Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Florida Keys

on 02/27/2013

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 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:96.43%
Percent of indicators rated Limited:3.57%
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

Marcia Tavares, Lead Reviewer and Consultant, Forefront LLC

Larry Barnhill, Clinical Manager, Lutheran Services Florida Southwest

Kristi Casteneda, Director of Program Support Services, Boys Town Central Florida Inc

Lashonda Chavis, Director of Admissions, Miami Bridge Youth and Family Services

Paula Friedrich, Delinquency Prevention Specialist, Department of Juvenile Justice

Persons Interviewed

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

0 Case Managers
1 Clinical Staff
0 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
6 Program Supervisors
3 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [ ] 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
- [ ] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [x] Sick Call Logs
- [x] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

3 Health Records
3 MH/SA Records
8 Personnel Records
6 Training Records/CORE
0 Youth Records (Closed)
3 Youth Records (Open)
1 Other

Surveys

3 Youth | 3 Direct Care Staff | 0 Other

Observations During Review

- [ ] Admissions
- [ ] Confinement
- [ ] Facility and Grounds
- [ ] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] Medical Clinic
- [ ] Medication Administration
- [ ] Posting of Abuse Hotline
- [ ] Program Activities
- [ ] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] 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
- [ ] Youth Movement and Counts

Comments

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

Other observations:

Medication Room

Staff Control Room

Strengths and Innovative Approaches

Rating Narrative

The Florida Keys Children's Shelter, Inc., is a non-profit community-based corporation sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary Children In Need of Services/Families In Need of Services (CINS/FINS) residential and non-residential services to youth and families in Monroe County. The agency provides a full range of services to both male and female youth ages 10-17 years of age. The program is located at the Tavernier's Jelsema Center, at the north-end of Monroe County next to the Tavernier Government Center.

In May of 2012, the Florida Keys Children's Shelter (FKCS) was re-accredited by the Council on Accreditation (COA) and has been continuously re-accredited by the Council on Accreditation (COA) since its accreditation in May 2004. This consistent achievement demonstrates the organization's commitment to maintaining the highest level of standards and delivery of quality services to its consumers.

During the QI visit, an interview with the Executive Director was conducted to ascertain agency and programmatic strengths and innovative approaches utilized by the provider. The FKCS is located in a geographic area that is prone to hurricanes, has a high cost of living, and limited labor pool. It has been a continued challenge for the agency to recruit professional, particularly male, staff. Given this challenge, the Executive Director, Kathy Tuell, has embarked on an Education Initiative effort to develop relationships with Universities near and far to provide experiential learning opportunities for Interns and training/skill development opportunities for staff. The agency is partnering with the University of Miami and Universities across the country to collaborate on web-based training, conferences, and other activities focused on dealing with youth issues. The program utilizes interns to assist with counseling and case management and has mutually benefitted tremendously from this assistance. Funded by an Eckerd Grant, this education initiative will help in bridging the gap and establish relationships that will facilitate the recruitment and utilization of interns and potential staff.

Another venture for the agency is its investment in a new data administration system called Efforts to Outcomes (ETO) by Social Solutions. ETO had an initial set up cost of approximately $20,000 and a monthly maintenance cost ranging from $800-$1200 per month, based on the provider's needs. The provider has completed a full year of data entry into ETO which will allow the provider to track program outcomes and generate customized reports on various outcomes indicators. The database is customized to the provider's needs and was implemented in 2011. All staff have individual access and both youth and staff have a dashboard to monitor day to day progress/performance.

Project Inspiration is an ongoing beautification project that has resulted in a facelift of the residential dorm rooms with the painting of murals of different themes in all of the bedrooms and dormitory hallways by local professional Artists. The next phase of the project will be the completion of the murals in the common area hallways. The provider has also recently added a bedroom as a result of a code compliance issue but the re-construction has enabled the provider to add an office for a counselor inside the dormitory. The former recreation room was relocated to the room adjacent to the dining room and improves supervision of the youth.

Another successful Mayor's Ball fundraiser was conducted in January 2012 and the agency had its highest attendance rate of 300 people since hosting this event. The ball is known to attract many high ranking local officials and businessmen and is a great publicity event for the program.

Standard 1: Management Accountability

Overview

Narrative

FKCS has been in operations since 1985. The agency has an eight-member Board of Directors, including a youth member, with representatives from the upper, middle, and the lower keys, to oversee the agency's goals, objectives and activities. The FKCS building houses the CINS/FINS shelter located on the first floor and the agency's administrative offices, on the second floor. The shelter provides separate female and male dormitories to children ages ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk.

The program has a Senior Management team that is comprised of the President/Chief Executive Officer, the Chief Operating Officer (COO), the Chief Financial Officer (CFO), the Chief Learning and Evaluation Officer (CLEO), and the Chief Development Officer (CDO). In addition, the program has a Counseling Services Coordinator and a residential Program Coordinator. There were no staff vacancies at the time of the review. The COO oversees the activities of both the residential and the non-residential programs. Shelter program staff includes: a Program Coordinator, three Team Leaders, a Youth Advocate, nine Youth Support Staff, a Food Service Manager, and a Maintenance staff. In addition to the Counseling Services Coordinator, the clinical component has three community-based Counselor positions, assigned to the upper Keys, Marathon, and Key West, and one Residential Counselor.

The program has an Annual Training Plan for all staff and all employees receive ongoing training from the program's CLEO, local providers, and the Florida Network. Orientation training is provided to all personnel by the CLEO. Each employee has a separate training file that contains a training plan and corroborating documentation for training received. Annual training is tracked according to the employee's date of hire.

