



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth Crisis Center

on 03/30/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

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

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services

Pamela Purnell, Residential Supervisor, CDS Family and Behavioral Health

Cyntoria Thomas, Program Manager, Thaise Educational & Exposure Tours

Crystal Westman, LMHC, Clinical Director, Arnette House

Gwen Nelson, Regional Monitor, Department of Juvenile Justice

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input checked="" type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input checked="" type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 3 Case Managers | 0 Maintenance Personnel | 1 Clinical Staff |
| 0 Program Supervisors | 1 Food Service Personnel | 0 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 6 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 7 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 12 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 12 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 3 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 3 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 6 # Other |

Surveys

20 Youth 11 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Founded in 1974, the Youth Crisis Center (YCC) located in Jacksonville, Florida provides short term residential shelter, non-residential services, transitional living services, outpatient behavioral health services and more. YCC contracts with the Florida Network of Youth and Family Services (CINS/FINS) program. Through this funding, the agency serves both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to youth who meet the criteria for Staff Secure Shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence and probation respite. YCC is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to runaway and homeless youth.

During the onsite visit, the CEO reported several accomplishments the agency has achieved since the last onsite QI Review in May 2016 as follows:

- YCC served 1,230 children, teens, young adults, and families.
- 96% of the children were reunited with their family upon discharge from services.
- 17,532 meals were prepared for children in the residential program.
- Expanded mental health services by providing onsite psychiatric services to include parents who may be in need of their own behavioral health services.
- Rebranded their logo and message to shift their focus from serving “at-risk youth” to caring for those affected by life traumas.
- YCC established new program opportunities with community partners with Cathedral Arts Project, DECA Club at Bartram Trail High School, Changing Homelessness, JASMYN (LGBTQ support system), Hope at Hand, Jacksonville University, UNF, Capella University, Bethune-Cookman College, Yoga 4 Change, Psych Ed Connections, Fun 4 First Coast Kids, Nova Southeastern, Jax Cares, Jaguars Foundation, Operation New Hope, community mental health agencies, Comfort N’ Quilters, Chick-Fil-A, First Baptist Church, and Police Athletic League.
- 100% of YCC employees donated to the global initiative, Giving Tuesday.
- Raised \$110,980 through charitable giving events.
- Four (4) therapists completed evidenced-based training which allowed for expansion in clinical interventions provided.
- Working on expansion service to provide shelter care, life skills training, and mental health counseling to homeless young adults ages 18-24 particularly those who identify as LGBTQ.
- Enhanced their treatment team approach for residential programming.
- Revised their behavior management system.
- Implemented screening process for suspected victims of sex trafficking.
- Enhanced supervisory opportunities by creating level systems for the residential program to include YCS II’s, Supervisors, Assistant Director and Director which has assisted in advancement opportunities by heightened accountability and supervision.
- Enhanced partnerships with outlying county judges for referrals for residential services for youth who are habitually truant (Clay, Baker, and St Johns).
- Added a non-residential therapist in St Johns counties due to the high demand for services.
- Revised the case staffing committee to ensure it is a robust system with resources from a variety of

stakeholders.

Standard 1: Management Accountability

Overview

Narrative

The agency has approximately sixty full-time, part-time and on-call staff members. The agency's background screening process is comprehensive. The training plan requires all staff members to complete core training topics. A review of twenty-two new staff and four volunteers required background screenings for the review period. The program had a total of twenty-nine CCC calls during the review period.

1.01 Background Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy and procedures in place for background screenings of all new hires prior to employment and prior to becoming an intern or volunteer. The program policy also addresses five year rescreening of employees and volunteers after the date of the initial background screening. The program maintains a file for each employee with a copy of the employee's background screening. The files were neatly organized and kept in a locked cabinet.

All staff interns and applicable volunteers must sign a criminal history acknowledgement form and an affidavit of good moral character form. All staff, volunteers and interns must receive an eligible rating prior to employment. Re-screenings will be completed every five years after the date of the initial screening. All screenings must be maintained in the human resources files. The program must complete the annual affidavit of compliance with good moral character standards form annually in January for all staff.

Since the last Florida Network review in May 2016, the program has hired twenty-two new employees and four volunteers. All of the staff and volunteer files had documentation of background screenings completed prior to employment or working as a volunteer with the youth population. A review of the program's staff/volunteer roster found no staff or volunteer required a five-year background screening.

The Annual Affidavit of Compliance with Good Moral Character Standards was sent to the Department of Juvenile Justice Background Screening Unit on January 10, 2017.

There were no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a policy and procedures for Provision of an Abuse-Free Environment. The policy lists all of the employee conduct and work rules. The program's code of conduct prohibits the use of physical abuse, profanity, threats or intimidation. Any infractions of the rules of conduct will result in disciplinary action, up to and including discharge of employment.

The agency is mandated by law to report all allegations of abuse/neglect to the Florida Abuse Hotline/Child Abuse Registry. Staff must notify parents/guardian of any report of abuse. Failure to report abuse is a second-degree misdemeanor. All staff members must acknowledge in writing they have read and understand the laws of reporting abuse. A copy of the acknowledgement is kept in the staff's personnel file.

The program provides an environment in which youth, staff and others feel safe, secure, and not

threatened by any form of abuse or harassment. All staff are required to acknowledge mandatory reporting of suspected abuse of a child, F.S. 39.201. A review of twelve personnel records found signed documentation of understanding of the abuse reporting obligations. The abuse reporting requirements are documented in the employee handbook and the program's operations manual. Observation of the Florida Abuse Hotline number was posted throughout the facility. A review of twelve personnel records indicated staff were trained on child abuse reporting. The program has a policy and procedures in place for the youth to file a grievance. All staff are trained on the program's grievance process. No grievance filed for the period being reviewed.

The program did not have any allegations of child abuse since the last review.

Twenty-three youth completed surveys. Twenty of twenty-three youth said they knew about the abuse hotline and reporting procedures. Twenty-two of twenty-three said staff were respectful when talking to them. Twenty-three of twenty-three youth said they have never heard staff use profanity. Twenty-one of twenty-three youth said they felt safe in the program.

