



Florida Network of Youth and Family Services

Quality Improvement Program Report

Review of Orange County

on 05/31/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory:85.71%

Percent of indicators rated Limited:14.29%

Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:96.30%

Percent of indicators rated Limited:3.70%

Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Keith Carr; Lead Reviewer; FOREFRONT/FNYFS

Felicia Goldstein; Regional Monitor; Department of Juvenile Justice

Janet Valdez, LMHC; CINS/FINS Non-Residential Supervisor; Children's Home Society Osceola

Kristi Castaneda; Director of Program Support; Boys Town of Central Florida

Jessica Szymczyk, LMHC; Clinical Director; Stewart-Marchman Act Behavioral Healthcare

Persons Interviewed

- | | | |
|--------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct-Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non-Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 2 Case Managers | 1 Maintenance Personnel | 1 Clinical Staff |
| 1 Program Supervisors | 1 Food Service Personnel | 0 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 7 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 9 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 8 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 8 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

8 Youth 6 Direct Care Staff

Observations During Review

- | | | |
|--------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|
| <input checked="" type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input checked="" type="checkbox"/> Searches | <input checked="" type="checkbox"/> Discharge | <input checked="" type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" type="checkbox"/> Youth Movement and Counts | |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Orange County Youth and Family Services, located in the city of Orlando, provides a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by the Orange County government. The program is also a Staff Secure Shelter and is also a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking.

Orange County Youth and Family Services (OCYFS or YFS) received re-accreditation from the Council on Accreditation (COA) in 2016. The YFS Division is accredited until 2020. Initial accreditation occurred in 2000. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

The program serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The emergency shelter offers a variety of services to meet the need of its target population. These services include: 24 hours a day, seven days a week shelter (residential) services; non-residential services; structured daily living programs employing positive behavior modification techniques; life skills groups to promote responsibility and independence; substance abuse screening services; case management; positive youth development; and health care coordination services to insure access to medical treatment.

Since the last onsite monitoring visit, Orange County Youth and Family Services has had many accomplishments. They include:

- The Youth Shelter has worked with OCPS to incorporate the STEM-Connect, an OCPS new learning model. The goal is to help students enter 21st century workplace by engaging in careers using technology and information that have not yet been discovered. Students are developing inquiry through problem-based learning in all content areas providing a platform that is both rigorous and relevant. By embedding STEM, students are introduced to numerous subjects within the STEM fields of science, technology, reading/language arts, engineering, social studies, and math. Youth Shelter students have participated in a virtual classroom session with experts in the aforementioned fields as well as a field trip to a UCF and a Robotics Program at the Naval Air Warfare Center.
- The Youth Shelter Counseling Services Supervisor was awarded UCF-School of Social Work, Field Instructor of the Year in 2016. She was recognized for teaching different methodologies to motivate the youth, taking time to listen, provide feedback, and assisting the interns with paving their career path in the field of Social Work.
- Learning Center lead teacher was awarded “Networker of the Year” by the Florida Network for her extraordinary accomplishments in providing quality services to troubled adolescents. She exposed the children to different educational and cultural activities such as collage and vocational school tours, museums, and theaters, guess speakers, and other hands on activities for the children.
- To better serve the Spanish and Creole literate residents in Orange County, the YFS Division continues to translate, not only division/program brochures in Spanish and Creole, but also many program forms. Telelanguage and deaf interpretive services (video remote interpreting software) are utilized with speakers of other languages when receiving YFS Division services.
- The Youth Shelter provided internship placements for 8 students. Additionally, the Youth Shelter utilized 17 volunteers from the UCF School of Social Work to conduct daily groups.
- In an effort to embrace Trauma Informed Care, the shelter continues to maintain soothing colors and positive affirmation in each bedroom and throughout the facility.



Quality Improvement Review

Orange County - 05/31/2017

Lead Reviewer: Keith Carr

- The YFS Division contracts with a Trauma Informed Care trainer to provide initial training for 1st year employees and annual refresher training. The trainer assists in reviewing the youth's handbook and work with staff to ensure best practices are used when dealing with the children.
- Counseling Corner: A therapeutic area for youth to relax, utilize sensory items that are placed on the table, and supportive ideas posted on the wall.
- On March 7, 2017 the shelter replaced its old and broken furniture with new dining tables, couches, chairs, desks and dressers for the bedrooms and the children's sitting area. (New beds are scheduled for delivery in July.)
- The shelter began the installation for new flooring and lighting throughout the building. The renovation will include other cosmetic upgrades. Renovation will resume on June 5th due to audit.

Standard 1: Management Accountability

Overview

Narrative

The agency is a local County operated full-service Residential and Non-Residential governmental provider. The agency is a self-insured entity and has extensive General and Professional liability insurance. The agency requires that all staff are background screened prior to hiring. All staff must be trained and complete all initial orientation. In addition, the shelter's direct care staff are trained to provide the following services for the youth: medication distribution; health, mental health and substance abuse screenings; first aid; cardio pulmonary resuscitation (CPR) and referrals. There were a total of eleven new hire background checks and four 5 year re-screenings conducted in accordance with Florida Statute 987 during this review cycle.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure to ensure that all employees have been properly screened according to Florida Statute 987 and in accordance with Orange County Division background screening policies.

The program's procedure requires all applicants (staff and volunteers) complete a criminal history background screening to ensure they are not a danger to youth. All employees and volunteers must have an eligible background screening completed through the Department of Juvenile Justice (DJJ) prior to their date of hire, or transfer date and a re-screening must be completed every five years thereafter. The program must wait for a completed background screening before hiring staff in any type of status. An Annual Affidavit of Compliance with Good Moral Character Standards is completed by the programs annually and sent to the DJJ Background Screening Unit by January 31st of each year. Any break in employment or more than 180 days requires a new background screening to be initiated and completed prior to the five-year screening. Any staff person transferring from a connected agency outside of DJJ will be screened through DJJ prior to official transfer.

At the time of this review the non-residential program had a total of sixteen employees, eight of which were hired, or transferred in, since the last annual compliance review. The residential program reported a total of twenty-two staff members, three of which were hired, or transferred in, since the last annual compliance review. A review documentation shows an eligible background screening was completed on all eleven staff prior to their date of hire or transfer. A total of four staff in both programs were due for a five-year rescreening within this review cycle and a review of documentation shows all four staff received an eligible rescreening prior to their hire date anniversary. The Annual Affidavit of Compliance with Good Moral Character Standards form was completed by both programs and sent to the DJJ Background Screening Unit on January 31, 2017.

No exceptions to this indicator were found as of the date of the onsite QI review.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure to address the provision of a safe and secure environment to protect all youth and families. The program strives to provide an environment in which youth, staff and others feel safe, secure and non-threatened by abuse or harassment. The procedures describe the process for child abuse reporting, staff conduct and grievance reporting.