FKCS maintains valuable interagency agreements with several agencies that ensure a continuum of services for the youth and families. The program has a strong outreach component, with participation of all program staff, with emphasis on the designated high crime zip coded areas. Community based staff provide services throughout the county and maintain offices in schools located in the upper, middle, and lower Keys.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure, 1.12, to ensure that background screening is conducted for all employees and volunteers. The program's procedures comply with the Background Screening Unit (BSU) requirements. Prior to an offer of hire, the program submits the appropriate forms to BSU, obtains an eligible rating, and retains proof of eligibility in the employees' personnel files.

A total of eight (8) background screening results were reviewed for five (5) new hires, two (2) rescreened employees, and one (1) volunteer who was active during the review period. All of the new hires were screened and received an eligible screening result prior to hire date. Similarly, the provider requires background screening for all volunteers who have direct contact with youth. A background screening of the volunteer was conducted and the eligible result was obtained prior to the volunteer's start date. Additionally, the provider had two employees who were eligible for a five-year re-screening and their re-screenings were completed prior to their five-year anniversary dates.

In addition to the DJJ Background Screening, the provider also conducts quarterly local background checks for all employees, annual driver's license checks through Greg Roe Insurance Company, and drug screenings at hire and randomly thereafter. During a quarterly arrest inquiry, the provider was informed that one of the staff had been arrested. In reviewing the arrest report, the reviewer found that the staff was terminated for job abandonment prior to knowledge of the arrest.

The Annual Affidavit of Compliance with Good Moral Character Standards was not completed and faxed to the DJJ Background Screening Unit prior to January 31, 2012. The provider submitted it on February 14, 2013.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures in place that address all elements of the indicator to ensure that youth, staff, and others are provided an abuse free and safe environment. In addition, the program has a comprehensive Personnel Policy and Procedure Manual that covers the rules and expectations in effect at the FKCS. The Code of Conduct is described in Section E of the manual and outlines all rules concerning physical abuse, use of profanity, threats, or intimidation. Upon hire, staff receives a copy of the Employee Handbook and an acknowledgement

of receipt in writing is maintained in the employee's personnel file.

The program also has a detailed policy and procedures regarding Child Abuse Reporting, policy # 1.07.01-1.07.03. Staff's responsibility and protocols for reporting child abuse are clearly outlined in the procedures. Orientation training was conducted on abuse reporting requirements with the three new program staff whose training files were reviewed. In addition, the Abuse Hotline telephone number is visibly posted in the lobby, administrative office hallway, staff office, youth living room area, and is also included in the Client handbook.

A review of ten calls made to the Abuse Hotline was conducted. The Abuse Hotline reports are maintained in a binder. Three of the calls related to youth's complaints against staff/the facility. In two of the three calls, the youth alleged that she had bed bugs. Staff inspected the youth's hair and did not find any head lice. The reviewer spoke with a representative at Truly Nolen who responded to the provider's request to investigate the issue. The technician did not find any evidence of bed bugs. The request was closed out with no need for treatment. A third client alleged physical abuse by staff and was allowed to make the call to the Abuse Hotline. The incident was investigated by DCF and the case is still open. The Shelter Manager provided a written report of the internal investigation and review of the security tapes which determined that staff had physically restrained the client. Per the Administrative Assistant, there has not been any incident of discipline imposed toward staff due to abuse.

All youth are provided with a Client Handbook upon admission to the program. Included in the handbook are the youth's rights, information on the grievance process, the abuse hotline number, and the code of ethics. During the program orientation, the youth and the youth's parent or guardian are advised of the program's mandatory abuse reporting requirements. The youth and parent or guardian sign the orientation checklist acknowledging receipt of the handbook and their understanding of the information provided during orientation. This form was located in all files that were reviewed.

All of the three youth surveyed indicated that they know about the abuse hotline and are aware of the location of the Abuse Hotline telephone number; two of the youth indicated calling the abuse hotline. All three youth stated that they feel safe in the shelter.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard another staff use profanity, threat, intimidation, or humiliation when interacting with youth.

Two of the ten abuse registry calls documented by the provider did not indicate whether the call was accepted or not. Instead, staff documented "unknown" on the report forms.

Two of the youth surveyed indicated that adults in the shelter program are sometimes disrespectful and use profanity when talking to youth. Their statements included staff trying to "abuse their power" and sometimes swear at youth and prevent them from using the bathroom or going outside.

1.03 Incident Reporting

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has written procedures documented in Incident Reporting Policy # 1.13 that comply with the Department's requirements.

During the review period, the program reported eleven (11) incidents called in to the Central Communications Center (CCC) that is documented on a Central Communication Center Incident Report form. The DJJ Contract Manager also provided the Reviewer with copies of the reports that were obtained from the Department's CCC. These reports were compared to the agency's reports to ascertain consistency and thorough examination of related incidences. Of the eleven CCC incidences reviewed, ten were reported within the two hour timeframe. The incidences reviewed were categorized as follows: 4 absconds, 2 contrabands, and one each youth behavior, medication, and baker act.

One of the incidents was not reported during the two-hour timeframe. The incident occurred on 12/19/12 at 7:40 p.m. CCC documents the call at 10:06 p.m. and the staff report of the incident states that the caller gained knowledge at 10:00 p.m.; however, this is contradictory to the statement on the same report that staff discovered the contraband on the youth at 7:40 p.m.

Another incident involving a youth's allegation of physical abuse by staff on 1/14/13 was reported to DCF but was not called in to the CCC. The provider was made aware of the reportable nature of the incident and made the call to CCC during the onsite visit; the report was accepted.

A third incident was discovered during the review to be reportable to CCC. The incident is regarding a youth who was given two doses of contraception medication without factual evidence the dosage was missed. The provider was made aware of the need to report the incident during the visit.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

While reviewing the Florida Keys Children's Shelter, Inc. Policy and Procedures, all training requirements were met according to the Florida Network standards. The agency has demonstated that they are following the standards through providing first year employees 80 hours of required training and 40 refresher hours for employees after the first year of employment.

