FLORIDA NETWORK
of youth and family services

QUALITY IMPROVEMENT PROGRAM REPORT FOR

Youth Crisis Center, Inc.

3015 Parental Home Road
Jacksonville, Fl 32216
(Local Service Provider)

Review Date(s):
July 17-18, 2012

CINS/FINS Rating Profile

Program Name:	**The Safe Place**	QA Program Code:	**N/A**
Provider Name:	**Youth Crisis Center**	Contract Number:	**V2021**
Location:	**Clay, Duval, Nassau / Circuit 4**	Number of Beds:	**22**
Review Date(s):	**July 17-18, 2012**	Lead Reviewer :	**K. Carr**

Indicator Ratings

1. Management Accountability		
1.01	Background Screening of Employees/Vol.	Satisfactory
1.02	Provision of an Abuse Free Environment	Satisfactory
1.03	Incident Reporting	Satisfactory
1.04	Training Requirements	Satisfactory
1.05	Interagency Agreements and Outreach	Satisfactory
1.06	Disaster Planning	Satisfactory
% Indicators Rated Satisfactory Compliance:		**100%**
% Indicators Rated Limited Compliance:		**0%**
% Indicators Rated Failed Compliance:		**0%**

2. Intervention and Case Management		
2.01	Screening and Intake	Satisfactory
2.02	Psychosocial Assessment	Satisfactory
2.03	Case/Service Plan	Satisfactory
2.04	Case Management and Service Delivery	Satisfactory
2.05	Counseling Services	Satisfactory
2.06	Adjudication/Petition Process	
% Indicators Rated Satisfactory Compliance:		**100%**
% Indicators Rated Limited Compliance:		**0%**
% Indicators Rated Failed Compliance:		**0%**

3. Shelter Care/Health Services		
3.01	Shelter Care Requirements	Satisfactory
3.02	Healthcare Admission Screening	Satisfactory
3.03	Suicide Prevention	Satisfactory
3.04	Medications	Satisfactory
3.05	Medical/Mental Health Alert Process	Satisfactory
3.06	Episodic/Emergency Care	
% Indicators Rated Satisfactory Compliance:		**100%**
% Indicators Rated Limited Compliance:		**0%**
% Indicators Rated Failed Compliance:		**0%**

Overall Rating Summary

Satisfactory Compliance:	**100%**
Limited Compliance:	**0%**
Failed Compliance:	**0%**

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2011).

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☐ DHA or designee
- ☐ DMHA or designee
- 2 # Case Managers
- 2 # Clinical Staff
- 1 # Food Service Personnel
- _____ # Healthcare Staff
- 2 # Maintenance Personnel
- 1 # Program Supervisors
- **QA VP & HR VP** # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☐ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☐ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☐ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☐ Sick Call Logs
- ☐ Supplemental Contracts
- ☒ Table of Organization
- ☐ Telephone Logs
- ☐ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- 6 # Health Records
- 6 # MH/SA Records
- 11 # Personnel Records
- 10 # Training Records/CORE
- 7 # Youth Records (Closed)
- 16 # Youth Records (Open)
- 24 # Other: **Interagency Agreements, Licensing Credentials, Admin. Docs. Etc.**

Surveys

- **3** # Youth
- **3** # Direct Care Staff
- **0** # Other: _____

Observations During Review

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

The Florida Network of Youth and Family Services and the Florida Department of Juvenile Justiceôs Bureau of Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Keith D. Carr, Lead Reviewer, Principal Consultant, Forefront LLC
Latrice Covington, Contract Manager, Office of Prevention and Victim Services
Angela Mills, Management Review Specialist, DJJ Bureau of Quality Improvement
Tracey Ousley, Regional Coordinator, CDS Family & Behavioral Health Services, Inc.

Please note that this report refers to each indicator by number and title only. Please see the applicable standards for the full text of each indicator. The standards are available on the Bureau of Quality Improvement website, at http://www.dji.state.fl.us.

Strengths and Innovative Approaches

The Youth Crisis Center, Inc. (YCC) provides a variety of services addressing different needs of children and families in crisis. The program serves 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. From emergency shelter to counseling to long-term housing, their programs are designed to keep at-risk youth safely off the streets, providing options for a better future.

According to data from the YCC website, over the last 36 years, more than 36,000 youth have received assistance either in their shelter or outpatient programs. Further, of those youth, 88% were successfully reunited with their families, and after one year they are still at home and attending school.

