Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Orange County

on 11/12/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Keith Carr, Consultant, Forefront LLC

Teresa Clove, Executive Director, Thaise

Felicia Wells, Program Director, Youth Advocate Programs, Inc.

Persons Interviewed

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

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

0 Maintenance Personnel
3 Program Supervisors
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [x] 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
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

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

Surveys

5 Youth | 4 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The Youth Shelter received the Florida Network “Agency of the Year Award.”

The Youth Shelter has a strong reputation with the UCF School of Social Work Department. Many students, clinical and non-clinical, benefited from the program as they gained valuable experience. The shelter’s youth benefited from the interns creativity and skills as they had more sessions to meet their individual needs and learned valuable coping, decision making, and problem-solving techniques, so they can excel when they return to their community. Each year, the Youth Shelter receives great evaluations from the interns.

The Village School is up and running successfully. For residents who are staying longer in the program such as Staff Secure youth, they will have an opportunity to earn up to two and a half credits by allowing them to register for Florida Virtual.

The school program was extended through the summer months to include Character Education and Course Recovery to meet the needs of all students. Students attending the program have the opportunity to earn up to two credits addressing life skills, truancy, and education. The school now caters to several academic levels by adding a second classroom to include an additional teacher.

The students also meet with an Orange County Public School Guidance Counselor and the Dean weekly to discuss their behavior expectation, school progress, and other educational/career goals. As a continued effort to provide positive learning experiences to the children, the school is hosting Ethnic Day on October 31st and Career Day on December 4th.

The collaboration between the shelter’s court liaison and the Juvenile Court has been effective. The court liaisons communication to the appropriate court staff has been instrumental in advocating on the youth’s behalf.

The youth shelter is newly painted and the interior is redecorated to align with a more therapeutic environment. The counselor’s offices were painted in a sage green color and the youth bedrooms in other soothing colors to create a calming effect.

All youth shelter staff are trained in Trauma Informed Care. The Trauma Informed Care sensory cart is available to all staff to utilize when working with youth to create a positive environment and de-escalate crisis situations using appropriate TIC techniques and tools.

To ensure that the program is meeting the needs of the community, all staff are ADA compliance trained to serve youth and families who are deaf and hard of hearing. A new interpretation contract to translate other languages is available to all customers who need the service.

The shelter’s entrance is easily accessible. A reconstruction of the wheelchair ramps on both sides of the shelter is accessible to everyone.

Human Trafficking Training for the youth will be provided by Department of children and Families (DCF) and the Metropolitan Bureau of Investigation (MBI) to bring awareness to human trafficking in the community.

The shelter has installed a new HVAC system.

The non-residential Family Counseling Program has recently moved their offices on-site so they are co-located with the residential program. This has resulted in more communication and referrals between the residential and non-residential services.

The shelter has a contract with a professional cleaning crew to come in the shelter and complete a deep cleaning every quarter.

Standard 1: Management Accountability

Overview

Narrative

Orange County Youth and Family Services Division (OCYFS), through the Orange County Board of County Commissioners, contracts with the Florida Network of Youth and Family Services, Inc. to provide shelter and non-residential services for youth and their families in Orange County. The program located at 1800 East Michigan Street, Orlando, Florida is under the leadership of the Orange County Government. Program Managers oversee the residential and non-residential components of the program, including the volunteer and outreach initiatives. The program managers are responsible for supervising and conducting staff meetings with their respective staff members and conducting program-specific outreach. The shelter is licensed for 20 beds; at the time of the quality improvement review there were a total of six youth who were CINS/FINS. The shelter is comprised of a building that has two separate hallways on opposite sides of the building, to house female youth on one hallway, and male youth on the other. Each hallway can house up to twelve youth. The hallways are separated by a dayroom, a kitchen and master control. When not in school, the youth spend a majority of their free time in the dayroom either engaged in group activities, playing video games, watching television or completing homework assignments on the computers. There is onsite school that the youth attend from 8:30 a.m. – 2 p.m. as well as a cafeteria on-site in which the youth eat their meals. The program maintains an individual training file for each employee, with training provided through the Florida Network, computer-based trainings and by Orange County staff. Upon attending outside trainings, staff members are responsible for submitting the documentation for recording in their training file. Annual training is tracked according to the employee's date of hire. At the time of the quality improvement review there were no vacancies in the youth shelter or the non-residential component of the program.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees, interns, and volunteers. The policy requires all staff and volunteers to complete a Background Screening in accordance with Chapter 985.407 of the Florida Statues and in accordance with Orange County and Division background screening policies. Orange County conducts preliminary background screenings and driver's license checks for all employees, interns, and volunteers prior to their official start date and requires a favorable screening result prior to offering employment.