The Florida Keys Children's Shelter provides first year training for their employees on Program Orientation, Crisis Intervention/Safety, Suicide Prevention, CINS/FINS Core Training, Title IVE Procedures, Fire Safety Equipment, CPR, First Aid, Signs of Symptoms of Mental Health and Substance Abuse, Universal Precaution, Cultural Competency, and an In Service Component. Following the first year, employees are provided refresher trainings such as Fire Safety Equipment, CPR, First Aid, Crisis Intervention Skills, Suicide Prevention, Signs/Symptoms of Mental Health and Substance abuse, Universal Precautions, and Cultural Competency. The agency also provided training certificates or training summary forms confirming trainings have taken place. The agency provided an annual training plan to the Florida Network and it was approved. The agency has its own trainer that provides most of the required training which are conducted by Ben Kemmer, Chief Learning & Evaluation Officer.

After reviewing three first year training files, all employees had 80 hours or more of the required trainings within the first year of being hired. After reviewing three training files for employees who have been employed over a year or more, all three had 40 hours or more of the refresher required trainings.

No exceptions were noted.

1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This reviewer finds the Florida Keys Children's Shelter is following the 1.05 Interagency Agreements and Outreach standards required by the Florida Network.

The agency maintains written agreements with community partners that include services provided and the referral process. The program also provides a strong connection in the community with providing various outreach events. The program has several brochures providing information about the agency such as criteria on program, what services are provided, and agency contact information.

Although community outreach is a shared responsibility, the program has a designated staff person, the Development Director, who conducts Community Outreach Activities. The lead Outreach staff coordinates and is accountable for the interagency agreements as well as any community partnership and collaboration. The program develops brochures describing the various services offered by the organization which are updated as needed. The brochures are published in English, Spanish, and Creole. The agency distributes printed material and makes presentations to audiences from low-performing schools, other prevention programs, and high crime neighborhoods.

No exceptions noted.

1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy outlining Disaster Planning Preparedness Procedure. The written policies comply with the procedures and guidelines by the Florida Network standards.

The agency has in place a detailed and organized Emergency Preparedness Plan for 2012-2013 which includes all emergency disaster types, emergency roster/contact list of employees, evacuation plan, and specific evacuation facilities used. The plan also includes procedures to follow during severe weather warnings, responsibilities of staff during an event of a disaster, and procedures that address what items are taken by the agency during an evacuation such as medications, log books, agency cell phone, radios, and other necessities. The agency also has a process in place regarding what staff is responsible to notify the Florida Network, DCF, and parents of client population. The agency sent copies of their Emergency Preparedness Plan for the year 2012-2013 to the Florida Network.

In a review of the Emergency drills and Fire drills, the agency shows they are completing fire drills on a monthly basis, but not on every shift in some months. The agency is adhering to their policy and procedure with the emergency drills being conducted on a quarterly basis. The agency has staff complete a child care fire drill log and fire drill report form is completed on each drill.

The agency has policy and procedures that fire drills will be conducted at least once a month per shift and on a few occasions there were only two drills for two shifts in a month. There were only two shifts that conducted fire drills for the following months: January 2013, August 2012, October 2012, and November 2012.

There were 12 fire drills that were conducted that did not meet the required evacuation time (2 minutes) to clear/exit the facility during the period 6/26/2012 to 2/25/2013.

1.07 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. In addition, there is a comprehensive Agency Performance and Quality Improvement (PQI) Plan that outlines the agency's PQI philosophy, staff responsibilities, overview of the PQI process, strategic planning, and delineation of the organizational outcomes and indicators.

The agency's CLEO is responsible for the implementation and oversight of its PQI activities. In practice, the agency's PQI program includes many activities that are conducted by various staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented.

Quarterly peer case record reviews are conducted quarterly by the program staff as directed by the CLEO who randomly selects 40% of client and human resource records. Using the records review checklist, staff conducts the reviews the first week of each quarter beginning in January. Upon completion of each record review, the CLEO aggregates the results and provides a copy of the aggregated report to the Executive Council, Leadership, and Direct Care Staff. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner. Deficiencies are corrected within two weeks of the records review.

The CLEO conducts quarterly reviews of all issues regarding employee and client safety. The Safety Review consists of statistical information compiled from risk management, human resources, performance quality improvement, direct care and program staff. Management and direct care staff meet to discuss safety issues, licensing audits, and reports related to safety and risk management. Data and reports are aggregated by the COO and CLEO and presented at meetings for review.

Consumer surveys are administered for staff and stakeholders annually and quarterly for the youth served in the program. The annual employee satisfaction surveys and Stakeholder survey data are aggregated by the CLEO and presented to the agency constituents.

Outcomes data is entered into and analyzed through the provider's ETO software and the reports generated are included in the Practice Review report. ETO allows the organization the ability to collect data on program effectiveness, client outcome tracking, and continuous quality improvement. The outcomes data incorporates all of the contract, NetMIS, and program outcomes required by the Florida Network and DJJ QI. A copy of the FKCS Program Output/Outcome Report for July-December 2012 was provided. An annual Performance and Quality Improvement Report for the period July 2011 through June 2012 was also provided and reviewed onsite. The latter report included a summary of records reviews, peer case record reviews, safety review, and risk assessment for the period.

The provider conducts reviews of NetMIS data on a monthly and the data is presented at the FKCS Leadership meeting by the COO. Copies of the agendas for the monthly meetings held during the past six months were reviewed during the visit.

No exceptions noted

Standard 2: Intervention and Case Management

Overview

Rating Narrative

FKCS is contracted to provide both shelter and non-residential services for youth and their families in Monroe County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Trained staff are available to determine the needs of the family and youth. Residential services, including individual, family, and group services, are provided. Case management and substance abuse prevention education are also offered. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on- going counseling, and educational assistance.