Youth Crisis Center offers an array of programs that includes Touchstone Village, the Family Link Program and Project Safe Place to children and families throughout Clay, Duval and Nassau Counties. YCC is a nationally recognized as setting a standard in youth services. YCC is ranked as one of the top five programs in the United States by the Youth Policy Institute in Washington DC. YCC has been honored with two Presidential Commendations for Excellence, and has received numerous state honors awards by the State of Florida. YCC has been featured on *60 Minutes*, *Sunday Morning* with Charles Kuralt, and *Wards of the Street*, a national documentary. YCC has also appeared in *The New York Times*, *USA Today* and *Readers Digest*, and has been featured numerous times by local media. In addition, YCC was selected as the 2011Agency of the Year by the Florida Network of Youth and Family Services.

The agency reports that they continue to maintain a part time nurse to oversee the storage, documentation and distribution of medication in the youth shelter. Other collateral program staff include a Volunteer Activity staff person.

Further YCC reports that they are now a Magellan Medicaid provider of Mental Health Counseling Services. The agency plans to provide Case Management Services in the future. In addition, the agency has submitted a formal request to the Council on Accreditation to initiate the process of becoming a Council on Accreditation (COA) certified service provider.

The agency also reports that their Transitional Living Program Touchstone Village is now in its third year and continues to serve residents 16-22 years of age.

The agency reports that they have made several new organizational appointments. The agencyûs President and CEO, Greg Steele appointed Kim Sirdevan to Vice President of Clinical Services, Darryl Matthews Director of Residential Services, Susan Spinella, Vice President of Quality Assurance, Joyce Farhat, Vice President of Human Services and Jim Smith Vice President of Facilities.

Youth Crisis Center secured a bathing chair and other equipment to assist youth that are physically challenged.

The agency reports that there are two (2) licensed clinicians on staff serving the CINS/FINS programs. In addition, the agency reports that they have recently discontinued the use of the Evaluation of Imminent Danger Survey (EIDS) and now use the Assessment of Suicide Risk. The agency also now completes a different follow up assessment if a child returns from a Crisis Stabilization Unit program. Further, the agency utilizes a client file review matrix table to conduct quarterly file reviews to ensure that all major areas of client file service delivery and documentation are accurate and completed as required.

Standard 1: Management Accountability

Overview

Youth Crisis Center, Inc. provides shelter and non-residential services for youth and their families in Clay, Duval and Nassau Counties. All YCC residential and non-residential programs operate out of their multi-program location that is located at 3015 Parental Home Road, Jacksonville, Florida. The agencyôs is lead by Greg Steele, President and CEO. Other Executive Team members include Butch Sims, Chief Operating Officer, Angie Srock, Chief Financial Officer and Pam Morgan, Chief Development Officer.

The company has re-structured its staff to include a tier of Management team members to more effectively oversee the execution and quality of it residential and non-residential services to youth and families. The YCC Management team includes the YCC President and CEO, COO, CFO and CDO, as well as Kim Sirdevan Vice President of Clinical Services, Susan Spinella, Vice President of Quality Assurance, Joyce Farhat, Vice President of Human Resources and Jim Smith, Vice President of Facilities. Additionally, the Management team is rounded out by Darryl Matthews, Director of Residential Services, Linda Wilson, Clinical Manager and Aimee Green, Program Manager. The residential team members include Kim Sirdevan Vice President of Clinical Services, Darryl Matthews, Director of Residential Services, Aimee, Green, Program Manager, three (3) Therapists, three (3) Shift Supervisors, one (1) Integrated Service Specialist, one (1) Registered Nurse (part time) and twenty-five (25) Youth Care Specialists. The non-residential team members include the Vice President of Clinical Services, one (1) Program Manager, five (5) Therapist and three (3) Case Managers.

Other areas of the organization include an Administrative team that is composed of the aforementioned Executive and Management team members, as well as several administrative/operational support positions that include YCC team members their respective residential, non-residential, fiscal/accounting, human resources, clinical, quality assurance, data entry, maintenance and food service areas.

At the time of the quality improvement review, the agency reports having (1) vacant fulltime Youth Care staff vacant position at this location. The Department of Children and Families has licensed YCC as an emergency runaway shelter, with the current license in effect until April 21, 2013.

The agency manages all personnel functions through its Human Resources division located in the administrative offices that are onsite. The agencyôs Human Resources Department processes all state and local background screenings. The agency delivers Orientation training to both residential and non-residential personnel following screening and reference checks. The majority of core training

is also provided by a combination of training provided by the Florida Network trainer, inter-agency training delivered by the agency and outside and on-line training resources. The agency maintains an individual training file on each staff member that includes a training plan and copies of documentation for training received. Annual training is tracked according to the Fiscal year of July 1 through June 30.