A total of six applicable personnel files were reviewed for background screenings prior to hire or a five year re-screen. Three of the staff were hired after the last onsite QI visit and both received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. The three remaining staff files reviewed were eligible for 5-year re-screenings. Both five-year re-screenings were conducted within the required time frame.

In addition to the DJJ Background Screening, the provider also conducts annual driver's license checks, local county background screenings, and Florida Sex Offender checks on all employees. Drug screening and a polygraph test are completed at hire and random drug screenings are also conducted thereafter. The Annual Affidavit of Compliance with Good Moral Character Standards was completed and submitted to the DJJ Background Screening Unit on January 24, 2014, prior to the January 31st deadline.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy in place. The policy provides telephone numbers and procedures to report abuse. This information is also posted throughout the facility.

Out of four staff surveyed, two reported working conditions at the shelter were good and two reported very good. All four staff knew the process for allowing a youth to call the abuse hotline. None of the staff have ever heard a co-worker telling a youth they could not call the abuse hotline.

None of the staff have ever heard another co-worker using profanity, threats, or intimidation when speaking with the youth.

Out of the five youth surveyed, all five youth reported they are aware of the abuse hotline and their ability to call the abuse hotline if wanted. All five youth reported they have not called the abuse hotline. All five youth reported they have never been stopped from calling the abuse hotline. All five youth reported they have never heard a staff member use profanity. All five youth reported they have never heard a staff member threaten another youth and that they feel safe in the shelter.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy in place.

A review of an Incident Report and the Program Log Book verified the incident was complete, detailed and reported within 24 hours of the incident to the CCC.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place that addresses training requirements. Each staff has an individual training file, divided into sections, that contains certificates and sign-in sheets from all training's completed, a running list of training hours, and an individual training plan for the training year. All training files reviewed were neat and consistently organized in the same manner, making documents and training's easy to find.

There were three staff who have completed first year training since the last on-site review. One was a residential and two were non-residential staff. All three staff documented more than the required 80 hours for first year training, with 165.5, 277, and 118.5 hours. All required training's, as well as, numerous additional training's were completed.

There were seven training files reviewed for annual training hours. There were five residential staff and two non-residential staff files reviewed. All seven staff documented more than the required 40 hours of annual training with, 69, 99, 87, 83, 93.5, 51, and 56.5 hours. All required training's, as well as, many additional training's were completed.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Written policy is in place. The policy has quarterly Risk Management fomrs completed before the quarterly internal file review. A full written report of the Program Review finds is provided to Program Managers withing two (2) weeks following the evaluation.

Two (2) Quarterly Risk Management Reviews dated 7/21/14 and 10/20/2014 were reviewed. Each was completed prior to the quarterly internal file review. This reviewer was able to verify the full written report of the Program Review findings was provided to the Program Manager within

two (2) weeks.

One (1) report was made to the Central Communications Center (CCC) which was documented in the the Quarterly Risk Management Review Report.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Family Counseling Program provides non-residential services for youth and their families in Orange County. The program's main office is located at 507 East Michigan Street, Orlando, Florida. The non-residential component consists of a program manager, a counseling services supervisor, an administrative specialist, six senior children's services counselors, a court supervision children's services counselor, and an intake and screening counselor. The program's intake and screening counselor initially handles calls from the public, as well as calls through the crisis intervention and screening unit (CISU). The screening counselor will either refer the youth and family to one of the program's counselors, or will make a referral for the family to another appropriate community agency, according to the youth's zip code. Case management and substance abuse prevention education are also offered. Referral and aftercare services begin when the youth are admitted for services. OCYFS 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

Orange County Residential and Non-Residential Services have written policies for this standard. Four (4) Residential case files were reviewed for compliance (three opened and one closed) and (4) Non-Residential files case files (2 opened and 2 closed cases). Centralized intake services are available 24 hours a day 7 days a week for both programs. Their initial screening for eligibility occurs within 7 calendar days of the referral by a trained staff member. Four (4) out of the four (4) Residential case files screening for eligibility were completed within 1 to 2 calendar days of the referral and within 1 to 4 days for the Non-Residential Program.