There were no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures in place for Incident Reporting. All reportable incidents must be reported to the Department of Juvenile Justice Central Communications Center (CCC) within two (2) hours of the incident or within two (2) hours of becoming aware of the incident.

The staff/intern who observed the accident/incident or the first person to become aware of the accident/incident must verbally inform their supervisor/designee immediately and complete an internal accident/incidents report form. The supervisor/designee shall submit the completed form to the VP of Quality Assurance immediately following a review of the form. The incident must be logged in the progress notes, the professional log and episodic care log.

For the review period, the program had a total of twenty-nine reportable incidents. Twenty-seven of twenty-nine incidents were reported within the two (2) hours. Two incidents (201701003 and 201701070) were reported after two (2) hours of the incident or within two (2) of becoming aware of the incident. The program completed follow-up communication tasks as required by the CCC in order to close the case and to assure that the incident had been fully examined.

Exception:

There were two incidents of failure to report within the two-hour time frame.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures for staff training requirements. The program has a training plan that is updated annually. All direct care CINS/FINS staff (full-time, part-time, and on-call) shall have a minimum of 80 hours of training for the first full year of employment and 24 hours of training each year after the first year. Direct care staff in residential programs licensed by the Department of Children and Families is required to have 40 hours of training per year after the first year. Following the first year of employment, direct care staff training for residential staff should include refresher training on the use of available fire safety equipment, crisis intervention, training necessary to maintain current CPR and first aid certification and suicide prevention. The program has individual training files for each staff member.

Training addresses the fundamentals of management accountability in CINS/FINS programs. Required training for new staff within first 120 days includes local provider orientation, CINS/FINS Core, managing aggressive behavior, suicide prevention, sign/symptoms of Mental Health and Substance Abuse, CPR/First Aid, behavior management, understanding youth/adolescent development. New staff must complete the remaining training hours within the first year. This training includes title IV-E procedures, in-service component, medication distribution for non-licensed staff, ethics, confidentiality, trauma-informed care, PREA, fire safety, information security awareness, LGBTQ youth, and cultural humility. Direct care staff employed for longer than one year must complete 40 hours training from the above list. The training includes refresher classes in fire safety equipment, crisis intervention, training necessary to maintain current CPR and first aid certification and suicide prevention. The program maintains individual training files for each staff member, which includes an annual employee training hour-tracking form and related documentation such as certificates, sign-in sheets, and/or agendas for each training attended.

A total of twelve (12) training files-- four youth care workers, two supervisors, two administrators, and four therapists were reviewed for this indicator. Six (6) files were reviewed for the first year of training and six (6) files were reviewed for the annual training. Six files reviewed for the first year of training reflected each staff member had more than the required eighty training hours with 100, 82, 129, 135, 127 and 129. Six files reviewed for the annual training requirements of forty training hours with 60, 65, 42, 87.5 and 55.

The training files were organized. The trainings were listed by staff name, type of training, date of completion and total number of hours.

There were no exceptions noted for this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures in place for the Quality Improvement process. The program collects and reviews several sources of information to identify patterns and trends. The quarterly committee meetings include documentation from Quality Assurance, data entry reporting, human resources, facilities, finance, residential, clinical, and development. All reports have summaries of activities for the quarter and annual. The reports are presented to the management team. Findings are regularly reviewed by management and communicated to staff and stakeholders. The quarterly reports also include case record reviews, reviews of CCC incidents, youth's grievances, customer satisfaction data (annually), outcome data (annually), and monthly review of NetMIS data.

The procedure for analyzing and reporting information is a part of the program's continuous quality improvement process. The program collects and review data to identify patterns and trends in processes and programmatic areas. These areas include quarterly monthly, quarterly and annual reviews of case records, incidents/accidents and grievances, client satisfaction data, NETMIS data and medication management practice utilizing the Knowledge Portal or Pyxis Med-Station Reports. Report findings are reviewed and discussed at the quarterly Quality Improvement Committee meetings. QIC members are listed as President/CEO, Director of Programs, VP of Human Resources, VP of Quality Assurance, VP of Finance, Director of Residential Programs, and Director of Development.

The program utilizes the Quality Improvement Council (QIC) notebook to compile aggregated data and meeting minutes. The information collected are used to identify strengths and weaknesses, improvements are implemented or modified. Staff are informed of all changes or modifications through monthly and quarterly meetings and memorandum of changes or modifications. All-Staff meetings are a venue for all staff to give input and receive information of programs and services.

There were no exceptions noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures in place for client transportation. The program has a list of all approved drivers. The facilities department conducts bi-weekly inspections of all vehicles. The residential program has a total of four vans. All the inspections are documented on bi-weekly van checklist forms.

The ratio guidelines require one staff to six youth when transporting youth. The procedures list the following requirements for staff when transporting youth. The staff must ensure that the ratio of staff to youth are within the program's policy; same gender transporting youth, when possible; if same gender is not possible, the use of multiple staff of another gender, the use of other direct care staff such as a case manager, therapist or a relief staff of the same gender as the youth. Only approved agency drivers may transport clients in the program's vehicles. The program may utilize a third party (staff, volunteer, interns or other client) when transporting.

The vans are inspected annually by Motor Vehicle Safety Inspection Center of Duval County. The reviewer inspected the four vans for a vehicle emergency response box which includes the first aid kit, bloodborne pathogen kit, fire extinguisher, and safety triangles. All of the vans have working seat belts, no broken windows, and seat belt cutter/window punch.

The program requires prior notification and approval by management for single client transport. The program requires two staff to conduct transport if the staff to youth ratio is more than six youth. The program requires staff driving a vehicle to conduct a safety check prior transporting a youth. A review of the vehicle transportation safety checks log indicated safety checks are being conducted as required.

There were no exceptions noted for this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program's staff participates in the local Department of Juvenile Justice board and council meetings representing CINS/FINS. The Youth Crisis Center maintains membership and attends several community advocacy groups.