The Florida Network approved the programôs emergency response plan and hurricane plan for FY 2011-2012. The agencyôs Vice President of facilities oversees weekly safety and physical plant checks.

1.01: Background Screening of Employees/Volunteers	Satisfactory Compliance

The agency has a comprehensive background screening policy that meets and addresses all major requirements of DJJ Background Policy 1800. The agency has a separate human resources department that conducts all initial background and 5 year screenings for prospective and current staff members.

A total of nine (9) eligible staff members files were selected to determine the agencyôs adherence to this indicator. Of the 9 staff member files reviewed, all files were organized in a standardized format with no exceptions found at the time of this program review. All had the required information and meet all requirements for this indicator. One (1) volunteer that works more than ten (10) hours a month was not background screened prior to volunteering. However, this volunteerôs personnel file did contain evidence was screened through the Department of Children and Families.

The agency has also demonstrated and provided evidence that the Annual Affidavit of good moral character has been sent to the DJJ Background Unit prior to the January 31 deadline. The agency provided a copy of the document that verifies that the Affidavit was completed on January 5, 2012.

1.02: Provision of an Abuse Free Environment	Satisfactory Compliance

A review of the agencyôs current disaster and emergency manual revealed that it is in adherence with the all requirements for Indicator 1.02 Provision of an Abuse Free Environment. The agencyôs current policy 1.08 indicates that it was last revised February 2012. The reviewer assessed a total of twenty (20) internal YCC incidents, nine (9) DJJ CCC Incidents, five (5) employee/staff personnel reports.

A review of twenty (20) internal YCC incidents indicates no evidence or presence of abuse, threatening or negative demeanor towards residents.

A review of nine (9) DJJ CCC incidents indicates no evidence or presence of abuse, threatening or negative demeanor towards residents. The documented incidents include three (3) medication errors, three (3) contraband discoveries, one (1) medical/injury and two (2) other types of medical incidents. The program posts the telephone contact number for the Florida Abuse Hotline number at various locations throughout the facility and informs youth of these procedures during program orientation and in the Resident Handbook. In addition, all staff members receive a copy of the Agencyôs Code of Conduct upon hire. A review of documented agency disciplinary action reports was conducted and a total of five (5) reports were reviewed. The Notice of Disciplinary Action resulted in a termination of one (1) male staff member for violation of the employee handbook rules. Grievances were requested to verify or confirm any existence of inappropriate staff member demeanor, attitude and negative temperance toward program residents. A request for CINS/FINS

residential program grievances revealed that no grievance reports have been submitted by residents for the past six (6) months. During the tour the monitor found that all grievance report boxes were accessible to residents and full with forms for residents to submit when needed.

At the time of this program review, the reviewer of this indicator conducted a discussion with the Director of Programs regarding staff behavior and client/youth actions that may have impacted the safety and security of the shelter environment. The agency utilizes a graduated method that includes a Verbal Warning, Initial Written Warning and Final Written Warning and Termination. The agency uses an annual performance and Development review process to evaluate staff member work performance. The Director or Programs provided all inter-agency written reports that occurred within the last six (6) months including work performance and disciplinary reports. A total of five (5) written personnel action reports were reviewed for this standard. The circumstances include work performance issues (improper call out, medication errors, employee handbook violations (behavior that led to termination) and driving status issues (2 staff members).

A review of documented agency disciplinary action reports was conducted and a total of five (5) reports were reviewed. These documents included Memorandums for the Record and supporting documentation of Understanding, 3 Supervision documents, and one (1) Notice of Disciplinary Action. The Notice of Disciplinary Action resulted in a termination of 1 male staff member for violation of the employee handbook rules.

During this onsite program review, the shelter housed a total of nine (9) residents on day 1 of the review and ten (10) residents on day 2 of the review. Four (4) youth surveys were conducted. Three (3) out of 4 youth are CINS/FINS are eligible youth. All eligible youth survey results indicated that all were familiar with the abuse reporting and grievance reporting processes. In addition, youth reported that they feel safe in the program and have never heard staff threaten them or other youth. No youth surveyed state that they have heard staff use profanity/inappropriate language; and none said they have been stopped from reporting abuse. Youth also report that they are familiar with the goals that they are working on and feel safe in the residential shelter.