The youth and family received written documentation for all available services, rights and responsibilities, grievance and any possible action occurring through CINS/FINS services and is evident by the client, parent and counselor's signature. All forms were signed and dated by them.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Orange County Residential and Non-Residential Programs have written policy for the Needs Assessment. Four (4) Residential case files were reviewed for compliance (three opened and one closed) and (4) Non-Residential case files were reviewed (2 opened and 2 closed cases). The Needs Assessments were initiated and completed within 1 to 2 calendar days of the admission for the Residential Program and signed by a Master's level counselor and supervisor. The Non-Residential Program's Need Assessments were initiated within 1 day, completed within 12 to 34 days and were signed by a Master's level counselor and supervisor. The case that took 34 days to complete the Needs Assessment was due to the parent rescheduling several appointments. One (1) out of the four (4) case files for the Residential Program were elevated as a result of the Needs Assessment. The youth was placed on Site and Sound and was referred for an Assessment of Suicide Risk. A license mental health professional screened the client the same day and placed him on a Suicide Safety Agreement. None of the Non-Residential case files were elevated after completing the Needs Assessment.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Orange County Residential and Non-Residential Programs have written policies for the Case/Service Plan. Four (4) Residential case files were reviewed for compliance (three opened and one closed) and (4) Non-Residential case files were reviewed (2 opened and 2 closed cases). All the Case/Service Plans were completed within 1 to 4 days of the assessment for the Residential and Non-Residential Programs and were based on the information gathered during the screening, intake and assessment. All of the case files addressed the date of the plan, identified needs and goals, type, frequency, location of services, person responsible, target date for completion, actual completion dates and the client, counselor and supervisor's signatures. Three out of 4 of the case files for the Residential program did not have the parent's signature on the Service Plan and did not indicate any attempts to contact the parent. The four (4) case files for the Non-Residential Program had the counselor's, parent, client and supervisor's signatures. All four (4) of the Residential Program Service Plan Reviews were signed by the counselor only. The best practice for the 30, 60 and 90 Day Service Plan Reviews are to have the client, parent and counselor sign the Service Plan Reviews after reviewing it with the counselor. If the parent is not available it should be noted in the case notes. Three (3) of the Non-Residential Program Service Plan Reviews were signed by the client, parent and counselor and one was signed by the client and counselor but was noted on the Service Plan Review form and in the case notes that the parent was not available.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Orange County Residential and Non-Residential Programs have written policies for the Case Management and Service Delivery. Four (4) Residential case files were reviewed for compliance (three opened and one closed) and (4) Non-Residential case files were reviewed (2 opened and 2 closed cases). Each youth in the Residential and Non-Residential Programs were assigned a counselor after admissions who followed them throughout the delivery of services. Out of the 4 Residential case files, two of the parents were not monitored or provided supportive services due to being unavailable. The families resided out of town. Only one of the case files stated this but the other case file had no documentation concerning why the family was not being monitored or providing services. The Non-Residential Program case files documented that the clients and their parents were being monitored and provided supportive services. Referrals for additional services were offered and noted in all the files for the Residential and Non-Residential Programs. The one (1) Residential and two (2) Non-Residential cases that were closed offered recommendations for additional services and informed the family of the 30 and 60 day follow-up services. No follow-up services were due to be completed on these cases at this time. None of the cases reviewed had Case Staffings or court appointments.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Orange County Residential and Non-Residential Programs have written policies for Counseling Services. Four (4) Residential case files were reviewed for compliance (three opened and one closed) and (4) Non-Residential case files were reviewed (2 opened and 2 closed cases). The Residential and Non-Residential Program provide individual and group counseling services to address the client and family's needs and is documented in the case notes. Two parents out of the four (4) reviewed in the Residential case files did not receive counseling due to being unavailable. The Residential Program offers group counseling 5 days a week as indicated in their log book and is documented in the case files. The Non-Residential Program offers therapeutic counseling in the homes and in the office and is documented in the case notes. They provide referrals for additional services or shelter placements as needed and is addressed in the case notes, referral log or a copy of the referral form is placed in the file. The Residential and Non Residential case files are maintained on all youth and are in chronological order. Both Programs maintain an on-going internal process evident by the supervisor's meeting with the counselor once a month reviewing the family's progress and documenting the meeting in the case file notes. The Non-Residential Program document the monthly supervision with the counselor in their case notes and on their Client Data Sheet.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place. The program has an established case staffing committe and has regular communication with committee members. The program has an internal procedure for the case staffing process and has a schedule for committee meetings. Case Staffing Committee included Program Manager, Representative from the Department of Juvenile Justices (DJJ), the youth, the guardian and a Representative from the youth's school. Revised service plans completed withing seven (7) working days of the Case Staffing.

