Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Capital City Youth Services

on 04/11/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability

Indicator	Rating
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 2: Intervention and Case Management

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

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

Standard 3: Shelter Care

Indicator	Rating
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	Limited
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory:87.50%
Percent of indicators rated Limited:12.50%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services

Indicator	Rating
4.01 Healthcare Admission Screening	Limited
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:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:92.59%
Percent of indicators rated Limited:7.41%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

Rating	Definition
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

Marcia Tavares, Lead Reviewer, Consultant Forefront LLC

Shawn Block, CINS/FINS Shelter Program Administrator, Anchorage Children's Home of Bay County

Jessica Fansler, Contract Management Specialist, Florida Network of Youth and Family Services

Sherri Swann, Clinical Director, Lutheran Services Florida NW

John Robertson, Program Services Director, Florida Network of Youth and Family Services

Persons Interviewed

- [x] Chief Executive Officer
- [ ] Executive Director
- [x] Chief Operating Officer
- [ ] Chief Financial Officer
- [ ] Program Director
- [x] Program Manager
- [ ] Program Coordinator
- [x] Direct- Care Full time
- [x] Direct-Care Part Time
- [ ] Direct-Care On- Call
- [ ] Volunteer
- [x] Intern
- [ ] Clinical Director
- [x] Counselor Licensed
- [ ] Counselor Non- Licensed
- [ ] Case Manager
- [ ] Advocate
- [x] Human Resources
- [ ] Nurse

0 Case Managers
2 Program Supervisors
1 Health Care Staff
0 Maintenance Personnel
0 Food Service Personnel
1 Clinical Staff
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [x] Logbooks
- [x] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [x] Fire Inspection Report
- [ ] Exposure Control Plan
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Fire Drill Log
- [x] Medical and Mental Health Alerts
- [x] Table of Organization
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Telephone Logs
- [x] Supplemental Contracts
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

9 # Health Records
9 # MH/SA Records
28 # Personnel Records
6 # Training Records
6 # Youth Records (Closed)
12 # Youth Records (Open)
0 # Other

Surveys

3 Youth
3 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [ ] Social Skill Modeling by Staff
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [x] Youth Movement and Counts
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Capital City Youth Services, Inc. (CCYS) was established in 1975 to serve children and families. The agency's Children in Need of Services and Families in Need of Services (CINS/FINS) program offers residential and non-residential services as outlined in Florida Statute 984 to the following counties: Jefferson, Madison, Leon, Wakulla, Franklin, and Taylor. In addition to CINS/FINS, the agency provides services to youth population referred by the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking. CCYS is also 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 run away and homeless youth.

Since the Quality Improvement review team last visited CCYS in March of 2016, the agency has made some accomplishments and programmatic updates as follows:

Non-residential - Since last QI visit, Family Place has had 7 personnel changes. This includes two positions in Gadsden, one in Taylor, one in Jefferson, one in Wakulla, and two in Leon. The Taylor and Jefferson positions were consolidated into one full-time position based upon historical trends in caseload that demonstrated the need for only one person. There is only one full-time position in Gadsden at the moment based average caseload size over the years and the current demand for services. While many strong clinicians were lost, recent hires bring unique skill sets in areas such as play therapy, Dialetical Behavior Therapy, and EMDR. Family Place has also carried four interns since the summer of 2017. Three are from the mental health counseling program and one from art therapy. Interns have assisted in Leon, Wakulla, Gadsden, and Madison counties.

SNAP –Through the SNAP In Schools contract, CCYS was able to make a huge impact within Hartsfield Elementary, Woodville Elementary, Pineview Elementary 21st Century Summer program, and Oak Ridge Elementary 21st Century Summer Program. During the last half of FY 16-17, 109 groups were presented and 121 for the 17-18 fiscal year. SNAP at CCYS applied for a grant from the Frueauff Foundation for $20,000. They were awarded that amount to aid them with purchasing food, gas, group supplies, etc.

In addition, CCYS has hired a part-time Case Manager who was a former Intern with CCYS/SNAP.