Four (4) staff members were surveyed during this onsite program review. No staff surveyed indicated that that they staff observed a co-worker using threats, intimidation, or humiliation when interacting with the youth. All staff agreed the working conditions have been adequate at the program. Further, staff members surveyed indicated that they are familiar with overnight bed check requirements, suicide prevention safety equipment and youth medical and mental health alerts.

1.03: Incident Reporting	Satisfactory Compliance

The agency has a comprehensive incident reporting policy that addresses Incident Reporting. The current policy was last reviewed on July 2011. The agency's policy program specifies that the agency notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident. The agency has a protocol that reviews the practice and execution of each documented incident.

An inquiry into the DJJ CCC database by the DJJ QI program review team member confirmed a total of five (5) official incidents documented in the system. Of these reports two (2) were Program Disruptions and Medical Incidents. Two (2) out of three (3) were called into the DJJ CCC outside of

the 2 hour reporting requirement. The agency submitted all Internal Incidents. A total of twenty (20) inter-agency incidents were reviewed during this onsite program review. The type of internal incidents documented by the agency range from client disagreements, absconds/running, contraband discovery, medication errors, minor physical injuries (no hospitalization), destruction of property and physical altercations.

1.04: Training Requirements	Satisfactory Compliance

A request for the agency policy on training was made during the Quality Improvement (QI) program review. At the time of this review, the agency did not possess a training policy that addresses annual training requirements for first year and on-going staff members. The agency has a Training Plan that addresses annual training requirements for first year and on-going staff members. However, the agency produced evidence of an initial draft Training Plan that requires a minimum 80 hours for first year staff members and 40 hours for all on-going staff members on an annual basis. Prior to the close of the onsite QI Review, the agency provide a Draft Training Requirements to the review team for review.

The reviewer assessed a total of eleven (11) staff member training files. Of these files, six (6) were first year staff member files and five (5) on-going staff member files. Six (6) out of 6 staff members have evidence that demonstrate that they are working towards or have completed year 1 training hour requirements. Each first year staff member actually had more than 100 document training hours. Of the five (5) on-going staff members, 5 out of 5 exceeded all of the minimum annual total training hour requirements. At the time of this review, all first year or on-going staff members training files contained documentation verifying that that had completed CPR and first aid training.

Several new/recent hires have outstanding training, but still have time to complete this prior to the close of their respective training year. There are noticeable differences in training file formatting across all files assessed during this program review. Some staff member training files have hand written training logs versus other training files that do not have updated hours. Additionally, some new/recent hires are using a slightly different training file format. The Residential Supervisor reports that they have not had or scheduled a CINS/FINS training at this site since her date of hire in October 2011.

The agency has begun training on Trauma Informed Care (TIC) for the entire agency. This new training component will better prepare the staff members for various youth and family issues.

1.05: Interagency Agreements and Outreach	Satisfactory Compliance

Youth Crisis Center has numerous interagency agreements with various agencies that provide the services listed in the indicator. The agency policy on interagency agreements and outreach is current. The agency interagency agreement binder was reviewed for current agreements. The reviewer assigned to this standard evaluated a sample of nearly twenty-seven (27) agreements. Type of agreements reviewed included schools in all service area counties served by the agency, local non-profit, local schools, health, mental health, and other system partners. In addition the agency has various interagency agreements with various agencies providing services such as substance abuse, youth education issues, information about CINS/FINS and other services programs. These program offerings also include information on other program

services offered by the agency including Transitional Living services for youth aging out of foster care and Outpatient Counseling for youth and families.

Parenting classes are provided through the full services schools but there are plans for the agency to start providing classes. There are interagency agreements for Clay, Duval and Nassau Counties. The agency has an office at a local elementary school to provide groups to assist the youth with transitioning to middle school and high school. Many of the interagency agreements have no expiration dates, but were initiated nine (9) or more years ago. All staff members perform outreach activities. There is documentation of outreach activities conducted in Duval County, but there is no documentation of outreach activities conducted in Clay and Nassau Counties.

The agency states that YCC is one of the largest Safe Place operations in the nation. Through the Safe Place program, YCC helps runaways and homeless children find their way back to their families across the U.S. Further, the agency partners with The National Runaway Home Free Program to provide transportation via Greyhound Bus for children whose parents cannot afford to pay for their return home. There is a designated staff person seeking Safe Place agreements.