Three (3) files were reviewed for case staffings. Two (2) files were closed and one (1) file remains open. All files had documenttion showing families and committee members were notified no less than 5 working days. Case staffings included Program Manager or designee, Representative from the DJJ, the youth, guardian and Representative from the youth's school. All files had a new or reviewed service plan, parents were provided with a written recommendations with reasons behind the recommendations.

One (1) file was referred to court, Petition was filed with the Court, an Order of Adjudication was entered.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Orange County Residential and Non-Residential Programs have written policies for Youth Records. Four (4) Residential case files were reviewed for compliance (three opened and one closed) and (4) Non-Residential case files were reviewed (2 opened and 2 closed cases). All youth records were marked confidential and kept in a locked file cabinet in a secure location. All eight (8) records were neat and maintained in an orderly fashion and was easy to access. The Non-Residential files had a lot of additional information in the case file which made it easy to locate the subject manner or find the information. The files were divided into sections with the Heading and underneath the Heading were the names of the forms. The Non-Residential Program created several other forms that assisted them in servicing the client such as: a Client List Data Sheet, a Gang Information Screening that was signed by the client, parent and counselor, a Parent Notification of Expectation Form, a Referral Tracking Form that tracks the outcome and the progress of the referral, a file Checklist that is used as a coaching tools for the counselors and the supervisors to know when things are supposed to be completed and if they have been completed.

Standard 3: Shelter Care

Overview

Rating Narrative

OCYFS Youth Shelter is located in Orange County. The facility is in operation twenty-four hours per day, seven days per week, every day of the year and is licensed by the Department of Children and families for twenty beds. Youth admitted in the shelter program are provided with an orientation of the shelter, which includes a review of the youth handbook with the staff, and a time to ask questions and take a tour of the shelter.

The shelter staff includes a program manager, an administrative specialist, a senior youth care supervisor, a counseling services supervisor, three senior counselors, two 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 shelter's direct care staff are trained to provide the following services for the youth: medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR) and referrals. The supervisory and counseling staff receive referrals and monitor the provision of services. The medication and first aid supplies are stored in the staff office adjacent to the multi-purpose room. The counseling staff have offices in the hallway adjacent to the girls dorm, and in the front office hallway. Residential services, including individual, family, and group services, are provided. Case management and substance abuse prevention education are also offered. The shelter has a color-coded medical and mental health alert system in place. The program also has an effective grievance process, in which both of the grievances were responded to within twenty-four hours of being submitted to management. At the time of the quality improvement review, the shelter was providing services to seven CINS/FINS youth. The shelter is not licensed under Chapter 397.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy to address the requirements for this indicator. The agency provided a binder that listed specific Orange County related policies to address this indicator. The agency addresses this indicator with policies titled Shelter Environment and Daily Activity Schedule. The date of the last revision for each of these polices is July 28, 2012.

An inspection of the facility was conducted on site with agency staff. The inspection involved a review of the facility interior and exterior areas. The facility interior consist of single one-story structure that includes 10 sleeping rooms, 2 large bathrooms per each gender, a large dayroom, utility/storage space, youth work station, multiple administrative offices and an conference room.

All interior areas a clean and orderly. The sleeping rooms for each gender are clean and each bed has linens, pillows and is numbered for classification. The agency also has each room painted in a pleasant, calming colors a decorative mural and matching comforters. Each hall contains a bulletin board that contains general program information related to the program rules, Abuse Hotline contact number, daily schedule, rights and other program related information. The bathrooms for each gener is an open layout and contains 2 sinks, 2 bathroom stalls and 2 showers. All bathrooms are clean and sanitary. The dayroom area is spacious and includes sitting chairs and couches. The dayroom also includes an air hockey table, TV and a bank of 6 computers. The agency conducts group meetings and host select guests in the day room area.

The agency has a kitchen that is located in t separated building that houses the cafeteria and training room. The agency's kitchen is a fully functional industrial kitchen that is equipped with ovens, dish washing machines and sinks, ice maker, mixers, and walk-in refrigerator and freezer. At the time of this onsite program review the kitchen is clean and the agency had its last DOH inspection with a Satisfactory rating. The agency conducts quarterly emergency shelter operational checklist. The agency conducted quarterly youth shelter emergency checks in the YCW work station, Intake Office, Lobby, Conference Room, Manager's Office, Girls hall and Boys Hall on February 21, 2014, May 22, 2014, August 1, 2014 and November 7, 2014. In addition, the agency has added a smart board to the training room. The agency has also added new flooring and chairs in the training room.