Residential- Since the last QI visit, CCYS had a number of residential staff changes. These changes included nine Youth Care Specialists (8 Full-time, 1 Part-time), two Youth and Family Counselors, and one Registered Nurse. With so much staff turnover, staff training has been a big part of the last year. The program supervisors along with the Human Resource Coordinator (serving her first year in the position) have done an excellent job making sure that all staff members utilize online training portals to receive all required trainings.

The program has also analyzed and made changes to program guidelines in hopes of creating a more inclusive environment. These changes are reflected in the program's room assignment process as well as where the youth sit during meal times. It should also be mentioned that although the youth were always able to use any bathroom they wanted, new restroom signs have been purchased to clearly indicate that all restrooms are unisex or gender neutral.

As for the physical environment in the shelter, the program has continued to make renovations on a regular basis. The goal has always been to create a more welcoming and/or therapeutic space throughout the shelter. New couches were purchased for the common areas, as well as new dining room tables and chairs. They continue to request/accept youth feedback to improve on the environment and provide a safe place for the youth to express themselves and have their voices heard. The youth continue to participate with the local Meals on Wheels program twice a week, as well as do road clean up with Beautify Tallahassee on a weekly basis.

The shelter also began using NoteActive (electronic) Logbooks during fiscal year 17-18.

As part of an ongoing strategic plan initiative, CCYS as an agency continued its marketing plan with the addition of a new website and new logo/branding. The Drop–In Center relocated and the Street Outreach staff and Shelter staff are working more closely together to have improved continuity of services/referrals for youth.

The agency continues to be very active with the local Homelessness Continuum of Care and has a solid partnership which helps with service delivery.

CCYS initiated the formation of a Youth Advisory Board. The staff committee has an initial draft of bylaws and member applications are set to go out in late Spring.

The agency was fortunate to have a generous donor give funds that allowed CCYS to create an endowment.

Standard 1: Management Accountability

Overview

Narrative

Capital City Youth Services (CCYS) is under the leadership of Kevin Priest, Chief Executive Officer. Mr. Priest oversees a team of educated professionals that includes Gina Dozier, Chief Operating Officer; Nancy Hillger, Chief Financial Officer; and Jess Tharpe, Outreach and Development Director. As COO, Ms. Dozier is responsible for the supervision of the following CINS/FINS positions: Rachel Greene, Clinical Director of Residential Services; Jason Ishley, Clinical Director of Non-Residential Services; and Patrick Minzie, Shelter Program Manager.

A total of 16 new staff were hired since the last QI visit. The agency trains all new and on-going staff as required using a combination of live instructor and online web-based training. In addition, the agency uses a training format that captures all training dates, topics, and hours that is maintained on each staff member.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CCYS has an established policy and procedure entitled Background Screening for employees and volunteers. The policy and procedure meets most of the requirements of the indicator and was last approved by the CEO on 2/1/2018.

The policy specifies that a Level II background screening through the DJJ Clearinghouse, local law check, drug screening, and driver's license check is conducted pre-employment for all Department employees. No employee, volunteer, or independent contractor providing direct service or having direct contact with clients mat be hired or utilized at CCYS prior to the successful completion of the background screening. Employees are re-screened every five years of employment. The Annual Affidavit of Compliance with Good Moral Character Standards (Form IG/BSU-006) is completed and notarized at the end of each calendar year and submitted to the DJJ Background Screening Unit by January 31st of subsequent year.

A review of the staff roster found sixteen staff members hired since the last QI Review, nine Interns, and three staff eligible for the 5-year background re-screening. Each of the new staff were background screened prior to their hire date and received a rating of eligible for hire. Similarly, all 9 interns were background screened and eligible results were received prior to their service start date. Two of the three staff members who were eligible for five-year re-screenings after the initial hire date were successfully re-screened prior to their five year anniversary dates. The 5-year re-screening date for a third staff was initiated on-time by the provider but completed late by DJJ due to rejection of the initial fingerprints and the need to resubmit the prints.

The program completed its Annual Affidavit of Compliance with Level 2 Screening Standards to Background Screening Unit (BSU) on January 9, 2018.