The Clinical component consists of a Counseling Services Coordinator, three community-based counselors and one residential counselor. The counselors are responsible for providing case management services and linking youth and families to community services. The community based services span the entire Monroe County. The program's non-residential counselors work out of local schools in the upper, middle, and lower Keys in Key West, and provide prevention services to youth in the county utilizing several schools as the base of operations in their respective communities.

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

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy, Florida Keys Policy #2.01, in place. The policy outlines the time frame for the initial screening for eligibility to occur within (7) seven calendar days of receiving the referral. The procedures also included the responsibility of staff to provide the youth and parent/guardian in writing, during the intake, available services options, rights and responsibilities of youth and parent/guardian, grievance procedures and information on the CINS process with regards to the Case Staffing Committee, CINS Petition and Adjudication.

Six (6) client files were reviewed: three (3) residential client files, two (2) non- residential client files, and one (1) which was both a residential and non-residential client. In all six (6) files, the screenings were completed within (7) seven calendars days of referral by a trained staff member using the NetMIS screening form. In all six (6) client files, there was written proof that the youth and parent/guardian received in writing the available services options, rights and responsibilities of youth and parents/guardians, and possible actions occurring through involvement with CINS/FINS services (i.e. case staffing committee, CINS petition, CINS adjudication). The youth/family also received information about the agency's grievance procedures. The Residential Coordinator or Community Based Counselor (for non-residential service) did review and sign each NetMIS Youth Screening Form completed.

No exceptions noted.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy, Florida Keys Policy #2.01, in place. The procedure states that the Psychosocial Assessment for youth who have open cases with the agency is initiated within 72 hours of admission (residential) or within(3) three face-to-face counseling sessions (non-residential). The assessment includes all relevant social, emotional, education, health, substance abuse, behavioral concerns, employment, prior abuse or neglect, and family history information. A copy of the Psychosocial Assessment form is placed in the youth's file. The assessment may be updated if additional information is subsequently obtained. If there is a delay in starting the Psychosocial Assessment or if the staff has been unable to complete the assessment within (3) three face-to-face counseling sessions, the youth's file must contain documentation explaining the reasons for the delay. If the assessment warrants a more intensive service, such as a psychiatric or in- patient substance abuse referral, the Counselor will consult with the Counseling Services Coordinator to assess what further services are available. Psychosocial Assessments must be completed by a Bachelor's or Master's level staff member.

Six (6) client files were reviewed, three (3) residential, two (2) non-residential, and one (1) which was both a residential and non-residential client. All six (6) files contained completed Psychosocial Assessments. All were completed by a Bachelor's or Master's level Counselor and signed by a supervisor. All six (6) were signed by the youth, parent/guardian, counselor and supervisor. All six (6) were initiated within (72) seventy-two hour of admission to the program and was completed within (2) two to (3) three face-to-face counseling sessions. Each assessment contained the following: Youth information including, name address, school attended, grade, address, DOB, sex and race; parent/guardian

information including name, address, work phone, place of employment and insurance coverage when applicable; youth and parent/guardian were present during the interview; referral problem; psychiatric/counseling history; education history; a list of all family members and others living in the home; the location/involvement of family/non-family members who do not live in the home, when applicable; family history, including but not limited to divorces, deaths, re-marriages when applicable; youths residential history; developmental/medical history including severe accidents, medical conditions; alcohol/substance abuse history for both youth and family/household members when applicable and DCF/DJJ services history including but not limited to previous or current abuse, neglect; financial history; peer relationships; potential for violence; suicidal assessment including but not limited to current or past ideations, plans and/or attempts.

The Clinical Staff did not always include their credentials when signing the assessments.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy, Florida Key Policy # 2.02, in place. The procedures outline the persons involved in developing the service case plan. For both the residential and non-residential programs, the youth, parent/guardian, and counselor are responsible for developing the service/case plan and the Counseling Services Coordinator oversees this process. The service plan is to be developed within seven (7) working days of the completion of the Psychosocial Assessment. Should there be a delay in the completion of the psychosocial assessment or if it cannot be completed in two to three face-to-face counseling sessions, the counselor may elect to develop an interim service plan to address the more immediate and apparent needs. All efforts are made to engage the youth and parent/guardian in the service plan development and review by scheduling it at a mutually convenient time. If the youth and or parent/guardian are not present, is unwilling to participate in the service plan development process, and/or refuses to sign the plan, such is recorded on the signature line. A case note entry is also made to indicate the reason or rationale for the lack of signature. The case/service plans are completed and signed by the youth, parent/guardian and counselor, and a copy of the form is given to the parent/guardian. The original form is placed in the client's file. Services and treatment to families in need of services is by voluntary agreement of parent/guardian and youth or as directed by a court order. The procedures also outline what each case/service plan shall contain and requires reviews by the counselor, youth and parent/guardian every (30) days for the first (3) three months and every six months thereafter.

Six (6) client files were reviewed, three (3) residential client files, two (2) non-residential client files, and one (1) file where the youth was both a residential and non-residential client. In all but one (1) client file there was a completed case/service plan which was completed within seven days of the completion of the psychosocial assessment. The one client file that did not have a service plan developed was due to the youth being in the shelter only three days and the Psychosocial Assessment had just been completed the day of the review. All of the five remaining plans were developed by the youth, parent/guardian, counselor, and signed by the Counseling Services Coordinator. All five plans addressed the specific needs identified in the assessment and listed the most appropriate services to be provided by the organization and external providers. All contained a realistic time frame for completion, responsibilities of the youth and family were designated in order for the family to complete their goals, they all contained responsibilities of the program to assist the youth/family in the completion of their goals, all contained measurable objectives that identified the problems and needs, and all contained the frequency and location of services to be provided. The service/case plans were reviewed every two weeks. The plans had target dates for completion of goals and when applicable dates of completion. Two of the files also had updated service/case plans.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is written policy in place, Florida Keys Policy #'s 3.03, 3.04, 3.05, 3.06, 3.07, 3.08, and 3.09. Each youth is assigned a counselor/case manager, upon admission to the program, who follows the youth's case and ensures delivery of services through direct provision or referral. Services available through the program and/or through referrals to other county service providers may include, but not limited to: intensive crisis counseling, case management preventive health education, including information about prevention of HIV/AIDS, TB and STD's (In partnership with the health department, Individual, group or family counseling, substance abuse and community mental health services, prevention and diversion services, services provided by volunteers or community agencies, runaway center services, truancy intervention services, vocational and job training or employment services referrals, recreational services, sleeping accommodations, food, clothing, personal hygiene supplies and facilities, mailing address, information and referral services, coordinating service plan implementation, monitoring of out-of-home placements (if necessary), referrals to the case staffing committee as needed, recommending and pursuing judicial intervention in selected cases, accompanying youth and parent/guardian to court hearings and related appointments, continued case monitoring, and review of court