The shelter has also completed a series of capital improvements throughout the campus. Since the last onsite program review the program has painted the exterior of the youth shelter and re-carpted the interior the administrative offices located in the building. The agency has a updated the covered area and has recently upgrade the basketball goals, lighting and the court flooring. The agency is working to renovate a pavillion on the campus.

The agency has a professional janitorial and cleaning agency that conducts a quarterly cleaning of the shelter. The agency also has purchased new transportation vans that will be delivered in the next several weeks.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place. The procedure included documentation of each component of orientation, including orientation topics and dates of presentation as well as signatures of the youth and staff involved in the youth record. The procedure also includes a "Client Orientation Checklist" which requires the initials of the staff, youth and parent/guardian that is also reviewed by a Supervisor or Designee.

Files are color coded for "Youth Shelter's Alter System".

Five (5) files were reviewed for this key indicator. All files indicated the orientation was conducted within 24 hours with appropriate initials and signatures.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A written policy is in place. The procedure included documentation for "Client Room Assignment"; which addresses all indicators indentified.

Five (5) files were reviewed for key indicators. One (1) file indicated during the screening the youth has substance abuse issues; however, on the "Client Room Assignment" there was no indiciation identified. One (1) file did not have the Netmis Sexual Orientation identified.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Logbooks that was last revised July 1, 2014. Logbooks were reviewed for the past six months. The shelter uses a permanent bound book to document daily activities, events, and other major occurrences. A highlighting system is utilized making important events easy to find when reviewing the logbook. At the front of each logbook is a legend that shows what the different colored highlights mean and the printed name and signature of each staff member making entries in the logbook.

Entries in the logbooks were brief, legible, and all written in black ink. Safety and security issues, new intakes, daily activities, medication distribution, and mental health concerns were all documented in the logbooks. There were instances observed when major events were documented in the logbook; however, they were very brief in detail. There appeared to be very few errors in the logbooks reviewed and the errors that were observed were handled correctly with a single line and staff initials. All entries made in the logbook were ended with the staff signature and date. The date was also documented at the top of each page. Pertinent events were generally highlighted according to the system identified in the front of the logbook, there were some instances observed of events not highlighted or highlighted in the wrong color.

There was documentation in the logbooks that reviews by the supervisors and staff are happening on a consistent basis. All supervisors consistently documented a review of the logbook each shift and all staff working the shift consistently signed in the logbook and reviewed for previous two shifts. There were also daily reviews of the logbook by the clinical supervisor. The program manager reviewed the logbook at least once each week, at times more frequently, and documented any recommendations or follow-up if needed.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a Behavior Management System in place. The system is designed to be easily understood by both youth and staff. It is designed to promote positive behaviors in the youth through the application of logical consequences. The system prohibits the use of group punishment and also prohibits youth imposing disciplinary sanctions over other youth. Youth are oriented to the system during intake and are given a handbook that outlines behaviors that may result in consequences, disciplinary action, or expulsion from the program. The system requires that when major program rule violations-cardinal rule is issued, the sanction must be reviewed and signed by a supervisor. A variety of rewards are used with the system including: The Way-To-Go Store, extra snacks, community outings, extended weekend bedtimes, pizza parties, and ice cream socials. All staff training files reviewed confirmed staff are trained on the proper use of the Behavior Management System.

The Behavior Management System is a level based system based on nautical theme. The system is designed for short term residential stays. Youth purchase levels based on the number of points they have earned throughout the day. Points are earned for successfully managing required behaviors by making good decisions, self-management, and social and life skill management. Points are deducted for unacceptable behaviors. There are four levels that can be purchased, the more points a resident earns, the higher the level that can be purchased, which directly coincides with more rewards and privileges for the youth. The four levels in the system are: Level 0 Ensign costs 349 points or less, Level 1 Lieutenant 350 points, Level 2 Commander 400 points, and Level 3 Captain 450 points. Youth can earn a maximum of 500 points daily.