To ensure orderly operations and provide a safe environment, the program expects staff to report all incidents of suspected or known abuse, abandonment, or neglect, or if a child is in need of supervision and care because they have no legal guardian or responsible adult relative to the registry. All reports of abuse are documented on an internal incident report and filed into the reports binder. Orange County Youth Shelter mandates that all employees participate in training annually on indicators of abuse, abandonment, and neglect. Violations of reporting procedures would result in disciplinary action, up to and including termination. The program requires that all allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline. The procedures for contacting the abuse hotline is listed in program policy, the youth handbook, discussed during the intake process and posted throughout the facility. The policy and procedure indicate at any time during program participation youth are permitted to use an agency phone to self-report abuse and/or staff are required to report on behalf of youth abuse or suspected abuse to the Florida Abuse Hotline.

All staff are required to review the program's policy and procedures as a part of new hire training. A review of all personnel files confirmed their training in this topic. The program has had no incidents involving abuse in this annual review period. The program indicates they have not had any staff disciplined for agency's abuse report mandate within this review cycle. During the intake process the youth and family are informed of the grievance process and their right to contact the Florida Abuse Hotline if they are experiencing or witnessing abuse or neglect. A review of eight youth case management records indicate all signed the Orange County Family Services Department Consumer/Client Rights Statement and Consent for Services which includes the process for filing a grievance.

The residential program has had two grievances submitted within the last six months; one for an unwanted room change and one for a conflict with staff.

Eight youth were surveyed about the abuse reporting process. Six youth were knowledgeable about the abuse hotline and process to call abuse. Five of the youth state they know where the abuse hotline number is located in the shelter. All eight indicated they have not attempted to call the hotline nor has any staff delayed them in the process of making a request to call.

Exception:

The residential program has had two grievances submitted within the last six months; one for an unwanted room change and one for a conflict with staff. One of the two grievances did not include the client's resolution agreement or disagreement in addition to their signature or date.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure addressing the requirements of incident reporting and notifications to all required parties. The program's policy indicates they are to comply with requirements and procedures outlined in Department policy and Florida Administrative Code (FAC).

Written procedures for incident reporting indicate the program will comply with requirements and procedures outlined in Department policy and FAC. Procedures include reporting a qualifying incident to the Department's incident report hotline within two hours of the incident or within two hours of staff becoming aware of the incident. The procedures outline thirty incident types which would require notification to the Central Communications Center (CCC).

The non-residential program had zero incidents reported to the CCC within the last six months and the residential program had a total of ten. Seven of the ten reports were for a youth injury that needed off-site medical attention. One report was for an altercation between two youth and two reports were for

medication errors. All reports were closed as information only.

Exceptions:

The program's procedures outline thirty incident types which require notification to the Central Communications Center (CCC); however, several of them are not in line with or required in the most current version of FAC 63F-11. One such incident type requiring notification to the CCC according to program policy is any abuse allegation accepted by the Florida Abuse Hotline where outside medical is not required.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy specific to training provided to all staff members. The policy is called Training Requirements and was last reviewed on July 28, 2015. The current policy includes details regarding the requirement of 80 hours for all newly hired staff member. The training policy requires all staff working directly with clients to receive training related to their specifics of their job role and duties. The policy includes provisions for first year and on-going staff persons.

The provisions of Training Requirements include required Trainings; Remaining Training; CPR and First Aid Training and others are listed. The agency has a designated training facility on campus that is adjacent to the youth shelter. The building is specifically designed and outfitted with modern training equipment including overhead projector and touch screen board for display.

Training is provided to staff members to be completed throughout the year. The agency training year is conducted from July 1 through June 30 of each year. All first year staff personnel must complete the training by the end of their first year. After the first year, all on-going staff members are then moved to an annual training year of July 1 through June 30, 2017. The agency utilizes a broad array of training to ensure that all staff members meet the annual training hour requirements. The agency uses live instructors certified to deliver training, on site or local training opportunities,

An individual training file is maintained on each staff member. Each staff member has a 6-panel training file that lists the training completed by the designated training year for each individual staff member.

The agency verifies completion of each training conducted with evidence such as a individual training log for each staff member, certificates, sign-in sheets, and/or agendas for each training attended by the staff person.

The review of the agency's staff roster was conducted on site. A random selection of employee training files for the most recent completed training year was conducted. It included full-time and on-call staff members. The files selected included a review of seven (7) staff member files. These files included staff from all work shifts.

Required training within the first 120 days includes certain required trainings. The agency had no staff members that were required to meet the 120 day requirement. The agency did have two (2) staff members that were hired in 2016 and in late 2015. These 2 staff members had evidence of an individual training file. Contents in each client training file includes certificates of completion and an individual training log that describes the training topic and number of hours completed. The reviewer assessed the training of all courses completed by the staff during their first full year. One first year staff member completed a total of 135 hours. Another first year staff member completed a total of 138 total training hours. Each first year staff member exceeded the 80 hour training hour requirement. The topics and hours completed by these first year staff members meet all the mandatory training and topic or course requirements.

Review of on-going staff members was also conducted. A total of five ongoing staff member training files were reviewed to assess their adherence to the training indicator. All five staff members had evidence of an individual training file that included an individual training log that describes the course and the hours completed by that respective staff person. One staff member completed 47.5 hours, the second staff person completed 58.5 hours, the fourth person completed 90.5 hours, and the fourth person completed 72.5 training hours. One staff member completed a total of 36 training hours.

Exception:

One ongoing staff member did not meet the 40 hour annual training requirement. The staff person had evidence of completing 36 out of 40 annual training hours required for ongoing residential staff members.

1.05 Analyzing and Reporting Information Satisfactory Limited FailedRating Narrative

The program has a policy addressing program data collection and review.

The procedures indicate several sources of information are analyzed and reviewed to identify patterns and trends. Quality Assurance (QA) conduct quarterly program reviews, which evaluate case files, risk management issues, service to clients, program data, review of external contractual audits and licensing reviews, and staff file reviews. The program managers are to conduct and document quarterly risk management reviews using a risk management template. This tool documents the nature of risks and actions taken.

The quality assurance plan operates on an annual outcome basis and uses monthly, quarterly, semi-annual and annual data collected to make on-going improvements to the program. The program has QA staff that will compile, review and analyze the collected data to determine compliance and status of goal completion. A Residential Program Review was completed for the last fiscal year and the shelter received an overall review score of 98%.