The Chief Executive Officer/designee meets with other agencies and groups to establish informal linkages and written agreements. The agreements include other prevention/early intervention programs, medical, educational, Mental Health/Substance Abuse and recreational and leisure organizations. All agreements are maintained by the CEO. The program must utilize staff and materials to increase public awareness. Project Safe Place is a program designed to assist youth in crisis providing a safe place for youth.

The YCC Quality Improvement Plan 2017 list sixteen community groups---Florida Network of Youth and Family Services, Changing Homelessness (Jacksonville's Emergency Services Homeless Coalition), United Way, DJJ Advisory Board, Jacksonville Children Commission, Jacksonville System of Care Initiative, Florida Department of Juvenile Justice's Bureau of Quality Improvement, Jacksonville Juvenile Assessment Center Board, Juvenile Detention alternatives Initiative, Nonprofit Center of Northeast Florida, Florida Department of Children and Families, Florida Department of Juvenile Justice Providers Meeting, National Safe Place, Clay County Action Coalition, Duval County Police Athletic League and Homeless Coalition of St. Johns County.

YCC is also involved in professional groups such as the National Association of Social Workers and Society of Human Resources Management. Management staff attends community meetings and provide the community with information on the services provided by CINS/FINS. The program representative collects information regarding community needs and the ability of the program to meet these identified needs that influences both long and short-term planning priorities.

There are staff members designated to attend certain community meetings. The program maintains minutes and support documentation of staff representative participation in community meetings.

There were no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Youth Crisis Center (YCC) operates residential and non-residential services to provide CINS/FINS services. The youth shelter has residential therapists under the supervision of the Clinical Director. The Family Link program has eight (8) Therapists and one intern. The agency routinely works with local colleges and universities to hire interns.

The program provides these services to non-residential services to Duval and metropolitan areas. The agency also provides these services in outer-lying counties that include Clay and Nassau. The agency also maintains on-going partnerships with local service organizations. YCC also maintains referral agreements to provide CINS/FINS services in the aforementioned Counties in the North Florida area.

YCC also performs Case Staffing meetings on an as needed basis to address identified problems and facilitate positive outcomes for both the youth and their family. The Case Staffing Committee can also recommend CINS Petitions to be filed in court to order chronic status offenders to participate in additional treatment services to assist and resolve serious non-delinquent issues.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The Residential program has a policy that will admit all youth to shelter who are runaway, throwaway/lockout, homeless, ungovernable, truant and/or a situation exists in the home that makes it unsafe for the youth to return/remain there. The non-residential program has a policy that requires an initial screening completed within seven (7) days of the client being referred. There is a process for centralized intake services including screening for eligibility, crisis counselling and information and referral. Once it is determined that the client is eligible for services, the program staff will the intake/assessment process. In addition, the operations manual that contains this policy was revised in 2017 and was signed by the CEO within the past year.

The program has a procedure that completes a screening/central intake form, checking for eligibility of client for both residential and non-residential. If a client is eligible for residential services the parents/guardians are informed of the necessary materials to bring with the client to the shelter. Information regarding school is also provided to the parents/guardians at this time. If the client is eligible for Non-Residential Family Link or Outpatient program, the information is sent to the Client Care Coordinator/Designee for review.

A total of eight (8) files were reviewed to assess this indicator which included four (4) residential and (4) non-residential.

All eight (8) files completed the eligibility screening either the same day as the referral for residential or within the seven (7) calendar days of referral for non-residential. All eight (8) files had documentation and signatures of the rights and responsibilities of the youth and parent as well as documentation via signature and date that the parents received the agency brochure.

Out of the four (4) residential files reviewed one (1) client was referred from the case staffing committee to go to the shelter.

There were no exceptions noted for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy (Operations Manual) that states that an assessment begins during the admission process of both residential and non-residential intakes.

The program has a written procedure also in the Operations Manual that states the therapist will meet with the youth and/or family in order to gather information to complete the assessment for residential clients. This is to be completed within 24 hours of admission into the shelter and to be signed off by the Director of Programs or Director of Programs designee within 72 hours. Non-residential clients' assessments needs to be completed no later than the third face to face contact following the initial intake. The non-residential assessment must be signed by the Director of Programs or Director of Programs designee within seven (7) days of completion.

A total of eight (8) randomly selected files were reviewed for this indicator. The client files reviewed included four (4) residential-- two (2) opened and two (2) closed-- and four (4) non-residential-- two (2) opened and two (2) closed.

All four (4) of the residential files had a Needs Assessment initiated and completed within 24 hours of the youth's admission.

All four (4) of the non-residential files had a Needs Assessment initiated at date of intake and completed within three (3) face-to-face contacts.

All eight (8) Needs Assessments were completed by a Bachelor's or Master's level staff and signed off by a Licensed supervisor.

Four (4) out of the eight (8) files identified with an elevated risk of suicide. The youth was referred for an assessment of Suicide Risk which was completed and reviewed by a Licensed Supervisor.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy (Operations Manual) for service plans, referred to as Goal Plans, are to be developed with the residential youth and family within 24 hours of meeting with the therapist and no later than the third (3rd) face-to-face session for non-residential clients.

The program has a written procedure (Operations Manual) for goal plans that are individualized to the client based on needs of the client/family as identified in the assessment process. The plans are developed and revised over time as according to presenting issues and potential completion of initial goals. Goal Plans for residential clients are developed within 24 hours of admission. The plan is reviewed and signed by a supervisor within 72 hours. Non-residential Goal Plans are to be completed no later than the third (3rd) face-to-face session and signed by the client and parents either written or verbal, and signed off by the supervisor.

The Goal Plans has individualized and prioritized needs and goal(s) identified by the Needs Assessment as well as service type, frequency, location, persons responsible, date when plan was initiated, target date for completion and actual completion date, signature of the youth, parent/guardian, counselor and supervisor.

A total of eight (8) files were reviewed for this indicator which included four (4) residential-- two (2) opened two (2) closed-- and (4) non-residential-- two (2) opened and two (2) closed. All eight (8) Goal Plans were completed within seven (7) working days of the assessment. All the eight (8) files had the following requirement completed service type, frequency, location, persons responsible, target dates, signature of youth, counselor and supervisor, and initiated date. One (1) of the residential goal plans was missing a parent/guardian signature, but showed evidence of trying to get parent signature.