The shelter has also implemented a Resident of the Week to promote the youth's good behavior, good hygiene, and build self-esteem. The clinical team recently implemented an incentive program for the youth, utilizing positive reinforcement and encouraging youth to make good behavior choices. Each counselor has created their unique version of $1, which is a token economy that the youth can use to purchase items from the treasure chest. Youth are presented with a $1 for making positive decisions or observed being good, a $1 for practicing integrity by following the rules of the youth shelter when no one is looking. Youth can earn up to $10 and have an opportunity to cash in their dollars on Thursdays or on their discharge date.

There were five youth files reviewed and each file contained daily point cards. Points are earned for different activities throughout the day. The card documented how many points were earned for each activity, the total points earned for the day, the level the youth is on, and how much money the youth has to spend in the Way To Go Store. Each file also contained Behavior Management Infraction Slips if points were deducted for negative behaviors. In the five files reviewed it appears that positive rewards and negative consequences are given on a consistent and fair basis.

The shelter is in the process of having the Behavior Management System revised and updated. The language utilized is more enhanced and therapeutic to match up with Trauma Informed Care practices.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Staff schedules were reviewed for the previous six months. There was consistent documentation of sufficient staff scheduled each shift, as well as, a supervisor. Logbooks reviewed verified staff working each shift corresponded to the staff assigned on the schedule. There was consistently a male and female staff scheduled each shift and the number of staff working usually exceeded ratio requirements. The staff schedule also indicates the staff member for the shift who is assigned to sight and sound supervision, the staff member in charge of medication, the staff member in charge of close observation, the staff member assigned to the office, and the staff member assigned to the staff secure youth if they have one. Any changes made to the staff schedule are documented on the actual schedule. All staff sign the schedule to indicate they have reviewed it and are aware of the days and times they are working. An overtime roster is maintained that documents each staff member with their phone number. When overtime is needed the next person in line on the roster is called, it is then documented next to their name if they worked, hours many hours and what shift, if they refused, or if they were unavailable. A review of the overtime chart confirmed all staff are given an equal number of overtime hours and the rotation is consistently followed.

The Resident Accountability Checklist were reviewed and documented observations of the youth every fifteen minutes during the sleeping

hours. Observations were documented with the time, staff initials, and a code indicating what the youth is doing, i.e. "S" for sleeping, "AR" for awake in room, "H" for hygiene.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has had one staff secure youth in the past six months. There was documentation from the judge in the file that the youth was formally ordered to a 90 day staff secure shelter. The youth received a more in-depth orientation to the shelter and a specific staff secure pamphlet. There is a staff member assigned to the youth each day, this is documented and highlighted in the logbook. The staff schedule also identifies the staff member who is to be assigned to the youth each shift. This staff member stays with the youth the entire time the youth is awake. The staff member assigned to the youth constantly updates notes, in the "contact notes" section of the youth's file, throughout the entire shift and after each activity. The youth has not had any court proceedings yet requiring a written report of the youth's progress; however, the Program Manager reported they are having the teacher from the on-campus school write a report for the youth's next hearing documenting how successful the youth has been in school.

The shelter was able to provide two files of youth admitted for Domestic Violence (DV) Respite. There was documentation in both files of prior approval from the Florida Network for placement. There was also evidence in both files that the youth had a pending DV charge; however, there was no evidence of a screening completed by the JAC indicating the youth did not meet criteria for secure detention. One youth remained in the shelter past fourteen days and was appropriately transitioned to a CINS/FINS bed. The second youth did not exceed the fourteen day length of stay. The case plans in both files reviewed documented goals focusing on anger management, family coping skills, and other necessary interventions to reduce violence in the home. All other services for the two DV youth were consistent with all other general CINS/FINS program requirements.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

OCYFS has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial 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 the CINS/FINS Intake Assessment page 2. 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 shelter manager, licensed clinician, and/or youth resident 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 in the daily log, on the alert board, 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 in a double locked 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 ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy that is called Standard Operation Procedures for Health and Mental Health Services and titled Healthcare Admission Screening. The agency uses the FNYFS CINS/FINS Intake Assessment Form to screen for health and mental health issues and also utlizes the Orange County Youth Shelter Client Admission/Emergency Information form. The Intake form screens for injury, illness, or health related issues; the existance of any medical, dental, or health conditions or concerns; history of being treated or hospitalized fo rany medical conditions in the last year; currently on medication; does client have any allergies; and screens for all general medication physical health issues.