orders, and case termination with follow-up.

Six (6) client files were reviewed, three (3) residential client files, two (2) non-residential client files, and one (1) client who is both and residential and non-residential client. In all six (6) cases the clients were assigned a counselor/case manager upon admission to the program. Of the six (6) client files reviewed, the counselor established that there were referral needs and referrals were made for four (4) of the clients (three (3) were substance abuse treatment referrals and one (1) was for mental health services). In each case the counselor/case manager coordinated the referrals to services based upon the on-going assessment of the youth/family's problems and needs. In five (5) of the cases, the counselor/case manager implemented the service plan; in the one remaining case plan, the youth's psychosocial assessment was just completed the day of the review so there was not a service plan implemented. Each file documented the monitoring of youth/family's progress in the case notes. There was detailed documentation that each counselor/case manager consistently provided support for the families. In one (1) case, the youth was placed out of home, she was baker acted, and the counselor monitored the status of the youth until her return to the program. There were two (2) youth out of the six (6) who were referred to the case staffing committee to address problems and needs of the youth/family. In one (1) case, a CINS Petition was filed and the youth was adjudicated a "Child In Need Of Service" (CINS). The assigned counselor/case manager accompanied the youth and parent/guardian to court hearings and related appointments. The youth was referred for additional services and the counselor provided case monitoring and reviews of the court orders.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy, Florida Keys Policy #304, in place. Both residential and non-residential youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process. The shelter provides individual and family counseling as well as group counseling sessions, which are held a minimum of five days per week, based on established group process procedures. The non-residential program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. Services are provided in the youth's home, a community location, or the program's counseling office. The counselors work closely with the parent throughout the duration of the case. Frequently, a youth receives CINS/FINS non-residential services prior to his/her placement at the shelter. The non-residential counselor works collaboratively with the residential counselor.

Six (6) client files were reviewed, three (3) residential files, (2) two non-residential files, and one (1) file where the client was both a residential and non-residential client. In all six (6) cases, the youth and family received individual and family counseling. The four (4) youth who resided at the shelter also received group counseling (5) five times per week. The counseling services the youth and families received were in accordance with the service/case plan. The youth's presenting problems were addressed in the psychosocial assessment, initial case/services plan, and case plan review. The case notes maintained for all counseling services provided and documented youth and families' progress in completing their service/case plan goals. There is also documentation of an on-going internal process that ensures clinical reviews of case records and staff performance.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy, Florida Keys Policy #2.06, in place. The procedures outline the functioning of the case staffing committee. The case staffing committee is scheduled to review the case of any youth or family that the program determines is in need of services. Such reasons are the youth is not in agreement with services or treatment, the youth/family will not participate in the services, or the program receives a written request from the parent/guardian or any other member of the committee. A case staffing committee is convened within (7) seven working days from receipt of the written request. The case staffing committee includes a representative of the youth's school district, a representative from the Department of Juvenile Justice, the contracted provider for CINS/FINS and others as deemed necessary including but not limited to a representative from the areas of health, mental health, substance, social or educational services; a representative from the state attorney; the alternative sanctions coordinator; the youth/parent/guardian; and any other person recommended by the child, family or CINS/FINS program. In truancy cases, a representative of the school system must be invited to attend. The CINS/FINS counselor or counseling services coordinator is the assigned Chairperson of the case staffing committee. The program works with the circuit court for judicial intervention for the youth or family as recommended by the case staffing committee in accordance with the procedures outlined in the CINS/FINS policy and procedures. The case manager or designee completes a review summary prior to the reviewing hearing, informing the court of the youth's behavior and compliance with court orders and providing recommendations for further dispositions.

Six (6) client files were reviewed, three (3) residential files, (2) two non-residential files, and one (1) file where the youth was both a residential and non-residential client. Of the six (6) clients, two (2) of them were referred to the case staffing committee and one of the two had a CINS petition recommended, filed, and the youth was adjudicated a Child In Need Of Service. In both cases the CINS/FINS Counselor was the person who initiated the case staffing. Both families received notification no less than (5) five working days prior to the staffing. In both cases

the committee members were also notified no less than (5) working days prior to the staffing. At both staffing, there was a representative from the district school, the local mental health provider, and the CINS/FINS provider. The parent/guardian received a written copy of the revised services plan created from the staffing immediately after the staffing. The CINS/FINS counselor accompanied the family to court and related appointment, prepared court documentation, and reported the youth's/families'/guardian's progress. One of the youth had a review hearing during the review. After the hearing the parent reported to the program how grateful she was for the assistance of the CINS/FINS program and how successful her daughter had become. She highly recommended CINS/FINS to any struggling parent.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The client files are very well kept. All files were marked confidential, consistently organized, provided extensive documentation of the needs of the youth and families and the reviewing of the service/case plans every (2) two weeks is above and beyond the requirement.