There were no exceptions noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy (Operations Manual) that states the case management is a process of service coordination that has a therapist assigned to follow the youth's case and ensure delivery of services through direct provision or referral.

The program has a written procedure also in the Operations Manual that coordinates and monitors the youth's goals, progress of youth and family, out-of-home placement, referrals to case staffing, recommendations to the court, attending hearings with the family and youth and any referrals and follow-up after discharge with the youth and family.

A total of six (6) randomly selected files were reviewed for this indicator. The clients' files reviewed included five (5) non-residential charts and one (1) chart that was both residential and non-residential. All six (6) files had counselor/case manager assigned, referrals were stabilized, service plan implemented, case staffing documenting and recommendations, youth/family progress was monitored and support was provided to the families and youth case staffing.

A total of four (4) clients had out-of-home placements, three (3) of which were placed in the shelter and one (1) was placed in a substance abuse facility.

There were no exceptions for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy (Operations Manual) that states youth and families will receive counseling services to help obtain their objectives on their Goal Plans. Residential clients will receive group counseling five (5) days a week.

The program has a written procedure (Operations Manual) that all client files will be marked confidential and will maintain chronological progress notes. The non-residential program provides intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of-home placement, and provide aftercare services for youth returning home from shelter.

A total of eight (8) files were reviewed for this indicator; four (4) residential-- two (2) opened and two (2) closed-- and four (4) non-residential-- two (2) opened and two (2) closed. All eight (8) files received counseling services in accordance with the case/service plan. They also were provided individual and family counseling when available and group sessions for residential clients. All eight (8) files had in-depth documentation that make reading the notes easy and understandable.

There were no exceptions noted for this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has policy in place that aligns with the requirements of this indicator.

The Case Staffing Committee Meets twice a month. Committee members are notified or reminded of Case Staff Meetings within 5 working days prior to meeting.

The therapist will submit a request to the Case Staffing Committee Chairperson to schedule a case staffing.

The family will be advised within 5 working days either by certified mail or hand delivered letter of the date and place of the case staffing and will request to attend with their child.

A copy of the Case Staffing letter will be placed in the client's file. The Committee consists of a DJJ representative, youth and guardian(s), CINS/FINS representative, mental health representative, and State Attorney's Office representative. The chairperson will give a written recommendation for immediately following the staffing.

Staff will document all client's progress notes.

This reviewer reviewed one file. Youth was brought in on 3/7/2017. Case Staffing Committee meeting happened on the same date 3/7/2017. Parents, Therapist, and Chairperson signed off on the recommendation form youth refused. Other attendees included representatives from DCPS, JSO, DJJ, SAO, and other various agencies.

There were no exceptions noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy in place for this indicator. The program maintains confidential records for each youth.

All youth receiving services have a confidential client file. Their file begins immediately following acceptance into the program. Each file contains all documentation accumulated from intake to discharge. Every case file is clearly stamped "Confidential and Privileged Information for Professional use only".

This program has a written policy in place for this indicator. The program maintains confidential records for each youth. Filing and storage rooms are separated per open versus closed youth. Case managers interviewed, reported that each case manager has a lock box for transport. Per audit observation each

manager has a personal office at their designated program's facility where they have a locked file cabinet.

Eight closed files were reviewed for this indicator. All client files reviewed were marked "confidential". All file records were maintained neatly and orderly.

There were no exceptions for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Youth Crisis Center is a large modern residential group care facility. The shelter operates a thirty-four (34) bed program. The shelter is well staffed and maintains proper staff to youth supervision ratio. The residential facility has separate male and female quarters with two (2) levels on each side. The building is equipped with 2 school class rooms, library, common areas, cafeteria and an intake room. There are daily activity calendars posted in the shelter and they include social, educational, spiritual and recreational activities. At the time of this on site quality improvement program review, the agency has emergency equipment such as fire extinguishers, knife for life, first aid kits, wire cutters and 2-way radios.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy stated that the attached buildings and grounds must be clean, landscaped and well maintained as well as the furniture in good repair.

The program ensures the policy is met by having the staff report any identified unsanitary conditions and/or items in disrepair. If staff has the ability to correct the issue, they can but if they are unable to they can get the condition addressed by filling out a Maintenance or Safety Hazard Report/ Request form which is sent to the Facilities Department.

The program met the requirements for this indicator. The facility is beautifully maintained and appears to be a fairly recent construction. The interior is nicely decorated with calming colors, warm themes and all furnishings are in good repair. The youth's area has more age appropriate decoration in their living areas. The grounds are free from debris and well landscaped.

All required licenses are up-to-date including the Health Department through 2018 and the Fire Inspection through February 2018. The program is licensed for thirty-four youth and they have sufficient room to accommodate the youth on four separate wings that are broken down by Level 1 and Level 2 females and Level 1 and Level 2 males. Furthermore, the facility has two observation rooms for youth who are brought into the program in the middle of the night and youth who are on sight and sound. All youth on Level two have a single room and the youth in Level 1 share a room with another youth in the program with each bed being identified with the letter A or B nicely painted on the wall over the identified bed.

All of the youth's bedrooms are clean with nice comforters on the bed. The bathrooms are clean and able to accommodate multiple youth at one time as there are multiple toilets in each bathroom and two showers in each bathroom area. The program's kitchen is large and commercial grade and is extremely clean and organized. The Laundry facility utilizes multiple commercial grade washer and dryers and is extremely clean and organized. There is a school located on the premises and is clean and organized with furnishings in good repair.

The Direct Care Staff area is centrally located in the middle of the male and female wings and the desk is positioned to look directly into the two observation rooms if they were to be utilized. There are two boards the staff utilize, one to identify the "Special Needs Population" and one for General Population.

Finally, the youth are afforded the opportunity to get at least one hour or more of physical activity either in the Club House, at the Park or on the facilities open field. The youth do have a copy of their Daily Schedule posted so they are aware of their structured time and activities. The program does provide Faith-Based activities every Thursday for the youth as a local Minister comes in and as he has done for the last 15 to 20 yrs providing the youth with different "Faith-Based" experiences. The agency met the requirements with no exceptions.