The QA staff complete quarterly reviews of critical and secondary standards required by the licensing agency and scores for each area are assigned. Quarterly risk management data is collected and covers licensing, compliance and incident reporting, client grievances, and program staff. Results are reviewed by the program manager of Accreditation and Quality assurance and then posts a copy in the risk management folder on the division's s-drive. A review of reviews for last fiscal year confirms this practice. Management team meeting minutes were provided to show discussion of monthly reviews of NetMIS data. A review of NetMIS reports for the last six months show thirty and sixty-day follow-up surveys are entered into the database and reviewed on an annual basis.

No exceptions to this indicator were found as of the date of the onsite QI review.

1.06 Client Transportation Satisfactory Limited FailedRating Narrative

The program has a written policy regarding transportation of clients and procedures to ensure the safety of staff and youth.

Written procedures require all employees transporting youth must have a valid Florida Drivers' Licensed per County Policy and Division standard operating policy. A driver's license check is completed on all staff upon hire and every year thereafter. According to the program all staff must complete a driver's safety course upon hire and every three years thereafter. Employees must only transport clients in County

issued vehicles.

Employees transporting residents or clients cannot exceed the contractually required ratio of one employee for every six youth in the vehicle. Employees are prohibited from transporting a client of the opposite sex, without maintaining at least one other passenger, or third party, in the vehicle during the trip and all exceptions of this must be approved by the program director. If an employee receives a traffic citation or is involved in an accident while in a County vehicle or a personal vehicle, proper procedures must be followed. Staff are to conduct safety checks of all County vehicles before transporting clients as indicated in the vehicle use and maintenance procedure and all passengers will use a seat belt.

Currently all staff are approved to transport youth in the County vehicles. A driver's license check has been completed on all staff and this check is maintained by human resources and a copy is placed in all personnel records. Transportation sign-in and sign-out logs were reviewed for the months of December 2016 to May 2017. On each log entry staff are to indicate which vehicle they are taking, time of departure, time of arrival, number of passengers and a staff signature. This procedure was completed with exceptions. The staff complete an undocumented safety inspection check of each vehicle prior to transport.

Exceptions:

At the start of this review the program's policy and procedure does not indicate staff are prohibited to transport a client without maintaining at least one other passenger in the vehicle during the trip. The procedure states additional staff will assist in the transportation of youth when available but the transport must have an additional passenger when the staff and youth are of the opposite sex. The procedure mentions this process requires approval from management and supervisory approval is documented on the vehicle sign-out log. Informal interviews with program management indicate all transports must be approved by a supervisor; however, a review of the logs indicate several transports did not document such approval.

The vehicle sign-out logs for the last six months were reviewed. Out of 104 total transports thirty-four were missing some type of element required by the form (sign-in or out time, number of passengers, staff signature, supervisor approval, number of passengers). The vehicle sign-out sheet for April 24, 2017 to May 25, 2017 is missing the columns for number of passengers and supervisor approval so these items were missing on all transport dates during this time period. Several entries indicate one passenger was on the transport. In speaking with staff and program management indicated differences in documenting transport which makes it difficult to determine if the one passenger indicated on the form is just the driver and no youth or if it was the driver and one passenger. This process also made it difficult to ascertain if program management consent and documentation was required when transporting only one youth. Several of the missing elements such as times and number of youth on transport could be found in the program's logbook. At least four examples were found in the logbook where one staff transported one youth without a third party. The program did not have documentation to show trip plan, submitted in advance to include: the destination, approximate mileage and anticipated time of arrival prior to the transport.

The program updated the transportation policy and vehicle sign-out log prior to the team's departure. Staff will be trained on this form at the next staff meeting.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy regarding transportation of clients and procedures to ensure the safety of staff and youth. The agency has a policy that is called Interagency Agreements and Outreach. The policy was last reviewed on July 28, 2017 by the agency Program Manager of the Orange County Youth and Family Services Division. The policy addresses the agency's approach to establishing partnerships and collaborations with local organizations to coordinate an integrated service delivery system and encourage

early referral and assessment for the public. The policy also includes an approach for the Orange County Youth Shelter to provide information, education, alternatives and early intervention services, as well as community development. The review of the overall policy indicates that it meets the general requirements of this indicator.

The agency's procedures related to Outreach Services includes using the Youth and Family Services Division interagency agreement to establish a working partnership with other entities. The interagency agreement includes a focus on Medical; Educational; Mental Health and/Substance Abuse; Prevention/Early Intervention programs; Recreation and Leisure. Specific staff members are designated to participate and coordinate and attend outreach functions. The purpose of the outreach function is to educate and promote the services and link with other needed services. The education and promotion is required to be done through the dissemination of printed materials, presentations to various audiences and groups. The areas of focus for outreach centers around substance use/abuse, adolescent behavior, education, information at CINS/FINS programs and parenting classes/family functioning. Other outreach outlets for promoting and creating partnerships includes radio and television coverage, newspaper reports, billboards, meetings, brochures, presentations, special events, and community involvement to include schools, community groups and youth centers.

The agency is a member of the local area Circuit 9 Juvenile Justice Circuit Advisory Board. The mission of the circuit board is to develop a comprehensive plan for the circuit and provide recommendations to the Florida Department of Juvenile Justice regarding the delivery of juvenile justice services and grants. The local Circuit 9 Advisory Board meets on a regular basis. The Orange County Youth and Family Services Division have evidence of attend meetings. Circuit 9 meetings are primarily attended by the agency's Department Manager of the Orange County Youth Services Division. The agency's Department Manager was recently appointed to act as the Chair person of the Circuit 9 Advisory Board.

Meetings attended in the last six (6) months include May 10, 2017; March 8, 2017; January 11, 207; and November 9, 2016. Other outreach activities conducted by the agency in the last 6 months include 10 outreach activities documented in NetMIS in May 2017; 4 in April 2017; 6 in March 2017; 5 in February 2017; 12 in January 2017; and 10 in December 2017. The agency also has designated staff members from administration participating in other local organizations such as statewide Florida Network of Youth and Family Services, United Way of Orange County, United Way of Central Florida, Bay Area Youth Services, and Circuit 9 Domestic Minor Sex Trafficking Board. The Program Manager for the agency also acts as the Liaison for the Orange County Government Domestic Violence Child Abuse organization.

No exceptions are documented for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Orange County Youth and Family Services' staff provides thorough and detailed documentation regarding services provided to the youth and client needs in the case files. All case files are organized and well maintained. Information is easily located due to tab inserts and a table of contents in the front of each file. Time-frames are adhered to as required per standard. Appropriate level staff are conducting assessments and assessments are reviewed by a supervisor. Eight client files were used to verify adherence to the Florida Network's Standard 2 requirements. Overall, Orange County has a satisfactory compliance rating for Standard 2.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written screening policy and procedure for the Youth Shelter and Non-Residential program to address all of the key elements of the CQI indicator. The policy manual is current. The Screening and Intake Policy meets the general requirements of the indicator.