Of these inter-agency agreements, each has information that indicates that the original duration of each agreement is open-ended and includes no indication of renewal. During this onsite program review, it was recommended that the agency establish a reasonable effective period (1 year, 2 years, 3 years, etc.) for all of its agreements and to establish a renewal process for all expiring or expired interagency agreements.

1.06: Disaster Planning	Satisfactory Compliance

A review of the agencyôs current disaster and emergency manual revealed that it is in adherence with the all requirements for Indicator 1.06 Disaster Planning. The agencyôs current disaster plan includes various types of emergency situations. These disaster scenarios include plans with emergency evacuation procedures for various emergencies and disasters.

The YCC plan has procedures for severe weather warnings, necessary and secure transportation for evacuation, when evacuation would occur, a specific evacuation facility and other CINS/FINS shelters. The plan addresses notifying all funders when applicable, bringing food, medications, log books, cell phones, radios, and other necessities. There is a copy of the disaster plan in the shelter and egress plans posted in various locations. Some supplies are kept locked in the medication room and food is taken from the kitchen when necessary. The agency participates in the universal agreement emergency disaster shelter. The disaster plan also addresses medical emergencies (eyes, nose bleed, bleeding wounds, teeth, choking, broken bones and sprains, and head, neck, and spine injuries) and pandemic/epidemic infections.

The agency is an active participant in the Universal Agreement for Emergency Disaster Shelter with all of the full service Florida Network Member Agencies. All new hires receive personal disaster training. The emergency plan states that supplies must be taken when an ordered. The facility has a general list of supplies to be taken when ordered to evacuate. All supplies are kept onsite and are checked weekly during hurricane season.

Overview

The Youth Crisis Center, Inc. is a local service provider that is contracted to provide CINS/FINS residential as well as non-residential services for youth and their families in Clay, Duval and Nassau. The agency provides outpatient counseling for Northeast Florida families with youth under 18 who are experiencing any problem that disrupts the health and stability of the family. According to the YCC website, agency therapists and case managers provide care for more than 600 youth and their families annually.

The agency has trained staff members that are available to determine the needs of the family and youth. The YCC Family Link staff include Kim Sirdevan, Vice President of Clinical Services, Aimee Green, Program Manager, five (5) Therapist and three (3) Case Managers. Family Link counselors have masterôs degrees and extensive experience in a wide range of family and youth issues including running away, poor academic performance, truancy, homelessness, depression, anxiety and Attention Deficit Hyperactivity Disorder (ADHD) and chronic behavior problems. The agencyôs Residential service component includes individual, group and family services. Discharge service planning includes referring youth to community resources, on- going counseling, and educational assistance.

The counselors are responsible for providing case management services and linking youth and families to community services. The agency also provides limited case management and substance abuse prevention education referrals. The Family Link program 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 as needed.

2.01: Screening and Intake — Satisfactory Compliance

A review of the agencyôs policy and procedures for screening and intake was conducted and found to be inclusive of all components required by Standard 2.01. A total of ten (10) client files were reviewed for this standard. Of these files, eight (8) were residential and two (2) were non-residential.

A review of the time cycle to initiate intake on referrals submitted was evaluated. Nine (9) out of the 10 files had eligibility screening within seven calendar days of the referral. All files have documentation that available service options, rights and responsibilities of youth and parents/guardians, and parent brochure were received in writing by the youth and parents/guardians. The youth and parents/guardians also receive information about possible actions occurring through involvement with CINS/FINS services and grievance procedures.

All youth files reviewed have documentation of available services options, rights and responsibilities, possible actions through involvement with CINS/FINS, and grievance procedures. Ten (10) of the 10 contain evidence that the Parent/Guardian brochure was received. All parents/guardians receive information on the agencyôs programs and a brochure on parent options for ungovernable children and possible actions occurring through involvement with CINS/FINS services. The brochure is available in English, Spanish and Creole. The brochure describes services for status offenders and includes various service options. The brochure also includes information about the Case Staffing Committee, CINS Petition, and CINS Adjudication process.

2.02: Psychosocial Assessment	Satisfactory Compliance

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by indicator 2.02. A total of ten (10) files were reviewed, six (6) residential, two (2) closed residential and 2 closed non-residential files. All psychological assessments were initiated within 72 hours as required.

The psychosocial assessments for all residential files were initiated within 72 hours. The psychosocial assessments for all non-residential files were completed within two to three face-to-face visits. All psychosocial assessments were completed by master level staff and signed by a licensed clinical supervisor. One (1) of the 10 files reviewed had an elevated risk of suicide on the psychosocial assessment and contained a completed assessment of suicide risk that was signed by a licensed mental health professional.