There were no exceptions are noted for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

It is the policy of YCC to provide orientation to youth immediately upon admission to the program or no later than 24 hours from admission.

To ensure the implementation of the policy, the staff will offer the client an Orientation Handbook and review the Client Orientation form.

The agency has a detailed Program Orientation policy that meets the general requirements of this indicator. The agency utilizes a 17-page handbook that is very detailed and provides a complete overview for the youth regarding program expectations, rights, daily operations and the grievance process. Five files were reviewed and all 5 files had the parent's signature consenting to services. Every youth underwent the orientation process.

Exception:

One of the youth did not sign her Orientation Form until 3 days after intake.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that demonstrates the goal to protect youth through a classification system that ensures the most appropriate unit assignment and sleeping room assignment.

To ensure the most appropriate sleeping arrangement, the agency interviews all staff upon intake to increase staff's awareness of classification issues.

The program meets the requirements of this indicator. The program has a clear process for room placement. Upon entry into the program, the youth are asked a series of questions that aids the staff in room placement. The program captures information about the youth's history, sexual orientation/gender identity, propensity for violence, current attitude, history of sexual assault or misconduct and demographics. With this information, staff determines if the youth will be placed on Level 1 or 2 on the male or female wing.

Exception:

Out of 5 files reviewed, 3 files did not have the room number assignment filled out on the Admissions Form.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

YCC's Log Book Policy states that the agency will maintain a permanently bound logbook with sequentially numbered pages to chronologically record the program events. The professional log book is used to record routine information, emergency situations and any incidents, especially those that affect the safety and security of the program.

The Youth Crisis Center ensures that their policy is followed by sectioning their Log Book down into three different columns. The first column is the date and time, the second column is the contact code and the third column is the narrative. In the event an entry is late, the staff is to identify the entry with "LE" for late entry and then enter the note with date and time.

The agency has a detailed log book that is in keeping with its policy and procedure. The book has an extensive guide outlining all of the books codes and their meanings and staff are diligent in using the codes on a consistent basis. The reviewer observed a consistent pattern of the staff following the Policy & Procedures as outlined by the agency by using brief narratives that captures emergency situations, incidents and safety and security issues in the program.

Direct Care Staff consistently signed in and out of the log book as well as reviewed the last 48 hours of entries. Additionally, it was observed by this reviewer that Supervisors reviewed the log book on at least a weekly basis. The one error that was seen in the log book had a single strike through it and was initialed as per policy. It should be noted that the Policy states all entries will be made in black ink but Supervisors regularly used red ink to document their entry of review.

There were no exceptions noted for this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The Youth Crisis Center has a policy that utilizes the point system which helps to foster accountability and compliance with the rules, expectation and consequences of the program. This is a part of there goal setting procedure.

Each youth per admission are informed of the Points System process. The more points a youth earns the more privileges they receive. Points are documented on the Points Tracker in youth's file every day and rewards are given at the end of the week.

The agency has a "Behavior Management System" policy in place that states the shelter uses a "Behavior Management System". Their system is called the Points System. The point system allows the clients to make choices in what and how they will perform their daily task. The behavior management system is based on a point system that tracks points from 0 to 104 per day per youth tracking behaviors. The behavior management system explains the expectations of how to earn points during the day. Depending on how many points have been earned throughout the day will determine the level the youth is on for the next day.

The behavior system has a total of 3 levels. Level 1 (0-61 points), Level 2 (62-74 points) and Level 3 (75-104 points). The points are displayed for the youth to see in both the male and female hallways. An updated monthly calendar is displayed with activities the youth can achieve with gaining points during the week or month. Youth are told of the points system during orientation and sign off on it per admission into the program. Staff are taught how to document and reward youth their points during orientation and keep track of points on Daily Point Tracker Sheet per youth files reviewed. Rewards vary from TV privileges Board Games (Level I), Video Games DVD movies (Level II), Offsite Activities Movies Request (Level III).

It has been noted that staff tries to implement strategies for any youth that may be struggling with taking them for a walk outside, having the youth get some space. The point system provides rewards, privileges, and natural/logical consequences. The behavior plan covers bed-time to wake-up, chores, table manners, school participation, respectful language, and shower/hygiene time. A binder for both the males and females was reviewed regarding daily points for the youth on-site, the point sheets are also placed in the youth charts which was reviewed for 4 charts; 2 open and 2 closed charts.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

It is the policy of this program to maintain a staff schedule to ensure staff coverage across shifts. The program maintains a 24-hour awake supervision of residents, which include a staff to client ratio of 1 to 6 during waking hours and community activities, and a ratio of 1 to 12 during sleep hours. Additionally, staff observe youth at least every 15 minutes while they are sleeping in their rooms, or during a period when the youth are in their room due to illness, quietly reading or writing or when the youth is allowed to be in his or her room during non-sleep times.

The agency ensures they meet this requirement by having the shift supervisor or designee develop a staff schedule to ensure proper staff to client ratio is maintained. A weekly staff schedule will be posted in the Youth Care Worker Station and all schedules will be maintained for at least one year. Additionally, a call list is maintained in the event a scheduling problem arises, staff can be called in. To ensure the safety of all clients, staff checks the youth every 15 minutes during sleep time, every 10 minutes if the youth is on sight and sound and does a check of every room during the night regardless if it is assigned to a youth or not. All checks on the youth are documented in either the Sleep Log or the Log Book. The practice of the program if at all possible is male staff supervising male clients and female staff supervising female clients.

The Program met the requirements of this indicator. Random selections of weekday and weekend log book entries were reviewed to ensure youth to staff ratio is met. The program log book was reviewed as well as the posted schedules and it was determined that the program was exceeding staffing youth ratios. The program has identified staff on each schedule to be called in in the event a scheduling problem occurs. If there is still a staffing issue, supervisors will come in for coverage.

The agency is equipped with a new surveillance system that captures and retains footage for 30 days.