A review of six (6) randomly selected client files was conducted to determine the agency's adherence to the requirements of this indicator. The agency captures this information on the OCG Client Admission Form, CINS/FINS Intake Form and in the mental health status in the Comprehensive Family Assessment that also captures mental health issuses.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a detailed policy on Suicide Prevention that that outlined the suicide prevention and response procedures for the program. The plan indicated each youth admitted to the shelter will be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. The agency follows the FNYFS contract requirements. The agency's practice requires that If the youth answers "yes" to any of the 6 questions, the youth care worker will immediately refer the youth to a qualified mental health professional to determine the specific level of suicide risk or, if a qualified mental health professional is not available the youth will be placed on Constant Sight and Sound supervision until a full suicide assessment can be completed by a qualified mental health professional. The shelter utilizes two (2) levels of supervision: close observation and constant sight and sound supervision. The plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

All 6 files reviewed (two open files and four closed files) contained documentation that indicated a suicide risk screening was completed during the initial intake and screening process. All 6 files contained documentation that indicated the suicide screening results were reviewed and signed by the direct care staff member and the designated supervisor. All 6 files contained the required assessment, safety contract and observation documentation. Six (6) of the 6 files were applicable for sight and sound supervision requirements. All youth were placed on the appropriate level of supervision based on the suicide risk assessment results. All applicable youth were placed on sight and sound supervision until the Assessment of Suicide Risk was completed by the assigned counselor. Each client file has evidence of a Suicide Assessment that is

completed by a Master Level counselor/professional or non-licensed staff under the direct supervision of the licensed professional (LCSW). The supervision level in the open cases were changed or reduced with evidence of the approved by a licensed professional. Supportive documentation was reviewed to include precautionary observation logs and 10 and 15 minute checks accordingly. Evidence of all youth being place on a designated supervision status is confirmed in the logbook. Each weekly staff schedule includes a staff member that is identified as the Sight and Sound point person for each work shift. Supervision statuses from Sight and Sound to Close Observation to Standard changes are also documented in the logbook as required.

All observation counts included evidence of counts being generally conducted as required. The agency uses a Client Observation Record to document all counts. The staff conducts all counts and the Licensed Clinician signs the form to verify that counts have been completed. All three (3) master level counselors have evidence of completing five (5) or more Comprehensive Family Assessments. This is verified by the Licensed Clinician.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency had evidence of written procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with FNYFS Policy and DJJ Health Services Manual requirements.

The program had a list delineated in writing of staff that are designated to have access to secured medications, and limited access to controlled substances. All Direct Care Staff are required to be trained on Distributing Medication. Following a recent training the DJJ Office of Health Services Registered Nurse Consultant conducted a training session on November 7, 2014. This training was attended by the staff that committed recent medication distribution errors. The agency also required the Shift Supervisors on duty during the mediation incident to also attend to medication training.

All medications (controlled and prescribed) in the shelter are stored in a prescribed medication cabinet that has a locking outside door. The prescribed medication cabinet also has a secondary interior locking door. The agency also has an over the count medication cabinet. Both cabinets are in-accessible to youth. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review.

All oral medications are stored separately from topical medications. All prescribed medications are placed in separate wire baskets in an individual slot with each residents name affixed to a label. All topical medications are stored on the right side and all controlled and prescribed medications are stored on the left side of the cabinet. All medications are counted on each work shift. Verification of the staff completing each shift-to-shift count is documented on the Daily Medication Schedule and Count form. The perpetual inventory is maintained, and documented for controlled, prescribed and over the counter medication. The agency's OTC medications include Tylenol liquid, Tylenol pill, Milk of Magnesia, Midol, Advil and Halls cough drops.

The agency maintains a best practice Medication Side Effects Log that is alphabetized by each medication. This binder lists all generic, name brand medication and all information pertaining to the use of the specific medication. In addition, the agency uses a Common Infectious/Illnesses chart to provide at-a-glance information to inform staff of all communicable diseases and recommendations on how to deal with them.

The agency does not maintain sharps in the youth shelter.

The agency does currently verify all prescribed current medications to determine if they are from a licensed pharmacy. The

The agency posts a picture on the front each youth medication file. The program utilizes an individual Medication Distributed Log (MDL). The MDL contained all the necessary information to include: youth's name (printed and signed), date of birth and age, prescribing physicians, dosage/frequency, time medication is given, reason for medication, allergies, common side effects, picture of youth, staff and youth initials on MAR when medication is disbursed and received.