2.03: Case/Service Plan	Satisfactory Compliance

The agency policy on Case Plan development was reviewed to assess this indicator from non-residential service delivery for compliance with standard 2.03. A written policy is in place that dictates the time frames and process for service plan completion and review.

A total of ten (10) files, residential and non-residential were reviewed for this indicator. Of these files, six (6) non-residential and four (4) residential case files. The agency for Service Plan or Goal Plan as the agency calls it includes all the required elements. Nine (9) of these case files contained service plans that were developed within the required time frame. Of the ten files reviewed, all had completed plans and the required signatures. Six (6) of the ten (10) files Service Plans required 30 day reviews. Five (5) of the six (6) case files contained timely reviews. One (1) file contained a plan that was not reviewed within the 30 day time period as required.

The reviewer noted that all goal plans contained individualized goals as identified by the psychosocial assessment; service type, frequency and location; designated person responsible; target date(s) for completion; actual completion date(s), required signatures; date that plan was initiated; and 30 day plan reviews. One (1) case did not have evidence of a 30 day plan review.

2.04: Case Management and Service Delivery	Satisfactory Compliance

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 2.04. The agency has a policy in place to assess and coordinate services for eligible youth and families. The written procedure includes all the required elements of the indicator. A total of ten (10) files were reviewed, six (6) residential, two (2) closed residential and 2 closed non-residential files. All 10 files had an assigned counselor/case manager. Additionally, all 10 files included documented evidence of case management services. Further all files, that includes confirmation of referral for services based on on-going assessment; refers to youth/familiar additional services when appropriate; coordination of goal plan implementation; monitoring of progress in services; referrals to case staffing committee and judicial intervention when applicable.

None of the 10 files reviewed were eligible for the 180 day follow up. However, a review of the Florida Network Youth and Family Services NetMIS Data Extract for June 2012 reflected a 98% follow up rate for the agency.

2.05: Counseling Services	Satisfactory Compliance

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 2.05. Counseling services are provided on a consistent and regular schedule for the youth across all CINS/FINS Non-residential and Residential program participants. A total of ten (10) files were reviewed, six (6) residential, two (2) closed residential and 2 closed non-residential files. Documentation in both residential and non-residential files reflected both individual and family counseling is provided regularly. Open and closed files are stamped with confidentiality statements and are kept in locked file cabinets.

A review of the residential group log substantiated that group counseling is provided a minimum of five days per week. Additionally, all 10 files reflect that there is coordination of services being provided through on site services and through referral. Service Plans/Goal Plans are developed around presenting issues and those that surface through the completion of the psychosocial assessment process. The plans are reviewed in accordance with agency policy and with QI standards. Case management activities are documented through chronological case notes which are present in each file. A review of the NetMIS data shows that the agency is compliant with follow up requirements.

Clinical reviews are conducted through weekly Treatment Team Meetings and documented in each file for all shelter youth. Further, YCC has a process in place where all youth files, both residential and non-residential, are reviewed at least monthly by a supervisor to ensure accuracy and completion of major documents regarding the services being provided. All psychosocial assessments and Service/Goal Plans are reviewed and signed by a clinical supervisor. Additionally non-residential cases are reviewed through quarterly peer reviews and documented on Quality Assurance Review Forms and maintained in the file. These practices were substantiated in the files reviewed for this indicator.

Staff meetings are held monthly and staff issues related to CINS/FINS services are addressed. The agency consistently displays compliance with major requirements and procedures outlined in the Florida Networkôs Policy and Procedure manual for CINS/FINS for this indicator.

2.06: Adjudication/Petition Process	Satisfactory Compliance

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by indicator 2.06. The agency has a written policy (2.12 Case Management Staffing) that addresses the case staffing process. This policy does not include the QI requirement to provide the youth and family with a new or revised plan for services.

Counseling services are provided on a consistent and regular schedule for the youth in both CINS/FINS Non-residential and Residential programs. A total of three (3) cases were reviewed

to assess the agency's performance regarding the requirements of this standard. Three files were reviewed for this indicator. All three cases were referred by the school system and case staffing proceedings were initiated by the assigned case manager. In each case, the family and committee members were notified of the staffing date and time within the required time frames. Case staffing recommendations were documented, signed by the committee members, placed in the client file and provided to the family in the timely manner required.

