS generally does not allow them to reach the upper two (2) levels of the BMS. The monitor had discussions with the Program Services Director and Residential Supervisor regarding components and function of the BMS. The plan includes consequences and sanctions used by agency staff members. Consequences are applied when a resident does not demonstrate appropriate behavior according to the requirements outlined in the BMS requirements. Youth are rewarded points when they demonstrate appropriate behavior such as actual examples of positive behavior, courtesy, sharing and completing chores. Agency staff members are provide training during the orientation phase of training.

3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are several updated and approved policies that align with this indicator. The policies prohibit the physical restraint, isolation, or locked seclusion to be used at any time. There is documentation that new staff members are trained on behavioral and crisis interventions. The resident handbook states the facility is hands off and lists guaranteed privileges that align with this indicator and the agency's client rights policy.

A total of seven (7) residential youth files were reviewed to assess the indicator. A total of five (5) files have documentation of behavioral interventions. None of the files reviewed resulted in instances of specific incidents of any type of physical interventions that violates the "hands off" policy. All files documented that youth are disciplined by staff only, disciplinary measures are used appropriately, and basic rights are never denied. There was no documentation that group discipline and room restriction was used. There were no grievances documented against staff in violation of this indicator in the last six (6) months.

3.08 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a policy in support of this indicator. The policy requires supervision ratios of 6:1 during awake hours and 12:1 during sleeping hours. The awake hours and sleeping hours for direct care staff members are noted on the youth daily schedule. Each shift schedules at least one male and one female on each shift in support of the gender reflected in the shelter.

Head counts are conducted at the beginning of each shift and a random count is completed throughout the shift. The staff members on duty are listed in the logbook at the beginning of each day. Each staff member is required to review the logbook and upon returning to duty documenting that they have done so. The staff's schedule shows that staff is in ratio with the head count.

The schedule supports the male / female ratio per shift which is stated in the policy. The reviewer found it difficult to know who was on shift at any given time without going to the schedule to match it up with the logbook. All though staff members are listed in the logbook at the beginning of each day who was working, it was very difficult to track actual daily staffing. In addition, it would be helpful if it is noted in the logbook the number of youth and staff that were in an area of the program to show ratio.

3.09 Staff Secure Shelter

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy in place that clearly states the procedure to support the indicators for this standard. The policy states the agency's procedures on providing staff secure services. The agency reported that one (1) file was all available for review. The reviewer examined one (1) eligible client staff secure file for this indicator which shows that the staff secure youth did received nineteen (19) individual sessions, five (5) family sessions and fifteen (15) group sessions, a weekly team meeting with YFA, Family Place YFA Program Service Director Clinical Director Youth and the client's Mother.

The Program has a security plan for staff secure youths to address the requirement for this indicator. All widows are equipment with alarms and the secure staff assigned to the youth is to carry a phone to call law enforcement if youth attempts to abscond while on community outings. The shelter exit door is not equipped with an alarm or alert to notify staff members. It would be helpful if the doors of the program were equipped with alarms that would alert them if a youth is absconding, this would cut back on reporting time.

The indicator for community services is in place for the youth. The reviewer determined that the program has service in place for the youth and family upon youth being release back into the community. There is information documented that indicates that the youth continued with school

and OASIS Center for Women and Girls and referrals made by Family Place YFA.

Monitor reviewed the logbook and progress notes and was unable to see increase in staffing or when a Staff Secure designated staff member was assigned to the youth. It was also difficult for the monitor to follow in the logbook by shift to determine who was assigned to the youth. A team leader substituted for the supervisor when reviewing the logbooks and documented the feedback.

There is evidence that the program did execute follow–up services with the youth and family in the first 30 days. There was a lack of evidence to support the policy of service for six (6) months. Monitor did not see any documents to support follow-up services from the agency after 30 days. In addition, the reviewer noticed a couple of late entries with a couple of incidents. One of the late entries was two (2) hrs late being documented into the logbook and another one was four (4) hours late being documented in the logbook.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Capital City Youth Services CINS/FINS program utilizes several 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 redundant mental health and health related risks alert system in the youth shelter. Specifically, the agency utilizes a general alert board and colored dot system to inform all staff members across all work shifts. In addition, the agency has an effective health screening process that screens all youth for acute medical, as well as mental health conditions.