Exception:

The current policy and procedure does not include the requirement for volunteers to be re-screened every five years as required. The 5-year re-screening requirement was mentioned twice for staff, in the policy and procedures, but not for volunteers.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has separate policies and procedures in place to ensure an abuse free environment namely: Supervision of Client and Staff Responsibilities (approved February 2017); Abuse Reporting (February 2018); Client Rights (February 2018); and Grievance (February 2017). The policies and procedures were approved by the COO.

According to program policy and procedures, the program ensures the safety and orderly conduct of youth through consistent use of standard policies and procedures, and basic client supervision. Staff and volunteers will abide by basic rules of conduct and failure to abide may result in disciplinary action up to termination of employment.

Staff receives the employee handbook and new hire packet during orientation. The handbook and packet includes a code of conduct that

prohibits the use of physical abuse, profanity, threats, or intimidation. Per policy, youth are not deprived of basic needs such as food, clothing, shelter, medical, care and security. Once hired each staff signs a code of ethics form.

If a staff or any person has reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, they are required to report such knowledge or suspicion to the Florida Abuse Hotline and CCC and notify the Program Director and the CEO immediately. Staff is made aware of the abuse reporting requirement during orientation and signs an acknowledgement of receipt. The abuse hotline number is reviewed with youth during intake.

The program has an accessible and responsible grievance process for youth to provide feedback and address complaints. Youth are allowed to grieve actions of staff and conditions or circumstances related to violation or denial of basic rights. Grievances must be deposited in the grievance box or submitted to the Residential Supervisor or a Program Manager. Direct care staff do not handle the complaint/grievance documents unless assistance requested by youth. Management takes immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

Per the HR Coordinator, all new staff receive an employee handbook and training regarding the agency’s code of ethics and conduct as well as abuse reporting requirement. A packet containing acknowledgement forms is provided for staff to sign and the signed copy is maintained in their personnel files. Three random personnel files supported this practice.

Per the HR Coordinator, all new staff receives an employee handbook and training regarding the agency’s code of ethics and conduct as well as abuse reporting requirement. A packet containing acknowledgement forms is provided for staff to sign and the signed copy is maintained in their personnel files. Three random personnel files supported this practice.

Postings of the Florida Abuse Hotline number were observed during the tour of the program. All child abuse hotline calls are documented on an internal incident form if made by staff. If a youth makes the call it is documented in the youth file. The program maintains copies of the hotline calls and subsequent calls to CCC in an Internal Incident Report file maintained chronologically. A total of 24 abuse calls were made to the Hotline during the review period. None of the calls were against program staff.

The program has a grievance box located near the staff monitoring station in an area that is accessible to youth. Supervisory staff checks the grievance box daily and handles all grievances and complaints from youth. The program reported one grievance that occurred during the reporting period; however, during the course of the review, Reviewer was informed of two additional grievances against a staff that was ultimately terminated after multiple disciplinary actions including use of profanity and withholding snack. While reviewing the termination documentation, another grievance filed by a youth was mentioned but a copy was not found in the grievance records. It was evident that management promptly addressed all the grievances with staff and implemented corrective actions.

Exception:

One grievance was initially reported for the review period; however, the Reviewer identified photo copies made of 3 additional grievances that were in a personnel file but were not provided to the COO and were not maintained in the program's grievance file.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CCYS has a detailed policy in regards to incidents and incident reporting. Their practice is also in compliance with the requirements and procedures outlined in the Department policy and the Florida Administrative code. The policy clearly states the procedures for completing both internal incidents and CCC reportable incidents. The CCC Hotline number is clearly posted on the wall by the front desk. The current policy was last reviewed and signed by the agency's Chief Operating Officer in December 2016.

All internal incidents were in an accordion file folder in chronological order. All CCC incidents had their own red folder with all documentation pertaining to the incident. The folder consisted of the Agency incident form, the CCC report, all correspondence between the CCC and the agency, the follow-ups and any corrective actions if needed.