Over-the-counter (OTC) medications that are accessed regularly are being inventoried weekly. The agency also maintains an over the counter perpetual log for when the each OTC is given to a resident.

A total of six (6) files were reviewed on site to determine the agency's adherence to the requirements of this indicator.

A review was conducted with the agency Supervisor Program Manager regarding the agency's low medication monitoring process was conducted. The agency contacts the parent/guardian when a youth's medication dosage is a 3 doses remaining. The agency documents this request to the parent/guardian in the program logbook to verify this practice.

A review was conducted with the agency Supervisor Program Manager regarding the agency's disposal process was conducted. The agency disposes of medication with two (2) staff member conducting the disposal process. The agency documents this event in the program logbook to verify this practice.

The shelter has a secured refrigerator designated for medication only, however at the time of the review it was empty. The medication refrigerator is located in the youth shelter.

The agency does not provide over-the counter medication and did not have any stock over-the-counter medications.

There are exceptions noted for this indicator. A review of the Central Communication Center (CCC) reports indicated that on October 27, 2014 a Direct Care Work (DCW) provided a resident with an extra dose of his medication. The youth was prescribed to take medication 3 times per day. The youth was provided with an extra dose that was not required. The youth did not suffer any adverse side effects due to the extra dose. The agency did conduct a root cause analysis. Agency administration indicated all staff members involved received appropriate corrective action. Written corrective action was documented and reviewed. The agency required the direct care worker staff distributing the medication and Shift Supervisor to be retrained by DJJ Office Health Services Registered Nurse Consultant on November 7, 2014.

The agency's policy requires that staff verify all medication entering the shelter. The agency documents verification on the daily medication schedule and count form. The current process documents the youth name, medication type, dosage and the specific staff on shift when medication was counted. This form does not capture who the person spoke with at the pharmacy to verify the medications. In addition these forms contain a blank or unsigned/initialed area on the form and are and not always signed by the staff member that verified the medication.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The aegncy has a policy that is comprehensive and is Called Alert Procedures. It contains all required elements and lists that it was last updated in January 2011. It provides a full description of the agency's process regarding the Healthcare screening process that occurs at time of admission to the program. The agency Alert Procedure protocol requires that staff execute and use a system that informs staff of medical, mental health, and or substance abuse conditions, allergies, side effects of prescribed medications, foods and other related alert information.

All identified conditions are required to be documented in the client file and in the Emergency Response System Log. The Emergency Response Log includes a copy of each client's OCG Client Admissions/Emergency Infromation form. Additonally, the agency utilizes a color-coded dot sticker to notify all staff of the current status on medical, mental health or substance status of the youth. This sticker is placed on the youth's file and also on the population board. The agency uses a total of five (5) circular dot stickers. The stickers describes a condition by a specified color. The 5 colors include yellow for mental health; blue for substance abuse; red fo rmedical; green for allergies; orange for trauma.

The reviewer asessed a total of seven (7) randomly selected files. Of these files, most includes evidence of the practice being followed as required. The files reviewed have evidence of a youth or medical or mental health condition or food allergy. The file also include evidence that the youth is placed on the program's alert system. The current alert syste also included precautions related to medications, medical and health issues and general health conditions. The files reviewed also included sufficient information and instructions to respond to the need for emergency care for medical or mental health problems.

The agency also has a policy that is called the Health Education policy that provides health education and awareness to residents. The goal of this policy is to provide health eduaction to residents that include, but is not limited to prevention of communicable diseases and substance abuse. The residentia counseling component of the CINS/FINS program delivers the education durin group skill training at least on a bi-weekly basis.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy that addresses the requirements of the indicator. The agency has a total of six (6) client files to determine the agency's adherence to the requirements of this indicator. The reviewer assessed a total of four (4) actual emergency events and a total of four (4) mock emergency drills. Of the 4 actual emergency events all are generally documented in the agency program logbook. All incidents document that resident was transported from the youth shelter to receive medical care. At least 1 mock drill was completed in the last two (2) quarters.

All agency staff are required to a broad range of safety and emergency response training. agency did have evidence of receiving CPR/First Aid for all files reviewed on site. In addition, the reviewer confirrmed that the staff receive universal precautions, emergecny response, fire safety, fire alarm system training, HIV, and infectuous disease training.

The agency has a knife for life and a wire cutters. In addition the agency has a total of four (4) first aid kits onsite and in all transportation vans.

Some incidents documented in the program log do not describe method or person transporting youth to the hospital for medical treatment.