There is a written policy-Screening and Intakes. The policy and procedures state that the initial screening is completed within 7 calendar days of referral to the program and documented on the CINS/FINS NetMIS screening form.

This policy further states that the CINS/FINS Consumer Handbook is provided to the youth and parents during intake. The Consumer handbook includes: 1) available service options, 2) rights and responsibilities, and 3) grievance procedures. The family is also presented with a brochure on drugs and alcohol use/abuse.

A total of eight (8) files were reviewed. Four (4) were residential files and four (4) were non-residential files. Of the files reviewed, (7) files were closed cases and one (1) file was an active case. Seven (7) files indicated that contact was made with the family within 7 calendar days from the date of the referral. One file showed referral date as 10/28/2016 and screening completed on 11/21/2016, previous attempt to complete the referral was noted on 10/30/2016.

The parents and clients were given the CINS/FINS services brochure which describes the case staffing committee, CINS petition process, and CINS adjudication at the time of intake. Consent to treatment, client rights and responsibilities, grievance procedures, and notice to privacy practices were also given to the client and parents. The youth and parents received a copy of the service availability options in writing. The parents and youth signed forms acknowledging they received this information. All 8 files that were reviewed had signed documentation from the client and parent that they received the information at intake.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy and procedure titled Assessment Process and Service Plan, which provides the procedures addressing the Needs Assessment and Service planning. The agency completes a needs assessment for each incoming youth receiving services. The policy was last updated on 5/17/2017.

The procedure details the process staff follows for the completion of the needs assessments. The needs assessment is initiated within 72 hours of admission for all assessments. Service plans are initiated at the face-to-face intake. The assessments are to be initiated within the required time frames. All needs assessments include a suicide risk screening section.

Eight (8) files were reviewed for four (4) non-residential cases (4 closed) and four (4) non-residential cases (1 open and 3 closed).

The needs assessments were completed in all eight (8) files within the required time and completed by a Bachelors or Masters level staff and with a supervisor's review signature upon completion.

All eight (8) files included Needs Assessments completed with a risk assessment for suicide indicators. One case was referred for an assessment of suicide risk and the results were "danger to self" and was considered (Moderately Low). The recommendation was a psychiatric screening to be incorporated in the Service Plan, and completed within four weeks. It was reviewed by a licensed clinician as required. All policies were adhered to with requirements pertaining to needs assessments and suicide assessments.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.03 Case/Service Plan Satisfactory Limited FailedRating Narrative

There are written policies under the policy and procedure, Assessment Process & Service Plan and the Service/Case Plans & Case Plan Review that address the procedures for Service Plans. Both policies were updated on 5/17/2017 and 7/28/2015.

The provider's policy requires Service Plans for non-residential youth to be completed within 7 days of the completion of the Needs Assessment and the service/case plan for youth in shelter will be developed within five working days of admission to the Youth Shelter.

The Service Plan forms all contained service goals, type, frequency and location of services. The person's responsible for completing of each goal, a target date for completion, and actual completion dates were also included in the Service Plans. The service plans also include a section for the 30,60 and 90 day reviews. The youth shelter service plan in addition to the 30/60/90 day service plan review also contain a 14 day service plan review section.

Each file had a service plan completed within the time frame. All eight (8) files had a case/service plan that included individual goals; service type, frequency, and location; persons responsibility; target and completion dates; plan initiation date; and signatures of the youth, parent/guardian, counselor and supervisor.

Four (4) residential service plans were completed as required at 14 days and/or 28 days.

Two (2) of four (4) non-residential files had the 30, 60 and 90 day reviews completed and documented within the allotted time.

One of four of the service plan reviews for the non-residential program had a late 30 day service plan review. Service plan was initiated on 02/09/2017 and the service plan was reviewed over the phone with mother on 03/16/2017. Services were provided by an intern.

In a second service plan (non-res case), the 30-day review was late. The service plan was initiated on 04/24/2017 and the 30 day review was completed on 05/25/2017 (the review was off by one day).

On four non-residential cases, the service plan reviews at 30/60 or 90 days were completed over the phone.

No exceptions.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy and procedure titled Case Staffing Committee, a Client/Family Involvement Policy and Procedure, and Client Eligibility Policy and Procedure and the policy was last updated on 6/24/2010, 5/17/2017 and 5/17/2017, respectively.

The family is taken to case staffing when the youth and family has not demonstrated substantial progress in achieving goals specified in the services during counseling services.

Seven of eight cases reviewed were closed. All of the cases showed evidenced that a Counselor/Case manager was assigned and were establishing and making referrals as needed for the youth and family.

The service plans were developed with youth and parent, as evidenced by service plan signature and record documentation.

The files showed written documentation of CM monitoring youth's/family's progress in services, as well as the monitoring of progress in services and family support.

One of the non-residential cases was taken to case staffing however, the case was not referred to court, as the youth made sufficient progress. Two case staffing meetings were held as planned. All required documentations were reviewed/documentated in the file: Case Staffing Summaries, Case staffing Recommendation, and Case Staffing Committee Invitations. There were two Case Staffing Committee invitations. One was completed on time. The other was sent out 3 days prior to the Case Staffing meeting. The parent and youth invitations were completed within the time limitations. The parents were provided with a copy of the case staffing committee recommendation within the seven days.

The program supervisor provided 6 months of Case Staffing Committee invitation, completed within the required time frame, as evidenced that they comply with the policy and procedures.

The recommendations made during the case staffing addressed the problems and the needs of the youth and family discussed during the meeting.

Three (3) of the Seven (7) youth were discharged at the middle and end of May 2017, the 30 day follow up were not due. All other 30/or 60 day follow-ups were completed on time.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy and procedure titled Counseling Sessions, and Counseling services, Services/Case Plans & Case Plan Reviews, which provides the guidelines addressing the Counseling Services. The policy was last updated on 5/17/2017, 6/24/2010 and 7/28/2015, respectively.

The Counseling Sessions policy addresses the development of a service plan, review of the service plan, follow-up monitoring of progress made, and revised service plans as a result of the case staffing and/or adjudication. Up to 12 sessions are made available to clients and/or their families. Counselors engage and motivate the client or family, as well as motivate and informs the family of service options, case staffing, and of resources and supportive services related to case staffing opportunities. Counseling Services Supervisor or Designee reviews the case plan and case plan reviews.

Eight (8) files were reviewed four (4) residential and four (4) non-residential.

All files reflected the youth and families received counseling services in accordance with the service plan. The program offers both individual and family counseling based and on the policy and procedures and as evidenced in the documentation and the referrals made by the counselors. Individual, family and group sessions were observed to be recorded in the files.