Standard 3: Shelter Care

Overview

Rating Narrative

FKCS is located in Tavernier, Florida and serves the entire Monroe County. The shelter is a nineteen bed facility that provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and youth from the Department of Children and Families (DCF). At the time of the quality assurance review, the shelter was providing services to four (4) DJJ youth. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

During the tour, the facility was found to be in good working condition and the furnishings in good repair. Some graffiti was observed on the walls and furnishings. The facility boasts tiled floors, professionally painted wall murals in the dormitories, new furnishing, exterior painting and well maintained landscaping. The shelter consists of a game/recreation room, a large day room/dining hall, dormitories, kitchen, two laundry rooms, staff offices and a conference room. The dormitory, restrooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. The sleeping rooms house two youth each with an individual bed, bed covering and pillows. A new bedroom containing three beds was added recently to increase the number of beds in the facility to nineteen. The youth have access to the game/recreation room, basketball court, and a nearby park. The Counseling Services Coordinator/CINS/FINS Counselor is a Licensed Clinical Social Worker (LCSW)/Certified Addictions Professional (CAP). Services provided include individual, group and/or family counseling, and any other applicable intervention required. The youth admitted to the program are screened using the Network Management Information System (NETMIS) Youth Screening Form, the CINS/FINS Intake Form, a brief FAM (Family) General Scale or Teen Screen, and a Substance Abuse Subtle Screening Inventory (SASSI), when applicable. If a youth answers “yes” to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form or if the staff member’s observations of the youth’s behavior would indicate any area of concern, an Assessment of Suicide Risk (ASR) is completed. The ASR is completed by either licensed professional or a non-licensed counselor under the direct supervision of the LCSW. A medical and mental health alert system is in place and the shelter staff that administers medications have been trained in the distribution of medication.

3.01 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The residential shelter program has a written policy. The provider uses the CINS Intake and Assessment Form for gathering information and observations of the youth at intake. Three open residential files were reviewed and all had completed CINS Intake Forms with Youth Room Assignments and classifications detailed. This form captures all required documentation for room classification. They also have a written policy on Medical and Mental Health Alerts that uses thirteen codes for alerts ranging from allergies to victim of sexual assault. Of the three residential files reviewed, all three had different alert codes (stickers) on the front of the files.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy for Orientation to the Program. The program has an extensive residential youth handbook that is 40 pages long with 36 different orientation areas. This handbook contains all required areas that must be covered with youth within 24 hours of admission. There is a mirrored handbook for parents and it is also reviewed and signed within 24 hours. There is separate form for youth and parent showing they acknowledge receipt, and have reviewed the handbooks. The youth are given a tour of the facility and there is documentation to support this on the CINS/FINS Residential Checklist form.

3.03 Shelter Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are eight written policies that are relevant to shelter environment. They are Maintenance of the Building, Sleeping Quarters/Bathrooms and Shower Facilities, Personal Hygiene, Residential Bathrooms, Linen & Towel Distribution, Searches, Secured Items Procedure and Contraband, Valuables, Restricted and or Inappropriate Items. All Annual, Quarterly and Semi Annual fire and health inspections were completed with no violations. The provider also had a certificate of inspection for the elevator as well.

The shelter rooms were all painted with different murals from different local artists and staff said this has helped with less graffiti on the walls. There was graffiti found on the wall in room #2 and in two places on the wall in room #3, both boys side. All rooms had separate beds and dressers and nice bedding and were in good repair. One room on the girl’s side had a bunk bed and another bed so they can put three girls in

that one room. During the walk through, there were no pests or insects noticed. The outside grounds were nicely landscaped and there was an area for the youth to play basketball or football. Bathrooms were clean; one of the bathrooms was missing a towel rack. Personal belongings of value can be kept in one of two locations, in a safe in the file closet and the Shelter Manager also has a safe to keep youth's valuables. The shelter has a nice sized kitchen and it was very clean and organized. Chemicals are being kept in a locked closet in the kitchen and are counted perpetually as they are used. A recommendation would be to have an Approved Chemical staff list posted in that closet.

In the youth surveys all three youth knew about the grievance process and one rated this process very good and the other two said it was fair. There were seven grievances in September, six in October, five in November, two in December and one in January. The majority of the grievances were around staff and two were around other youth. All were reviewed with the client within 72 hours. When asked if staff were respectful when talking to youth, one said yes and two said no. One youth answered the staff swears at them and keep their rights of using the bathroom and going outside from them. Looking at the shelter's key control log, there were five entries by Patrick that had "given to" with no name listed. All other logs were complete and signed for. The shelter has a warm feel to it when you walk through it and the personnel have been very cordial and helpful. I observed a few youth that were going through their homework with staff. They were interacting positively with youth.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy for logbooks and what information should be in them. The logbook has all important information highlighted in yellow. This could be an intake, a runaway, self-harm, medications, or disruptive behavior while in the shelter. All entries have the date and time of event or activity along with youth involved and staff initials at end of the entries. The Shelter Director does Administrative Reviews every week. The supervisors are doing required reviews but they are just writing reviewed logbook and not that they reviewed to their last shift. With all important information highlighted in yellow, it makes it a bit difficult to find specific events when looking in the logbook. For instance, if you had to find a youth who made self-harm statements or tried to hurt him/herself, you would have to scan through all the yellow highlights to find it. A recommendation would be to use different color highlights for different significant events.

Several entries that had errors were not being documented according to the standard. These errors were scribbled out or not initialed and dated. A few examples were 10/31/12 at 11:00am, 11/1/12 at 5:25pm, 11/3/12 at 6:00pm, 2/19/13 at around 9:30pm, 12/30/12 at 1:30pm, 1/13/13 before 4:10pm and 1/17/13 after 4:05pm. Another finding in the logbook was that not all direct care staff are reviewing the logbook while on their shift. Two examples are on days 11/29/12 and 12/5/12.