In two (2) of the files reviewed, some of the case staffing recommendations were added to the clients existing Service/Goal Plan at a later date after the case staffing. There was no evidence of the case staffing recommendations being added to the plan in the third case reviewed. While it was clearly documented that the case staffing recommendations were provided to the family, there was no documentation to support that a revised service plan was provided to the family as required.

On each of the case staffing committees, the required personnel was in attendance. No CINS petitions were recommended in the files reviewed for this indicator.

Standard 3: Shelter Care/Health Services

Overview

The Youth Crisis Center is located on a residential area of the City of Jacksonville. The Youth shelter and Administrative offices are co-located on the same site. The youth shelter is licensed by the Department of Children and Families (DCF) for twenty-two (22) beds and it primarily serves youth from Duval County, as well as youth from surrounding counties. There are a total of 8 bedrooms with four (4) on the male resident wing and 4 on the female resident wing of the facility. There are a total of thirteen (13) beds within the 4 male resident rooms, and a total of eleven (11) beds within the 4 female resident rooms. Each bed has an individual bed, bed coverings and pillow.

The shelter also admits youth from the Department of Children and Families (DCF) through other contractual funding sources. At the time of the quality assurance review, the shelter was providing services to nine (9) CINS/FINS youth on day one of the QI review and ten (1) youth on day 2 of the review. The shelter is designated by the Florida Network to provide staff secure services. The agency has two (2) staff members onsite that are Licensed Clinicians.

During the tour of the facility, the review team toured all major areas include sleeping rooms, kitchen, female and male bathrooms, dining area, medication storage area, recreation area, wash room, as well as other areas. All areas observed on the shelter inspection were found to be clean and in good working order. All major furnishings were in good repair. The maintenance staff members are primarily responsible for hygiene and cleaning of the shelter. The bedrooms were found to be clean. The outside grounds are surrounded with perimeter fence and residents have access to green space, volley ball, a covered sitting area and an open basketball court.

The day to day operation of the residential program are the responsibility of Darryl Matthews, Director of Residential Services. Mr. Matthews is supported by three (3), Shift Supervisors, one (1) Integrated Services Specialist, one (1) part time Registered Nurse and twenty-five (25)Youth

Care Specialists. Youth Care Specialists are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The residential programôs counseling services are managed by Aimee Green, Program Manager ï Family Link Program and three (3) Therapists.

3.01: Shelter Care Requirements	Satisfactory Compliance

The YCC Policy 3.02 ñProgram Orientationò covers all requirements for Orientation, Grievances and addresses all requirements for this indicator. The YCC Policy 3.03 ñGrievance Processò addresses all the required elements of indicator 3.01 in Standard 3. A total of nine (9) residential files were reviewed for compliance with Indicator 3.01. A total of nine (9) file were reviewed to assess this indicator. All 9 files contained a client file checklist that is utilized upon intake with the youth during orientation. The checklist contains the required program orientation components including a review of client rights and the grievance process. All 9 of these forms were signed by the youth, parent/guardian and staff. A copy of the youth handbook was provided to the review team. The hand book covers all the general aspects of Orientation that include Rights and Responsibilities, Appointments, Services, Point System. The parents are also provided with the CINS Brochure that includes the service options. The current handbook list Client Rights on page 13 of the youth handbook. All nine (9) residential files were reviewed and found to have evidence of meeting all Orientation Requirements.

At the time of this review, there were no grievances submitted to the agency in the last twelve (12) months. The client handbook that was provided to the review team also contains a description of the grievance process. The agency policy manual does address Orientation.

At the time of this review, there were no Staff Secure Youth admitted to the agency in the last twelve (12) months. The agency provided a written letter to the review team to confirm that it has not received any official Staff Secure Referrals.

The current policy requires that all youth admitted to the shelter and resident bedrooms be checked via visual observation and documentation every 10-15 minutes during sleeping hours. The agency uses an electronic scan gun to scan and track all bed checks. Each bed check is conducted by the Direct Care staff member. At the time of the onsite Quality Improvement review, 1 female staff member and 1 male staff are conducting bedroom checks per DCF licensing requirement. Evidence of documented bed checks were found in the overnight bed check log. Bed Checks indicate that checks are conducted within 15 minutes or less. The agency utilizes a camera surveillance system. The surveillance camera footage was dark in certain areas of the youth shelter. This created difficulty in reviewers being able to verify/confirm actual bed counts documented in the overnight or sleep log.