Group counseling were offered at least 5 days of the week for the past 6 months.

No exceptions to this indicator were found as of the date of the onsite QI review.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place named Case Staffing Committee, last revised on 5/17/2017.

Orange County Family Counseling utilizes a Case Staffing Committee in an attempt to obtain solution when the Counselor is unable to assist in resolving a client's problem. The Case Staffing Committee is used when all other reasonable efforts to resolve the problem fails. Upon receipt of request for a Case Staffing from parent/guardian, the case staffing committee must meet with the parent/guardian within 7 working days. Notification to the parent/family and case staffing committee are provided within 5 working days of the scheduled meeting. A copy of the case staffing committee recommendation report is given to the parent within 3 days of the case staffing meeting. Within 7 days of the case staffing committee, a written report/letter is sent to the parent/guardian outlining the reasons of the case staffing recommendation. If the case staffing recommends modification within five days the youth and family are provided with a new or revised service plan.

One (1) of the eight (8) cases reviewed was a case staffing case. The file showed evidence of service initiation within the designated time. Notification to the family, case staffing meeting, was no less than 5 working days. A revised service plan was in place and provided to the family less than 5 working days. There was evidence of the case staff committee report/review summary and recommendations. Evidence of the case staffing committee invitation was provided, there were two case staffing meetings held for this youth. One of two committee invitations was completed in compliance with the recommended time allotted.

This case was not recommended for court as sufficient progress was made during the initial case staffing and the follow-up review.

Staff interviewed provided a copy of multiple case staffing committee invitations for the past 8 months, all showing the committee members were invited to case staffing committee on time (showing that late invitations to the committee members were not the norm for the program).

Exception:

One of the Case Staffing Committee invitations was sent out three days prior to the case staffing. Nonetheless the staff provided additional copies of Case Staffing committee invitation for the past six months as evidence of their best practice services, the copies of the additional invitation showed late invitation was not a usual occurrence.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a standing operating procedures process that involves admission and case planning. The agency's policy as it relates to youth records requires that the youth shelter create an individual client file that is maintained and organized in a uniform and professional manner for each client that meets the eligibility requirement to receive CINS/FINS services. These files are required by policy to contain all relative client information involving the youth receiving the CINS/FINS services.

All youth files must contain specific content related to the youth that has been admitted to a residential or non-residential program. The client files must be organized according to an established format by the residential counseling service supervisor or their designee.

All files both open and close are required to be stamped confidential. All files are required to be kept in a locked file cabinet marked confidential that is located in the intake office. There is no copy equipment permitted in the file room. Files must be organized and arranged in alphabetical order and kept locked in the file cabinet at all times.

All records that require transport must be secured in an opaque container that is marked confidential. The open container must remain locked during transport.

The agency must maintain a separate file for health information and it also must be maintained and marked confidential.

A review of random records during the quality improvement review process were evaluated to ensure that they met youth records maintenance standards. All records are kept in a secure a room that is located adjacent to the conference room. This room is secure and locked at all times. All file cabinets are marked confidential.

The agency uses containers that are marked confidential when records are required to be transported. The reviewer observed that non-residential records generally require transport.

All records are maintained in a uniform manner and are in order according to the agency's client file protocol. There is no copy machine located in the client file room.

No exceptions to this indicator were found as of the date of the onsite QI review.

Standard 3: Shelter Care

Overview

Rating Narrative

OCYFS Youth Shelter is a twenty-four hours per day, seven days per week facility. The youth shelter is licensed by the Department of Children and Families for twenty (20) beds. Once a youth is admitted, the shelter provides an orientation of the shelter and program. The orientation includes a review of the youth handbook with the staff, and questions and answers. Also, the shelter provides new youth entering the shelter with a Trauma Informed Care Bang that includes a journal, t-shirt and rights and responsibility manual. The shelter staff includes a program manager, an administrative specialist, a nurse, a senior youth care supervisor, a counseling services supervisor, three senior children services counselors, seven case workers, four family teacher assistants, and two youth resident coordinators. The family youth resident coordinators and teacher assistants are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The supervisory and counseling staff members receive referrals and monitor the provision of services.

Residential services, including individual, family, and group services are provided. Case management and substance abuse prevention education are also provided. The shelter has a color-coded medical and mental health alert system in place. The program also has an effective grievance process, in which the grievances are responded to within twenty-four hours of being submitted to management.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a shelter environment policy. This policy requires the agency to operate an Emergency Youth shelter 24 hours a day, 365 days a year. The policy was last viewed by the Program Director on July 28, 2016.

Policy requires that the Orange County Children's Services Department facilitate the operation of a youth shelter. The facility is officially called an emergency shelter youth shelter. The shelter serves residents age 10-17 that meet the eligibility profile that includes status offenders, runaway, ungovernable, truant, homeless, lock out.

A review of the policy indicates that it meets all the general requirements to ensure adherence to this performance indicator.

The agency has a protocol and process for operating the youth shelter on a daily basis. The agency has a policy that requires the shelter to be properly staffed with adequate female and male staff members on a daily basis. The facility is required to be licensed by the Department of Children and Families on an annual basis. The agency is to maintain a residential supervisor and qualified lead staff on 3 work shifts per day, 24 hours a day 365 days a year. The shelter is required to have properly trained staff in the areas of managing and overseeing adolescence, safety training, emergency training, behavior management training, mental health, prevention of suicide, CPR and first aid, and many other training topics. The facility is required to have licensed mental health clinicians and a registered nurse.

A review and tour of the entire shelter was conducted during the quality improvement review. At the time of this on-site program review, the shelter environment appears clean, organized, and all equipment, furniture, living and sleeping areas are well maintained. The shelter is undergoing renovations and improvements to its physical plant. Shelter renovations currently in process include new wood flooring, replacement of bedding, new day room furniture, and re-painting of walls.

The agency has record of conducting and completing health and fire safety inspections. The program is free from any visible insect infestation. The exterior of the facility is landscaped and there is no visible trash or debris. The exterior of the shelter is surrounded by a larger campus. The campus includes a

school, cafeteria, training room, and a baseball field.

The Youth Shelter facility has a split plan with female dormitory on one side, the day room in the youth work area, as well as a recreation room and a mini kitchen in the middle and a boys dormitory on the opposite side. The youth shelter is also equipped with many offices and a conference room and reception area. There is no visible graffiti on the walls, doors, or windows.

All youth bedrooms have individual beds with clean linens and comforters and pillows. Both female and male dormitories are equipped with large bathrooms that have multiple toilets, sinks and showers. All areas in the shelter are really lit and bright—sufficient for reading and other general activities. All residents have available space to keep and maintain necessary personal belongings upon request. The youth shelter has a daily program schedule that is posted and accessible.