There were no instances found where the agency didn't meet the male/female ratio-- the 1 to 6 ratio during the day or 1 to 12 ratio during sleep time. It needs to be noted that there was one finding upon review of the bed checks. On 2/5/17 a female staff documented that she did a bed check at 1:45 am, 2:00 am and 2:15 am; however, upon review of the footage, she actually completed bed checks at 1:48 am and then 2:16 am.

There were no exceptions noted for this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has its Special Population policy indicated in the Operational Manual.

Youth Crisis Center provides Domestic Violence Respite services for appropriate special population cases. In addition to youth residing at YCC for temporary respite periods, the client's family will have access to specialized therapeutic respite services. Length of stays are no greater than 21 days but vary due to court appointment or needs assessment.

Each youth identified under The Domestic Violence Respite program had a current arrest for Domestic Violence. Three (3) charts were reviewed. Of these 3 cases, all cases were discharged from the Domestic Violence respite program and opened in the CINS/FINS program (which was reported as a common practice to provide longer term care to help obtain the goals). Of the 3 files reviewed, none exceeded a 21 day length of stay in Domestic Violence Respite program. All three (3) cases included case plan goals targeted at reducing the re-occurrence of violence in the home. All three (3) cases were consistent with all other general CINS/FINS program requirements.

Staff Secure - This reviewer asked for a list of clients for staff secure for the past 6 months. The agency reported 1 staff secure for the past year, none in the past 6 months. Client was admitted September 2016 and released October 2016. Clients length of stay totaled 30 days. Youth was court ordered to YCC up to 90 days due to flight risk at previous shelters. Youth didn't successfully complete program due to absconding from the shelter.

Probation Respite - This writer asked for a list of clients for probation respite for the past 6 months. The agency reported that they had one client for probation respite within the past 6 months. Client length of stay totaled 21 days. Client's paperwork had all required documentation from DJJ/DCF. All objectives of goal plan were completed.

Domestic Minor Sex Trafficking - This writer asked for a list of clients for domestic minor sex trafficking for the past 6 months. One sex trafficking charts was reviewed. Client was discharged from Minor Sex Trafficking program and opened in the CINS/FINS program. Client's case plan goals targeted monitored communication and counseling until the client was released from program. Client length of stay totaled 59 days but appropriate documents of case management was given to justify this extended time.

There were no exceptions noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

YCC does have a camera policy. The agency has a security camera system to monitor staff interactions with youth, activities and events and ultimately the safety of their facility.

The agency recently acquired a new monitoring system with sixteen cameras capable to store video for a minimum of 30 days recording date, time and location. There is written notice that is posted at the front of the facility that lets the public know that the premises is under video monitoring. The cameras are located on the interior and exterior of the building and are centrally located in plain view to the public. The agency has 3 designated staff that can access review of the video surveillance system for third party persons as well as review for supervisory purposes. There are no cameras in the sleeping or bathroom quarters. It should be noted that the system is not operational during power outages as it is not on the facilities backup generator. Supervisory review of video is conducted a minimum of once every 14 days and noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts.

Exceptions:

Back-up capabilities do not consist of cameras' ability to operate during a power outage.

Agency policy notes videos are to be reviewed by the Director of Residential Services or designee monthly or as needed based on any incidents; while the requirement is review of video shall be conducted a minimum of once every 14 days.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The agency conducts health and mental health screenings to determine eligibility and presence of current and past mental health status risks. In addition, the agency has an active suicide risk screening process. The agency also has numerous master level counselors that complete the assessment of suicide risk to determine the youth's level of risk.

The residential program uses a general alert board to inform all staff members on each shift of the health and mental health status of all residents. The agency provides assistance to all youth admitted to the program that require medication. The agency provides medication distribution training to select direct care staff members. The agency does provide all staff with first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that is named Health Care Admission Screening. The policy was last reviewed and updated by the agency's Chief Executive Officer on March 27, 2017. The policy was developed to ensure that youth admitted to the shelter have no medical health condition of a nature that renders admission unsafe from a medical standpoint. The policy contains a basic definition explaining its purpose and the general principle. This review of the policy resulted in an opinion that the agency's policy in this area meets the general requirements of this indicator. The agency has an additional related policy called Medical Health Follow-Up. The policy is designed to ensure staff seek guidance for conditions, that warrant guidance from the parent/legal guardian or health care professional.

The agency's procedure indicate the agency staff members must complete a physical health screening for all clients upon admission to the residential program. The screening information is located on the Admission form. The admission form requires staff members to ask screening questions and for evidence of acute health conditions and also conduct observation of evidence of any illness and/or symptoms. The form screens for a vast array of health issues and lists those accordingly.

Further, the procedures require that if the screening indicates the client has a health or medical health condition of a nature which render admission unsafe from a medical standpoint, the agency must take certain action steps to address the possible health issue. The procedure also requires that the agency include any positive answers directly into the client's progress notes. When screening is completed, the agency must refer to the sections on the medical follow-up and mental health alert processes for additional requirements.

Any client with visible pains or problems with sustaining program activity may be denied admission until medical clearance is granted and documentation is provided. The procedure also allows them the right to refuse a child for health-related issues due to the potential liability of the youth and others while in the program. Follow-Up policy requires that staff notify a shift supervisor of any youth that are admitted with specific conditions.

A review of eight (8) active client files was conducted onsite to determine agency's adherence to the requirements of this indicator. Each file contained evidence of a health screening form called a YCC Admission Form. This form is in subsection 6 under the Intake tab in the 3-ring client case file. All 8 client files has evidence that the Physical and Health Screening section is completed as required. All 9 general health questions, as well as an additional 9 health symptoms were documented as being completed. All files were organized in a uniform manner. There were examples of the registered nurse documenting when a the Health Admission Section of the client file was reviewed by a licensed nursing staff member.