Rating Narrative

The agency has several written policies around daily programming. The program's weekly school day schedule, weekend schedule, and non-school day schedules are posted in the facility. The daily schedules contain one hour of physical activity along with designated homework time and recreation times. They also have monthly activity schedules that show all different kinds of activities for the youth such as martial arts, movies, craft day, sports activities, dolphin research center, holiday festivals etc. The shelter has a room with books for the kids to read and reading time is also on the daily schedules. Group sessions are provided nearly every day during the week. There are many topics discussed in these group sessions such as gossip, alcohol, tobacco, making friends, saving money, goals, respect, purpose, conflict etc.

3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has several written policies that outline their behavior management system in detail. Staff receives their behavior management training as part of their orientation. Youth learn about it during their orientation to the program. The system is also outlined in the residential youth handbook. This behavior management system was designed to change behaviors of youth, increase the youth's accountability in addressing behaviors, enhance social skills and improve the level of compliance with program rules. The program uses a point scale that ranges from 0-6 points. Zero to 3 points equal poor performance to good performance. To earn 4 or 5 points, the youth have to earn for overall weekend chores, and 6 points is bonus points for voluntary chores, tours of program, or helping with activity or special projects. There are three levels, Orientation Level, Level 1, and Level 2, which entitle youth to earn certain privileges. In order to obtain privileges or rewards, youth must receive a minimum or 54 points a day. All new youth start at Orientation Level. A youth can move up to Level 1 after achieving 54 points or more for two consecutive days. Moving to Level 2, a youth must earn 64 or more points for two consecutive days. All levels involve skill building and are meant to be an incentive and motivating for youth while in the shelter. These points are recorded on a Youth Development System and Point Sheet. Each youth has their own sheet in a binder and staff records all earned points and add them up daily.

The expected youth behavior is listed in the handbook as well as the types of consequences that do not earn points or rewards. This system was designed to recognize youth's strengths. Consequences are given for violation of system or program rules; consequences do not violate

youth's rights.

Staff is provided ongoing feedback by their supervisors. The staff's compliance in implementing the behavior management system is part of their probationary period and annual performance plan. Additional training on the system is provided when necessary. The program's Youth Development System Staff Monitoring policy details staff compliance to the system and ongoing supervisory feedback that is crucial for success of the system.

3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has several policies that address Behavioral Interventions: Physical Restraint, Crisis Intervention and Emergency Procedures, Crisis Intervention Counseling for Youth, Consequences of Violation of Program Rules, Disciplinary Sanctions Other Youth and Room Restriction. The agency uses T.E.A.M., which stands for Techniques for Effective Aggression Management Program. Any physical restraint is the last resort for intervention and they concentrate on verbal de-escalation techniques. The client handbook outlines the Behavior Management System but does not advise youth/family about the possible use of physical restraint if imminent danger to self or others is evident and that staff receives T.E.A.M. training. A recommendation was made to add this verbage.

3.08 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy outlining the requirements of indicator 3.08 on Staffing and Youth Supervision procedure. The written policy complies with the procedures of the Florida Network quality improvement standards.

The program follows the procedure by having a bi-weekly schedule that is developed by the program supervisor and the schedule is posted in the office located in the shelter. The agency has a log book for staff to sign in and out on each shift. The schedule includes youth care work hours/days over three shifts. The agency also has on-call rotation roster, which includes names of staff and contact numbers. According to Staff Log Book and Staff Schedule, the agency has a minimum of one female staff and one male staff on each shift.

The three shifts run from 6:00am to 2:00pm, 2:00pm to 10:00pm, and 10:00pm to 6:00am. The agency has two or more staff on each shift to accommodate having female and male clients during the day which meets the requirements for the staff ratios required. The agency also has two staff during the over-night shift which meets the male-female staffing and ratio requirements and the program has not had more than 10 CINS/FINS clients since August of 2012.

On 11/2/2012, it was reviewed in the log that one of the staff did not log what clients were doing or where clients were located starting from 12:30am until 6:00am. According to log book, staff wrote only the initials of the clients on this particular day during the overnight shift.

3.09 Staff Secure Shelter

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Florida Network does not designate the agency as a Staff Secure Shelter. This indicator does not apply to this agency.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The FKCS has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted into the program. Upon admission, Youth Support staff will interview youth and complete the intake. An initial intake assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history (including gang or criminal involvement), potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment form.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The licensed Clinical Coordinator or Program Coordinator is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board that discreetly mounted in the staff control room and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored the medication room in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication. Medication records for each youth are maintained in a binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

In accordance with the standard, the policies and procedures maintained by this agency require a preliminary physical health screening for each youth at the time of admission to the shelter. The preliminary health screening includes screening for medications; existing (acute and chronic) medical conditions; allergies; recent injuries or illnesses; the presence of pain or other physical distress; observation for evidence of illness, injury, physical distress, difficulty moving, etc.; and observation for presence of scars, tattoos, or other skin markings. The program's written policy & procedures ensure medical care for youth admitted with chronic medical conditions (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.) and include a thorough referral process and mechanism for necessary follow-up medical care as needed. The program documents all medical referrals on a daily log for both emergent care as well as non-emergent medical appointments.

A review of three (3) open residential client files demonstrated that the practice adheres to the standard and the agency's policy and procedures as all three (3) files reviewed contained a completed heath care admission screening.

One (1) of three (3) youth surveyed reported participating in services for Mental Health or substance abuse and these services were rated as "good" by one (1) youth and "fair" by another youth. One (1) of three (3) youth surveyed reported participating in medical care services while at the shelter. Two (2) youth rated the care provided as "fair" and one (1) rated it as "very good".

No exceptions noted.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains a written Comprehensive Master Plan that details its suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS. The plan clearly delineates staff positions, duties, supervisory roles, involvement of licensed professionals, documentation protocols, notification procedures, and referral systems in connection with suicide prevention and response.