The agency has a structured daily activity schedule that is posted that includes time for education, recreation, counseling services, social and life and group skills. Residents are also required to participate in physical activity for at least an hour or more per day. Residents can participate in a range of faith-based activities. These activities are voluntary. The facility provides the necessary transportation for school, outings, and necessary medical and/or mental health appointments.

Facility is also equipped with a youth care workstation. The youth care workstation is outfitted with a Pyxis MedStation 4000 med cart, digital camera system, fire and safety equipment, first aid kit, radios, copy machine and other necessary work-related equipment.

There are no exceptions documented for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on program orientation. This policy was last reviewed on July 28, 2017.

Program Orientation is to be completed with the youth within 24 hours of admission. Youth are given a welcome shelter bag that includes the Youth Shelter Handbook. The handbook includes kids rights, program rules, the behavior management strategies system and the schedule. The youth then get a facility tour and get an overview of the shelter policies such as grievances, telephone use, abuse reporting, emergency drills, medical services and more. The orientation checklist is signed by the youth and caseworker or designee.

This writer reviewed seven open files and they had an orientation checklist that was completed within 24 hours. The checklists reviewed their BMS system, grievance procedures, emergency practices, their rules on what contraband is and what is not allowed, tour of facility, daily schedules, abuse hotline. All checklists have the youth's name and the staff who completed the orientation and a supervisor's signature.

All files had the CINS Intake Assessment to alert to any suicide risks. An interview with a youth confirms that orientation is being conducted when youth enters the shelter. The youth mentioned that the grievance procedure and program rules were discussed, but she did not get a tour of the facility. When asked about the procedures around the Abuse Hotline, she said she read about that in the handbook she received.

No exceptions to this indicator were found as of the date of the onsite QI review.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on room assignment that was last reviewed on July 28, 2016.

After the youth's intake is complete, a caseworker, Senior Counselor or Children's Services Counselor will determine the appropriate room assignment. Efforts are always made to keep siblings together if possible. There are many factors that these staff take into consideration when making the determination for an appropriate room assignment such as age, gender, physical size, suicide risk, levels of aggression, risk history, gang affiliation and many more. If a youth has been identified as having an area of risk, that risk is immediately entered into the program's alert system.

The youth room assignment is located on the back of the CINS Intake Assessment form. This assessment looks for risks that the youth may have such as substance use, mental health, medical and observations on behavior and attitude. Under the room assignment section lists: age, gender, height, weight, build. There are questions around medical or physical disabilities, history of aggression and criminal or gang activity. Also, there are questions if they are chronic runner, history of sexual assault or susceptible to victimization.

Observations on the youth are made by staff at that time around their behavior, demeanor and attitude. NetMIS provides information around sexually aggressive or reactive behavior as well as gender identification. Per policy, if any risks are identified they are immediately put into their alert system. The alert system is color-coded as follows: yellow is mental health, blue is substance abuse, red is medical, green is allergies and orange is trauma. Five of the seven files reviewed had identified alerts and there were stickers in the appropriate colors on the files. The alert board had the same color dots as appropriate by the youth's name.

No exceptions to this indicator were found as of the date of the onsite QI review.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on logbooks and was last reviewed on July 28, 2016.

The procedure for logbooks is to have the Program Manager review it weekly. The Supervisors review the previous two shifts. The Residential Counseling Services Supervisor or designee reviews the previous two shifts and the direct care staff review the previous two shifts and all sign and date. The logbook entries have the date and time of incident, event or activity, name of youth and staff involved and a brief statement with any pertinent information.

Logbooks reviewed were from December 2016 to May 2017. There is a color guide on the first page as well as staff names and initials. The color guide of the highlights in the logbook are as follows: Blue is intakes, Pink is medication, Yellow is discharges, Green is AWOL youth and Orange is for any other information that could affect the safety and security of the shelter. These highlights are being consistently documented throughout the logbook, with the exception on 12/5/16. There was a medication entry that was not highlighted pink. Direct care staff, supervisors and the counseling staff are completing the required reviews and signing and dating their reviews consistently.

The Program Manager completed the following reviews: two in December, four in January, one in February, four in March, four in April and three in May. The Program Manager is making notes on the reviews about upcoming events and other information that staff would need to know. Some entries by staff were hard to read. Visitation, outings, events and home visits were all well documented. Three fire drills are documented in the logbook monthly. There were three drills in March and one in April that was not entered in the logbook.

Per policy, any errors are to be struck through and "void" written then staff signature and date. On 1/20/17 and 1/30/17 only void was written with no staff signature or date. On 1/21/17, 1/25/17, 2/2/17, 2/26/17, 3/28/17 and 4/8/17 just initials were written by the error lines. Safety and security issues, like abuse hotline calls,

constant sight and sound, suicide risk assessments are being entered in the logbook. These entries are always highlighted in orange.

Exception:

On 1/20/17 and 1/30/17 only void was written with no staff signature or date. On 1/21/17, 1/25/17, 2/2/17, 2/26/17, 3/28/17 and 4/8/17 just initials were written by the error lines.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on their Behavior Management Strategies (BMS) and it was reviewed on July 28, 2016.

All youth receive a handbook at intake that describes the agency's BMS. Staff uses a checklist at intake and discusses the BMS then as well. All new staff are trained on this system. And during staff's performance evaluation, their knowledge of this system and how they use it is evaluated.

The agency has a written description of their Behavior Management Strategies (BMS). This description is in the youth handbook that is received at intake. There is a checklist for all the intake procedures in each youth file and the description of this system is part of the intake process. Five files were reviewed and they all had gone through this system during the intake process as evident by the checklists. The system is a nautical theme with a point system and four attainable levels.

The agency's BMS has a wide variety of incentives for positive behavior such as their Way to Go Store, treasure chest, extra snacks, outings, extended bedtimes, pizza parties and ice cream socials. There are fines that can be issued for youth who display inappropriate behaviors and these points are issued in 10, 20 and 30 point increments. Skill building is encouraged and often a part of the youth's goals on their service plan.

All new hire training files showed that staff completed BMS training. Four staff performance evaluations and one supervisor's evaluations were reviewed. The documents showed an evaluation of the BMS. The shelter has a form that has each day of the week on it that keeps track of the youth's daily points earned, level purchased, level cost and a point balance for the Way to Go Store. Youth must earn a minimum of 350 points a day or that youth is put on level 0. They also have a daily master sheet with the youth's name, level awarded and Way to Go Store points to help with motivation.

No exceptions to this indicator were found as of the date of the onsite QI review.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on staffing and supervision and it was reviewed on July 28, 2016.