3.02: Healthcare Admission Screening	Satisfactory Compliance

The written procedures for this indicator addressed the referral process and follow-up medical care. Six (6) open residential files were reviewed. All files contained shelter admission form which is yellow and was filed consistently in all files completed on youthsôadmission date and reviewed by a supervisor. The form addressed all Department Juvenile Justice required elements.

3.03: Suicide Prevention	Satisfactory Compliance

The shelter had a written plan that outlined the suicide prevention and response procedures. A total of six (6) open files were reviewed. All 6 youth were screened for suicide risk. One (1) youth was Baker Acted. The file contained observations logs prior to the Baker Act. Upon the youthôs return to the shelter from Baker Act the youth was placed on constant sight and sound. The file contained the observations logs. The file contained the assessments of suicide risk.

Three (3) closed file were reviewed. Three youth were placed on constant sight and sound at admission. All three received an assessment of suicide risk which was reviewed by Licensed Mental Health Counselor. Two (2) youth were removed from constant sight and sound and placed on standard supervision. One (1) youth was Baker Acted. The Baker Acted youth did not return to the shelter. Two of the files contained supervision logs which documented constant sight and sound until the time of the assessment of suicide risk. One file did not contain a supervision log however the case note and logbook reflect the youth slept on cot in the day room area and was on constant sight and sound until the time of the assessment of suicide risk was completed.

3.04: Medications	Satisfactory Compliance

The agency had written procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. A local hospital funds a part time Register Nurse position. The shelter has a special alarm set to alert employees when it is time to administer medication. The shelter has implemented a process where two employees are required to conduct medications counts to ensure accurate medication count. There were four (4) CCC reports regarding medication errors. One (1) report was due medication administration and the remaining three reports were related to incorrect medications counts. The employee responsible for the medication error received remedial training and no longer works at the shelter at time of this review.

All medications are stored in a separate secure area which is inaccessible to youth. There were no injectable or topical medications on site at the time of this review however there are separate store bins designated for topical, injectable, and oral medications. There were no refrigerated medications on site at the time of this review however there is a refrigerator designed for medication only and was locked. There was one youth a controlled medication which was stored behind two locks. The controlled medication shift to shift counts were accurate. Three over the counter medications were randomly selected and the perpetual weekly counts were accurate. The end shift count for the controlled medication was observed and accurate. The shelter has a listing of employees which are authorized to administer medications. The employees have received the training regarding medication administration. There were no syringes or sharps on site at the time of this review.

The medication administration logs contained the youthsôname, allergies, and side effects. The start and stop dates for medications were clearly documented on the medication log. The medication log contained the youth admission date and time. The medication log clearly documented when a youth is off site for temporary release. The process was observed. The employees counted both the medications before giving the medications to the parent and clearly documented temporary release on the medication log. The medication logs contained full printed names of employees administering

medications. Employees and youths clearly initial each dose of medication. The youthsôpictures with

their birth date are kept in the current monthôs medication log book.

3.05: Medical/Mental Health Alert Process	Satisfactory Compliance

The agency has a written procedure to address medical and mental health alert process. The shelter maintained a large dry erase board with appropriate color to identify various medical/mental health conditions. The shelter has an alert system in place which ensures information concerning youthsômedical and mental health needs are documented and communicated to employees.

The alert system includes documentation in the logbook and an alert board. At the time of this review there were two (2) youth with medical alerts and one youth on special diet. The alerts are consistent in the logbooks and on the alert board. There is an additional alert board in the kitchen for youth with special diets. The logbooks entries clearly document when youth were placed on alerts with special instructions and when youth were removed from alert status.

3.06: Episodic/Emergency Care	Satisfactory Compliance

The shelter has a written procedure to address Episodic/Emergency care. In the past six (6) months four (4) youth were sent off-site for emergency medical care. In each case the parents and or family was notified. All four (4) events were documented in the logbook. All training files reviewed confirmed employees have current CPR and first aid certifications. The shelter regularly conducts medical drills. The knife-for-life and wire cutters are located in the master control area in locked box with number code access.

The shelter has one first aid kit located in the master control area. Additionally, the agency has first aid kits both transportation vans. Each first aid kit was examined and no expired contents were found. Further, each transportation van has emergency equipment that includes a window punch and seat belt cutter. At, the time of this review, the shelter had a knife for life. Staff members are also required to be trained on the location to use of the knife-for-life.

Overall Rating Summary	
Satisfactory Compliance:	**100%**
Limited Compliance:	**00%**
Failed Compliance:	**0%**