Further the agency maintains a secure and detailed medication distribution system that provides training on providing medication distribution assistance, first assisstance and suicide intervention techniques. The agency specifically designates all staff members that have been identified to assist distribute medication.

The agency has the benefit of two (2) licensed clinicians. Each licensed clinician directly oversees the residential and non-residential program respectively. The agency has a full complement of staff members across all three (3) work shifts. Staff member training files indicate staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy/procedure that ensures all youth admitted to residential programs are not in need of immediate medical attention. All youth are provided a preliminary physical and mental health screening at the time of admission to make sure that they are suitable for placement. The health screening form addresses all elements of the indicator: history of suicide attempts/self injury, current or prior substance use/abuse, current medications, existing medical conditions, physical/dental health issues, specific inquiry as to symptoms of tuberculosis, allergies, recent injuries or illnesses and the presence of pain or other physical distress. Staff makes observations for evidence of abuse and neglect, substance abuse and/or intoxication, illness, injury, physical distress or disability. Staff will also observe client for presence of scars, tattoos, or other skin markings.

The procedures indicate youth have unimpeded access to emergency medical care at all times. The procedures indicate if a major medical condition exists the youth will be immediately referred to their physician, emergency room or a public health care department. The policy lists examples of major medical conditions to include, but are not limited to: severe chest/abdominal/head pain, poisoning/drug overdose, severe shortness of breath/wheezing, loss of consciousness or breathing, prolonged bleeding from any site, sudden change in mental status (disorientation, threats of violence or suicide, delusions/hallucinations), convulsions/seizures, sever multiple injuries (including multiple fractures, burns or bleeding), allergic reactions accompanied by swelling of the face lips and wheezing or hoarseness, Cyanosis (blue discoloration of the lips and skin), 103 or higher fever and vomiting that looks like coffee grounds.

Six (6) open files were reviewed and all contained documentation of the Healthcare Admission Screening Form, two (2) filled out a day prior to admission and the other four (4)on the day of admission. All files contained the Intake Assessment form that was completed the day of the youth's admission. The form addressed all elements of the indicator. All 6 are currently on medications and all are properly documented on the Medication Oversight & Inventory Record within the file; 4 have existing (acute and chronic) conditions; one has an allergy; one has a recent injury; one had an observation of physical injury and three (3) had observations for the presence of scars, tattoos or other skin markings. The 1 recent injury had no further documentation of care in the shelter or aftercare.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A review of the agency policy related to this indicator was conducted. The agency provided an updated and approved policy for this indicator. A review of this policy indicates that it addresses the requirements contained for the Suicide Prevention indicator.

The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services. The Program has a written Master Plan that details their suicide prevention plan and response procedures, including staff positions, duties, supervisory roles, involvement of licensed professionals, documentation protocols, notification procedures, and referral systems in connection with suicide prevention and response.

There is also a Suicide Prevention plan that includes specific language for staff interacting with youth who are experiencing suicidal thoughts, and detailed instructions and strategies for calming and supervising them.

A review of four (4) residential files and two (2) non-residential files was conducted. In all six (6) files, suicide risk screening was completed during the screening and intake process. In all 6 cases, the youth had a "yes" response to the identified questions and proper procedures were followed. For the residential cases this included being placed on Sight and Sound (S&S) supervision until an additional Suicide Assessment could be conducted by a clinician supervised by a licensed professional. In these cases, the youth was removed from S&S supervision only after the case was staffed with the licensed professional. Review of the Professional Log and S&S Logs supported that these procedures were followed.

For the non-residential cases, the YFA completed the Suicide Assessment and took the appropriate steps, including informing the parents. Neither non-residential case warranted referral for Baker Act Screening. Of the four (4) staff surveyed, 100% were aware of the procedures for working with youth who express suicidal thoughts.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter had written procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. The program had a list delineated in writing of staff members that are designated to have access to secured medications, and limited access to controlled substances. All medications in the shelter are stored in a designated separate, secure room that features separate storage cabinet each with double locking cabinets that are inaccessible to youth. Oral medications are stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review.