Staff schedules are developed by a Youth Care Supervisor or designee and are done two weeks in advance. Schedules are typed and posted in the control room three days prior to the beginning of the workweek. Staff will initial the tentative schedule and if there are any needed changes staff will notify supervisors. Staff ratio's are 1 to 6 awake hours and 1 to 12 during sleep hours. There is always a staff of the same gender on all shifts. Overnight checks are done every fifteen minutes.

Staff schedules and logbooks were reviewed and compared to show appropriate staff ratios during awake and sleeping hours. The staff schedule not only shows the staff on each shift of each day but what those

staff are assigned to do as well as monitor youth. The associated acronyms are: SS is sight and sound, M is medication, CO is close observation, SSC is staff secure client and O is for office.

On the schedule is the rotating overtime schedule. The overtime schedule does not have the staff's phone numbers due to the youth access to where the schedule is posted, when they are in the office to take medication. Overnight shifts have at least two staff on consistently, this was evident through schedule and logbook. Overnight checks on youth are in monthly binders and are done in real time. Four overnight checks were reviewed on the video surveillance system. All but one night on May 4th the girls checks from 11:30pm – 12:15am were unable to be seen, video was too dark.

No exceptions to this indicator were found as of the date of the onsite QI review.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on special populations that was last reviewed on July 28, 2016.

Staff secure youth are formally court ordered to the shelter. These youth will be assigned a designated staff and will be placed in the shelter for up to 90 days. DJJ provides referrals for Probation Respite youth. The Florida Network is contacted for approval before admission. The length of stay should be determined at admission. The length of stay will be between 14-30 days. Youth on probation should have adjudication withheld. Domestic violence (DV) youth have certain requirements to meet for admission into the shelter. Youth must have a pending DV charge. These youth must be screened by the JAC/Detention or screening unit. The length of stay cannot exceed 21 days. Case plans should address aggression, coping skills and any others that would help decrease violence in the home.

One staff secure file was reviewed. The client file did acknowledge the status of youth on the front. This youth is still in the shelter and has received all relevant assessments. His case plan goals included education, constructive use of free time, anger management skills. There is a staff assigned to him every day through the schedule. A copy of his court order was in the file.

There were two Domestic Violence client files reviewed. All files had a screening by the JAC/Detention and had a pending DV charge. Each youth was in the shelter less than 21 days. Neither of these two youth stayed and transitioned to CINS. In both case plans, there were goals around coping skills.

Two Probation Respite files were also analyzed. Both had referrals from DJJ and they both had adjudication withheld documentation. One of the files has evidence that the Florida Network had sent an approval prior to admission. The other file had a referral date from DJJ on 9/13/17. On 9/14/17 youth was admitted to the program and request was sent to the Florida Network (an email) asking for approval on 9/14/17. Another email was sent on 9/16/17 stating there was not yet a reply on the approval received. Later that morning, the Florida Network emailed back stating that another person at the Network said she spoke to the program manager about this youth and she assumed the youth was approved.

The length of stay in both files was not documented at admission and in conversation with the Program Manager they had not been documenting this up to this point. She since has added it to the intake paperwork and will start documenting immediately. One of the two youth was transitioned to CINS at the 30-day mark and the other youth discharged four days after intake. Individual counseling was offered to each youth and documented on their case plans.

Exception:

Length of stay for probation respite youth had not been documented up until the time of this review.

3.08 Video Surveillance System

Satisfactory Limited FailedRating Narrative

Orange county government has standard policies and also standard operating procedures for the safety, health and welfare of clients and staff members. Orange County has a policy that addresses the requirement for operational video camera surveillance systems in their youth shelter. Orange County's policy was last reviewed on August 22, 2016. This policy was reviewed and approved by the agency's program manager. A review of the policy indicates that it meets the general requirements of the video camera surveillance system.

Orange county requires the youth shelter staff to constantly monitor the residence at all times during their shelter stay. Orange County has a shelter video surveillance system that is required to be in operation 24 hours a day, seven days a week to monitor and capture recording of happenings continuously to ensure the safety of all youth, staff, and visitors while guaranteeing personnel accountability.

The agency utilizes the video system to assist as a deterrent means for any misconduct and to ensure that any allegations of incidents are identified through recorded visual means. Orange County requires a video surveillance camera system to capture and retain video photographic images for storage purposes for a minimum of 30 days. Orange County's procedures indicate the system must be able to record date, time, and location, as well as maintain resolution that enables clear facial recognition.

The agency has limited access to video camera footage and supervisors are required to review video once every 14 days and/or sooner and document reviews in the program logbook. Reviews by supervisors are required to include a random review and sample of overnight work shift activity. The agency must also post visual notice to visitors, staff and residents that video camera surveillance systems are in use in the shelter facility. Video camera surveillance systems are to be placed in general areas, and not in areas including bathrooms and or sleeping areas.

Orange County Government has a video camera surveillance service system that operates 24 hours a day, seven days a week. The reviewer onsite observed the camera in operation and it was working properly as of the date of this onsite review. The camera system includes a total of 16 separate camera views of appropriate areas related and recording is ongoing within the interior and also exterior of the building. Specifically, these cameras are positioned at the entrance, rear-facing of the building, side-facing of the building, and front-facing of the building. The entrance is also under surveillance, as well as the day room, youth care workstation, kitchenette and the lobby areas.

The reviewer of this indicator found that all cameras were visible, and no cameras were placed in bathrooms or sleeping quarters. The system can capture and retain video of photographic images including reasonable facial recognition. The system can also record day and time for up to a minimum of 30 days. The agency reported that the camera system can operate without power on a battery backup system for up to 12 hours following a power outage.

The agency has a list of authorized personnel who are permitted to access the video surveillance systems as required. The system does include offsite or remote capability for these designated personnel. The agency does require supervisors to review the video once every 14 days or less and document this event in the program logbook. The reviewer of this indicator found that there was evidence of ongoing and consistent reviews every 7 to 14 days by a supervisor. The supervisor does document the review of agency practice including reviews of overnight work shift staff members.

During the on-site quality improvement review, Orange County youth and family services manager updated the current policy to include a process for third-party review of video camera surveillance recordings following official request from either a quality improvement visit and/or when investigations require such information from system partners and/or need to know authorities.

There was no exception for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Orange County Government Youth and Family Services Youth Shelter has policies and procedures in place to manage and address a healthcare admission screening upon admission, suicide prevention screening, medication management, medical and mental health alert screening and identification process and episodic/emergency care. The shelter utilizes a CareFusion Pyxis MedStation 4000 to store medications.



4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place Titled "Healthcare Admission Screening". In general, this policy meets requirements of this indicator. The policy was last reviewed and approved on July 1, 2016 by the Program Manager.