There were no exceptions noted for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that is named Health Care Admission Screening. The policy was last reviewed and updated by the agency's Chief Executive Officer on March 27, 2017. The policy is a written description that includes a plan for mental health/suicide risk and substance abuse screening, a Risk alert process, mental health and substance abuse services, suicide prevention procedures and mental health, crisis intervention and emergency response procedures for clients in need of these types of services. The governing principle of the policy is to ensure that prevention and intervention methods are applied to the children in care by agency staff members through in-depth procedures on how to prevent crisis. This review of the policy found that the agency's policy in this area meets the general requirements of this indicator. The agency's suicide assessment has been approved by the Florida of Youth and Family Services. The agency's current suicide risk policy has not changed since the last review conducted in May 2016.

The second section is titled one-to-one supervision. The agency has a total of three levels of supervision. The first level of supervision is called standard supervision. The second level of supervision is called sight and sound supervision. The third level of supervision is called one-to-one supervision. Sight and sound supervision requires the resident to be within the sight and within sound of staff at all times. One-to-one supervision requires that the resident be no less than 5 feet of an assigned staff member at all times.

The agency is required to screen 100% of all residents admitted to both the residential and non-residential CINS/FINS program. The agency is required to train all direct care and counseling staff to screen all admitted clients for any past or current suicide risks. The agency screens for suicide risk primarily through the use of two agency forms. These forms are called the Screening Admission Form for Residential Clients and the Needs Assessment for Non-Residential Clients. Other associated forms for suicide risks include the Observation Log, Follow-Up Assessment, Client Safety Contract, and Request for Discontinuation of Suicide Precautions and Observation Form. All youth are required to be screened no later than 24 hours after being admitted to the shelter. All assessments are to be completed only by counselors under the supervision of a licensed clinician. All assessments must be completed no later than 72 hours from the screening.

A review of seven (7) randomly selected client files was conducted by the reviewer. Of the files that were viewed, a total of five were closed cases two were open client cases. All cases were from a sample cohort of clients in the last six months. Each file reviewed contained a yellow intake form that contains the rescreening section to assess the past or presence of suicide risk. The rescreening form includes two sections. One section is titled sight and sound screening.

There is evidence of completed intake forms. The forms are completed by direct care staff and reviewed by a supervisor. There was evidence of three of the seven cases being reviewed by a registered nurse. Seven cases have evidence of a completed risk screening that indicated a positive result for either sight and sound status or one-to-one status. All 7 files contained screening results that were reviewed and signed. A total of 5 cases had evidence that the resident was placed on sight and sound. A total of two cases had evidence that they were placed on one-to-one supervision status.

All 7 cases had evidence that residents had been placed on observation checks in a timely manner. Observation checks contained evidence of timely checks being conducted by direct care staff that included observations of the time, behavior, and initials of staff member conducting the check within the

required time period of 30 minutes or less intervals. The agency completes our observation checks every 15 minutes during the week hours and every 10 minutes during sleeping hours. Observations in the agency Pro Log of each resident being placed on sight and sound or one to one supervision status are documented. In addition, times when youth were removed or discontinued from the original placement status were also found.

All 7 client files reviewed contained documented evidence of each assessment being completed by a Masters level staff member under the supervision of a licensed clinician. Each person had 20 hours of assessment training under the supervision of a licensed clinician.

Each client file review had evidence that the established supervision level had not changed or been reduced until a licensed professional or non-licensed under the supervision of a licensed professional completing the assessment reviewed it. The agency has Discontinuation of Risk Level form that is used to either step down or remove the resident from their current supervision level.

There were no exceptions noted for this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a medications policy called the Youth Crisis Center Medication policy. The policy was developed to provide a safe, secure and effective medication distribution process and system that includes storage, access, inventory, and disposal of medication. The policy has all the general requirements to ensure that the agency has safe storage, access, inventory, and disposal of medication that meets the general requirements of this indicator. Policy was last reviewed by the agency's chief executive officer and was signed and reviewed on March 27, 2017.

The agency has a procedure that outlines how the agency will execute the process of safe storage, access, inventory, and disposal of medication. The agency requires all medications to be stored in the Pyxis Med-Station 4000 medication cabinet. The agency must store medications and ensure that they are not accessible to residents of the residential group care facility. The agency must maintain a minimum of ten (10) trained key staff to use and operate the Pyxis medication cabinet. The procedure also requires medications to be stored separately from topical medications. The agency must also have a refrigerator where they can store medications that require refrigeration in a secure manner. Medication must be stored behind two (2) locks. Any sharps must also be secured in the designated area. Access to medication must be limited. Medication inventory must be conducted every shift for controlled medications. All other medications including prescribed medications must be counted on the medication form by the third shift on the dates designated in gray area on the medication form. Perpetual inventory must be documented and maintained when given.

Documentation of medication distribution must be made on the medication log. Periodic medication inventory counts must be initialed by Tuesday. The agency must conduct weekly inventories of sharps and all non-controlled prescribed medications. Sharps must be counted once a week. Over-the-counter medications may also be counted once a week.

Non-controlled prescribed medications must be documented daily in the medication form by the third shift on the dates designated by the light gray areas on the form. Documentation must be marked for each time a medication is given as well as once a week on the third shift.

Medication disposal must also be conducted once a child is discharged and the child's parent or guardian fails to take custody of the child's medication. The agency staff must document that following the discharge, any and all attempts to contact the parent/ legal guardian to pick up the medication. Medication

that has not been picked up for seven (7) days from the client's departure must be disposed of. There must be a witness to the disposal. All disposals must be conducted by a manager and a witness to conduct and document inventory of the medication being disposed of. Disposal of the medication is to be done by flushing the medication down a staff toilet.

Policy also includes steps to distributing medication by appropriate staff. All medication must be documented on the medication distribution mark form. Staff must document missed client's medications. Staff must report all refusals and/or missed medications and/or medication errors to the Florida Department of Juvenile Justice's (DJJ) Central Communication Center (CCC).