A review of the Central Communication Center (CCC) reports indicated a total of four (4) medication errors within the last six (6) months. On April 14, 2012 staff members failed to give a youth evening medications (staff was written up for this error); on April 17, 2012 a staff member failed to give a youth her evening medication (staff was written up for this error); on June 8, 2012 medication was missed due to inaccurate medication distribution instructions. This resulted in the youth not receiving an evening dose that was corrected the next morning. (agency gave a verbal warning to the staff person involved); on June 13, 2012 2 staff members failed to give youth their midday prescribed medication for 3 consecutive days (06/11/12, 06/12/12 and 06/13/12) (agency gave verbal warnings to all designated staff members across all shifts. Two (2) of the staff members involved in the June 13, medication error incident were terminated for failure to follow the necessary steps to correctly assist in the delivery of medications to resident on prescribed medications. Overall, medication errors appear to be a function of staff members transcribing instructions incorrectly and missing actual times to distribute medication.

In March of 2012 the agency conducted an internal assessment of intermittent medication errors and utilized the agency's Performance Quality Improvement (PQI) process to address overall occurrences of medication errors. This plan involved internal planning to improve oversight of medication. In August of 2012 the agency revised the current medication distribution form that added 2 signatures for staff transcribing the medication instructions and documentation and a signature review line for the agency Program Services Director. As a result of these errors, a review of training files of staff involved in the aforementioned incidents was conducted to determine if any evidence of follow up medication training was provided. The agency did not have evidence of actual training, but did have evidence of reviewing a newly revised version of their medication distribution too. While onsite the Lead Reviewer observed a staff member assisting in the delivery of medication. The staff member followed general medication distribution protocols as required, however the staff member did not view inside youth's mouth to verify and confirm that you actually swallowed medication.

Further review on the agency policy revealed that the agency does not currently address Verification of Medication. Based on recent information from the DJJ Office of Health Services. The agency must revise its current policy to incorporate the agency's ability to verify all medications entering the residential youth shelter. Due to recent concerns regarding risks related to the distribution of medications, the FNYFS has deemed it necessary for all local CINS/FINS service providers to implement Medication verification procedures. The agency must update and its current practice in the area to be able to meet this requirement.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a written policy to address medical and mental health alert process. The shelter maintains a large dry erase board with appropriate color coded dots to identify various medical/mental health conditions. This legend is coded by color as a guide for the various conditions to maintain the youth's privacy and confidentiality. The Green dot indicates youth with Mental Health and Behavioral conditions; Blue dot indicates youth with Non-Controlled Medications (prescription and over-the-counter), Yellow dot indicates allergies (non-food allergies, medication allergies, food allergies); Orange dot indicates youth with Sexual Behavior Concerns (perpetrator or victim); Pink dots indicates youth on Controlled Medications; Red dot indicates youth with major health issues (seizures, heart problems, Asthma, any other major health/medical issues). At the time of this onsite program review there is not alert for youth on sight and sound supervision or sharps restriction.

A review of six files (4 open and 2 closed) was conducted to assess the agency's adherence to the requirements of this indicator. All open files

contained the appropriate color coded dots which were documented on the dry erase board and the individual files. Shift Exchange Information entries and log book entries were reviewed to indicate staff members were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a written procedure to address Episodic/Emergency care. There were four (4) episodic events within the last six (6) months. There was documentation for the parent/guardian notification requirement and obtaining off-site emergency services i.e. EMS or the police for Baker Acts in all five (5) cases. In one (1) case the parent transported the youth to the hospital; 2 cases involved the paramedics transporting youth to the hospital; the last case involved onsite first aid provided by agency staff members. Of the 4 Episodic/Emergency care incidents, 2 episodic events were documented on the agency's internal incidents log and in the program log book.

A review of seven (7) direct care staff members indicates that all 7 staff training files indicated that there was evidence of CPR and First Aid certification. The shelter has two (2) first aid kits, wire cutters and a knife for life. There are also first aid kits in both vehicles.