In accordance with the standard and the agency's policy and procedures, a review of three (3) client files demonstrated that each youth is screened for suicide risk in accordance with the Florida Network's Policy and Procedure Manual for CINS/FINS. Suicide risk screening is included as part of the initial intake and screening process and in all three (3) files the results were reviewed and signed by the supervisor and documented in the youth's case file. Two (2) of the three (3) files whose initial screenings indicated suicide risk were assessed within the required timeframes.

Two (2) of two (2) youth awaiting assessment by a licensed professional were placed on constant sight-and-sound supervision and the supervision level was not removed until the completion of further assessment by the required personnel.

Three (3) of three (3) staff surveyed responded that if a youth expresses suicidal thoughts the direct care staff are responsible for notifying a mental health authority, placing and maintaining the youth on constant sight and sound supervision, documenting the supervision, and searching the youth and the youth's room for hazards. Three (3) of three (3) staff surveyed responded that the suicide response kit is kept at the staff station desk or cabinet and one (1) reported it as being wall mounted.

No exceptions noted.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program follows written procedures that address the safe and secure storage, access, inventory, disposal, and administration/distribution of medications in accordance with the DJJ Health Services Manual. Observation noted that the program's procedures include the following mandatory components:

- All medications are stored in a separate, secure (locked) area that is inaccessible to youth (when unaccompanied by authorized staff)
- Oral medications are stored separately from injectable or topical medications
- Medications that require refrigeration are able to be stored in a locked refrigerator that is used for medication only. On the date of this review there were no medications requiring refrigeration. The locked refrigerator is located inside the locked medication room
- Narcotics and controlled medications are stored behind three locks (the locked door to the med room and a cabinet with two locks)
- Only designated staff delineated in writing have access to secured medications and the written list was provided during the review
- a perpetual inventory of controlled substances with running balances is maintained, and shift-to-shift inventory counts are conducted and documented
- Over the counter medications that are accessed regularly are inventoried weekly by maintaining a daily perpetual inventory
- The Youth Support staff member interviewed was immediately able to state where they find information on medication side effects, the training received, and the need for observing the youth on medications for signs of possible side effects

Two (2) of the three (3) staff surveyed indicated that they assist youth in the delivery of medication. Three (3) of three (3) staff members responded that they were informed of medication side effects via the alert form in the file and via the Physician's Desk Reference. Two (2) of three (3) staff members responded that they were informed of medication side effects via the staff meetings and the medical alert log. One (1) staff member indicated shift transition as a means of being informed of medication side effects.

EXCEPTIONS NOTED:

- A review of medication records for a client on once daily oral prescription birth control documented that on January 8, 2013 two doses of the medication were administered at 9:09pm when only one dose should have been administered. No documentation was available to document that any medication doses were missed and the CCC reports verified that no calls were made to the CCC to report any missed mediation. Initial review of a Medical Appointment Information Record not yet filed in the client file indicated that a medical appointment had occurred on 01/07/13 but no medications were prescribed or discontinued during that appointment. A review of the calendar for routine medical appointments verified that this client had an appointment at the Health Department at 2:00pm on Monday, 01/07/13. Program staff contacted the Health Department staff who completed the Medical Appointment Information Record, on the date of this review, and the health Department Staff provided written clarification that medication had actually been prescribed and provided on 1/7/2013. Health Department Staff corrected the 01/07/13 Medical Appointment Information Record to confirm that the medication had actually been prescribed and provided. The youth's Client Medication Log also shows receipt of the filled medication on 1/7/13. Based on the corrected documentation, it appears that no doses of the medication were actually missed and the additional dose given on 01/08/13 at 9:09pm was a medication error. A CCC report was made to report the double dose incorrectly administered on 01/08/13 during the review.
- The standard requires that syringes and sharps (needles, scissors, etc.) be secured, and counted and documented weekly. A review of the sharps inventory log (red tool box) for the past six (6) months documented that on seven instances the counts of sharps

were documented on the Sharps Inventory less frequently than weekly (no counts documented from 9/22/12 to 10/4/12; 10/11/12 to 10/25; 11/8/12 to 11/22/13; 11/22/13 to 12/6/12; 12/6/12 to 12/20/12; 1/17/13 to 2/1/13 and 2/7/13 to 2/21/13. Also, no counts were documented for the tweezers, nail clippers, and scissors that are documented on the Non-prescription Medication Count Page, for the date on or about 11/19/12.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains written policy and procedures to ensure information concerning a youth's medical condition, allergies, common side effects of prescribed medications, food and medication contraindication, and other pertinent treatment information is effectively communicated to all staff through an alert system. The Provider's Alert system includes 13 different alert types including medications, medical and mental health conditions. Each alert type is represented by alphabetic abbreviations. Alerts for youth present in the shelter are posted daily on the reverse of the control room door. Staff have the codes for all alerts printed on the reverse of their ID cards for easy verification of alert codes. Alerts for each youth are displayed on the outside of the client file, written on dot stickers, using the same alphabetic codes.

Three (3) of three (3) staff members surveyed reponded that they are informed of youth medical/mental health alerts via the alert form and the youth file. Two (2) responded that the log book was a source of alert information and one (1) staff member indicated the shift meeting as a source of alert information. The Youth Support staff member interviewed were able to state the training received on the alerts system during orientation.

No Exceptions Noted.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains written policy and procedures that comply with the standard to ensure the provision of emergency medical and dental care. The program's procedures include the following mandatory components relating to obtaining off-site emergency services: 1) parental notification requirements, and 2) development/implementation of a daily log.

Training on first aid and emergency medical procedures are completed and current for all staff. Emergency medical care is logged and that log book is maintained in the medication room. Non-emergency medical appointments are logged on a monthly calendar which is maintained in the youth care control room. The First Aid Kit, wire cutters and knife-for life are located in the locked med room which is accessible to staff. First aid supplies are maintained and inventoried monthly.

No Exceptions Noted.