This reviewer identified where medications are stored. Medications are stored securely in a locked room inside a locked Carefusion Pyxis Med-Station 4000 medication cabinet. All medications in the shelter were found to be stored in the MedStation cabinet. The cabinet is not accessible to the residence unless they are accompanied by an authorized staff person. The room is only accessible with a key. The agency maintains a total of 10 super users. The agency has more than twenty (20) trained regular users. All medications including controlled, prescribed, and over-the-counter medications are stored separately. All medications are stored in their own cube in a medication cabinet drawer that is inside the medication cabinet. The facility does have a medication specific refrigerator. All medications that require refrigeration are stored in the secure refrigerator. There is a thermometer located inside the medication specific refrigerator that reads the temperature is between 36 and 46°F for storage purposes.

Controlled medications are stored in the cabinet. All controlled medications are counted three times a day. All shift-to-shift counts must be conducted with a witness and include one person coming off a shift and one person coming on a shift. Each person was found to have documented shift-to-shift counts as required. All medication is stored in its own cubicle in the drawer and the drawer was accessed as required to verify this requirement. Perpetual inventory with running balances were documented for all controlled substances.

The agency uses a medication distribution log to document all medication distributed in the shelter.

Evidence was found that medication distribution logs were completed by both non-licensed and licensed staff as required. There are weekly and monthly reviews of the medication management practice. The agency is familiar with the Carefusion Knowledge Portal and process in which to produce instant reports.

At the time of this onsite review, the reviewer found that the agency had a total of three registered nurses on their staff roster. When the nurses are on duty, all medication duties are conducted by the respective nurse. All trained persons are required to resolve medication discrepancies that have occurred prior to the close of the work shift.

A review of a total six (6) open client cases found that all client files included confirmation of verification of medication. All 6 client files had evidence of medication logs that had all sections completed. All 6 files contained client pictures, parent consent forms, medication information and side effects information. The client sharps log captured evidence of weekly reviews of sharps. The sharps are also counted each day on the third shift. In general, the onsite medication documentation process in the medication logs used by the agency meets the requirements of the Florida Network of Youth and Family Services medication management policy.

The agency has a total of 3 part-time Registered Nurses. The nurses are assigned on the morning and evening work shift when clients are required to received their medications. The reviewer observed one of the RNs administer five (5) clients their medications on the morning work shift. These medications were distributed as required with no observable issues. The Registered Nurses also review the CareFusion Pyxis MedStation 4000 for all discrepancies when they are on duty. Nurses and supervisors also review Knowledge Portal on an as needed basis to review the trends for medication distributed in the last month, quarter and other designated periods of time.

Exception:

There were a total of two (2) medication errors that were documented to have been reported. One

medication error that occurred in October 2016 was a missed medication and the second incident occurred in December 2016. The corrective action on the first incident consisted of a re-training with the staff member involved. The corrective action taken by the agency was found in each incident. In one case the staff member was re-trained by the registered nurse and the documentation was found attached to the incident and in the file accordingly. The second incident involved the agency taking action to terminate the employment of the staff member due to this incident, as well as that staff person's overall work performance.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a medical/mental health alert system in place that includes information related to the youth's medical condition that include allergies, common side effects of prescribed medications, food and medication and conditions or other permanent treatment information. The current policy was last viewed on March 27, 2017. Goal of the policy is to ensure that staff are provided sufficient information and instructions that provides the opportunity for them to recognize and respond to the need for emergency care and treatment.

The procedure requires all staff to be trained to conduct a physical and mental health screening using the admission form at the time the client enters the program. The staff policy indicates that staff member must alert all other staff on any client with a physical medical or mental health concern. Staff can document in the file and in the professional log.

Staff are required to use codes. Staff can highlight special needs as well. Staff can use initials for special needs. Staff can alert others by using the code on the census board to indicate a client has a special-needs condition. If the client does not have a special-needs condition, there is no marking to be used on the general alert board. The client general alert board is also called the census board.

In general, the staff are to indicate conditions that include medication, any general allergies, any food allergies, or medical conditions. Clients are also required to document any high risk for suicide. It is a part of the alert process. All staff are required to be trained in CPR, standard first aid, signs and symptoms of mental health conditions, substance-abuse, proactive intervention, and crisis intervention and risk assessment. These trainings require staff to know how to recognize and respond the need for various types of emergency care.

The agency provided access to both open and closed files over the last six (6) months. A random selection of seven client files was conducted to test the agency's adherence to this indicator. Of the seven files, all files contained the required screenings related to medical, health, mental health, allergies, food allergies, and/or any type of behavior or mental health risk. All client files were found to be organized in a clear manner and all risks associated with each client were clearly identified and marked. Four (4) open cases out of six contained evidence that the clients' current medical and mental health status were clearly marked in both the client file and on the agency's census board.

There were no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy related to episodic emergency care. The policy was developed and used in their processes and procedures that are in place for episodic emergency care so staff can adequately respond

to routine and non-routine care. The policy provides a process for providing emergency care that includes training to staff, awareness, and proper response for various types of emergency situations. The policy was last reviewed by the agency and signed in March 2017. The agency has made no major changes to the policy since the last review occurred in May 2016.

The agency's procedure requires that they have specific equipment that includes first aid kits and emergency equipment. The agency must also conduct emergency drills. The agency must also post emergency numbers. The agency must also be prepared for any type of episodic emergency that can occur on a daily basis that includes severe physical pain, acute dental pain, and conditions in which the severity of the illness or injury is known. The agency is required to provide basic first aid and to intervene and provide an appropriate emergency transfer when indicated.

The agency is required to maintain an episodic or first aid/emergency care log. The agency is to provide emergency care by calling 911. The agency is to be prepared to provide CPR. The agency is required to notify the parent or guardian of the situation and where client was transported to receive medical treatment outside of the agency. The agency is required to report the incident and record on the internal accident/incident report form. The agency is also required to inform all staff of environmental stressors that include inclement or severe weather.

A total of eight (8) episodic emergencies had been reviewed. Four (4) of them had all the correct documentation in order for both the care log form and in the Internal Accident Report log book.

On 11-4-2016 for a residential client, the Internal Accident Report Form and CCC report was completed, but it was not documented on the care log form that this youth went to the Hospital. On 12-6-2016, missing was the hospital discharge summary in the Incident Accident Report/CCC binder. On 12-25-2016, missing were all the information on the Care Log Form.

There were no exceptions noted for this indicator.