The policy indicates who shall be responsible and who is able to conduct the screening. A procedure is identified if any health concerns are identified that require referral or further action.

This reviewer looked at seven (7) residential youth files, four (4) open (current clients) and three (3) closed files. This reviewer also asked for clarification from staff members during the review when needed.



Exceptions:





4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place titled "Suicide Prevention", that describes minimum training required of staff as well as signs/indicators of elevated risk. In general, this policy meets requirements of this indicator. The policy was last reviewed and approved on July 28, 2015 by the Program Manager.



Policy titled "Suicide Prevention" indicates how staff will maintain currency in training as well as how other youth in shelter can contribute to identifying at risk youth.



This reviewer looked at seven (7) residential youth files, four (4) open (current clients) and three (3) closed files. This reviewer also asked for clarification from staff members during the review when needed.

Of the seven (7) files reviewed, two files (one open and one closed) had a youth indicate the need for Sight and Sound procedures to be initiated, and in both files sight and sound was documented at the appropriate 10 minute intervals. In both files supervision was maintained until a Mental Health professional assessed the youth and cleared the youth from sight and sound, and both files were co-signed by a licensed professional. Of the two (2) files where the youth was placed on sight and sound, the closed file did not indicate in the SANS note that the youth was cleared off sight and sound.

There are no exceptions for this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The goal of the policy is ensure that prescription and non-prescription medications, syringes and sharps are properly distributed, stored, inventoried and disposed of properly. The policy includes sections that focus on ordering and delivery of prescription medications, storage of all prescription and nonprescription medications, medication inventory, disposal of unused and outdated or contaminated medication and biohazardous materials.

The procedure includes the process in which the shelter will receive medications from parents and guardians or the Department of Children and Families when they bring the youth in for mission into the shelter. The policy requires a senior youth care supervisor to maintain an updated list of approved medications. The senior supervisor or designee is required to keep an inventory and also required to keep a supply of approved over-the-counter nonprescription medications and first aid kits and supplies that are to be made available to all staff at all times. The procedure lists items that must be kept and maintained in all first aid kits in the shelter and shelter vehicles. All first aid kits must be sealed.

Syringes require all oral and topical medication to be stored in separate containers. The agency does not accept most types of syringes unless it is an EpiPen that is prescribed by a doctor. All medication requires refrigeration must be stored in the small refrigerator that is designated only for refrigerated medications. Procedures require at no time that residents be able to access the medication cabinet or medication refrigerator. An inventory is required to be documented for all residents that bring in outside medication to the shelter upon their mission.

The weekly inventory counts of all medication and/or syringe has to be documented on a form or tracking system. A direct care staff that has the authority to distribute meds must notify a supervisor if a resident does not have enough medication for the length of stay and has a minimum two days of medication remaining. All unused or out-of-date medication or contaminated medication must be destroyed by the nurse and/or senior supervisor staff and at least one other staff. Any and all bio-hazard materials must be placed in bio-hazard trash containers that are located in secure designated areas in the shelter.

At the time of this onsite Quality Improvement (QI) review, there were no active or current residents on prescribed or controlled medications.

The agency has all medications stored in a Pyxis Med-Station 4000 medication cabinet that is not

accessible to residence. At the time of this review the agency has a total of seven specific super users that are permitted access to the medication cart. Oral and topical medications are not being stored together. Each medication type is stored in its own separate cube in a drawer inside the med cart.

The agency has a designated medication refrigerator that is locked. This refrigerator is located in a secure a room behind a locked door that has a keypad pin code access. The refrigerator does contain a thermometer at the appropriate temperature of no less than 36° and no more than 46°F. Narcotics and controlled medications are being stored in the MedStation as required. Medication is counted prior to the close of each shift with one staff person that is authorized to distribute meds and at least one witness. Over-the-counter medications are tracked and inventoried on a weekly basis and when given. The agency does not provide any razors. The agency does provide access to a prescribed EpiPen for all applicable residents that need this type of medication during their shelter stay. The agency does maintain a paper medication distribution log to track medication distributed to each resident on prescribed medications during their shelter stay.

The agency does utilize the services of a registered nurse. The nurse reports for Duty several days a week. The nurse is the primary overseer of the agency's medication distribution process. When the nurse is on duty, the nurse is the primary person distributing medications. The nurse reviews all first aid kits to ensure that they are fully stocked. The nurse is the primary source to train all new hires and to conduct refresher training for any staff person that commits a medication error. The nurse also reviews the Pyxis med cart for any discrepancies. All discrepancies are required to be cleared from the Pyxis med cart prior to the end of each work shift. The nurse also provides oversight of the general wellness of residence in the facility during their shelter stay. The nurse also conducts reviews of each residence's health admission screening form.

The agency has committed a total of two medication errors in the last six months. Each of the documented medication error incidents has the necessary follow-up documenting the root cause of the era and all personnel action taken to retrain the staff persons involved.

There are no exceptions for this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place titled "Alert Procedures" that describes minimum training required of staff as well as signs/indicators of elevated risk. In general, this policy meets requirements of this indicator. The policy was last reviewed and approved on July 28, 2015 by the Program Manager.

The Policy clearly indicates a color-code system for alerts regarding medical conditions, mental health conditions, substance abuse, allergies, and trauma.

This reviewer looked at seven (7) residential youth files, four (4) open (current clients) and three (3) closed files. This reviewer also asked for clarification from staff members during the review when needed.

This reviewer observed a board in the control room that utilizes the color system with dots clearly indicating the various alerts in practice. The color codes on the board matched the color dots on the youth's files. Staff interviewed were able to verbalize and demonstrate where they would find information on side-effects and precautions concerning medications and medical conditions.

Of the seven (7) files reviewed, six (6) appropriately followed protocol as outlined by the policy.

Exception:



Of the seven files reviewed, one (1) closed file did not indicate if the youth had a medical or mental health condition or food allergy and therefore it was unable to be determined if the youth was appropriately placed on the program alert system.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place titled "Medical and Dental Procedures (Episodic/Emergency Care)". In general, this policy meets requirements of this indicator. The policy was last reviewed and approved on July 28, 2015 by the Program Manager.

Policy clearly outlines the steps required during medical emergency situations. It indicates the minimum requirements for training of employees as well as parental notification procedures.

This reviewer looked at seven (7) residential youth files, four (4) open (current clients) and three (3) closed files. This reviewer also asked for clarification from staff members during the review when needed.

Of the three (3) youth that required off-site medical care, one file did not have verification of medical clearance as per medical discharge instructions. It was noted, however, that in this particular case, the mother had been documented as being uncooperative in general with shelter programming and policies.

There are no exceptions for this indicator.