From March 6, 2017 through April 8, 2018 there were a total of 27 incidents reported to the CCC; during the past six months (October 1, 2017 to April 8, 2018) there were a total of 17 reportable incidents called in to DJJ CCC. Six incidents were randomly pulled and reviewed. There were four in the medical category and two in program disruption category. In the medical category, two were medication errors, one youth behavior and one medical transport. Both medication errors had corrective action plans in place. The two program disruptions were a vehicle traffic crash and a contraband incident. Of the six incidents reported to the CCC, 4 were reported within the two hour time frame, all 6 had completed follow-ups, 5 were noted in the program logs and all six were documented on incident reporting forms and were signed by a program supervisor/director.

Exception:

Two incidents were not called into the CCC within the two hour period and one was not noted in the log book.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

CCYS' Training policy (updated 2/1/18 and approved by the CEO) and their 2017-2018 Training plan closely align with the QI training indicator, 1.04 and the CINS/FINS Policy and Procedure Manual.

All staff is required to receive the necessary training and acquire the essential skills needed to perform specific job duties and functions. All full time staff is required to have 80 hours of training during their first year and must have at least 40 hours of training every year thereafter. The training plan also addresses all of the required training outlined in the QI 1.04 Training indicator, including the newly implemented DJJ SkillPro Life Management training.

A total of three first year training files were reviewed. Two employees completed all of the training topics required in the first 120 days and exceeded the 80 hours required annually. The third first year training file reviewed six months remaining to complete all of the required first year training.

Another three files were reviewed of staff who have been employed for longer than a year and they all have met the necessary hourly and subject matter requirements.

The training files were very organized. All certificates, and sign-in sheets were behind an excel spreadsheet with the listed training; the hours were listed on the right with a cumulative total.

Exception:

One of the 3 first year staff (DOH 10/20/17) did not complete CINS/FINS Core or Title IVE training as required during the first 120 days of hire or as of the date of the QI visit.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedures in place for analyzing and reporting information. The policies and procedures were approved by the COO in February 2018.

As part of its performance and quality improvement effort, Capital City Youth Services regularly collects data and review several sources of information, including reports from that data, to identify patterns and trends.

The COO and Clinical Directors will coordinate the selection and peer review of a sampling of client case records. The COO or designee will aggregate the findings from the file reviews and forward the peer review reports to the appropriate PQI subcommittee.

Youth and Family Counselors or other assigned staff members collects and enters client specific information into NetMIS on each individual case. The Chief Operating Officer (COO) reviews official monthly NetMIS data and program outcomes reports received from FNYFS then forward reports and any noteworthy observations to Program Managers and Clinical Directors. Information is then shared with staff.

Incidents/accidents are reviewed immediately by the appropriate program supervisor. Information collected about incidents are documented on a monthly summary sheet and addressed at the Clinical, Programs, and Facilities subcommittee meetings. Grievance data is compiled monthly and includes the number of grievances as well as reasons for grievance. There is no grievance data for the current FY since there are no relevant grievances.

Client satisfaction data is collected by each program and entered into the provider's database, NetMIS, and in Survey Monkey. Results of the survey are aggregated on a monthly basis by the COO and the RS also aggregates the data from Survey Monkey on a regular basis. Data is shared with staff at staff meetings.

There is documentation of the program collecting and reviewing as part of its performance and quality improvement effort. Capital City Youth Services regularly collects data and review several sources of information, including reports from that data, to identify patterns and trends.

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The program provided its most recent report of peer record reviews that were conducted for files that were closed during the 4th quarter of FY 2016-2017. The peer record review appeared to be conducted around October 2017. Per the Non-Residential Clinical Director, no peer record review has been conducted since October 2017 which signifies that there has not yet been a review of cases that were closed in the first and second quarters of FY 2017-2018

The COO provided data for review of all incidents that have occurred for the review period. A total of 120 incidents were documented of which according to the report, 15 were reported to CCC.

Client Satisfaction data is entered into NetMIS by program staff and in the program's database by the COO. The COO runs regular reports of the survey results and reviews the report with management. In addition, the Shelter Manager aggregates client satisfaction data entered into Survey Monkey as needed. The provider presented an annual staff satisfaction survey completed in July 2017 and client satisfaction survey completed in October 2017.

The COO receives NetMIS reports monthly and CINS/FINS Report card that addresses program outcomes every six months from the Florida Network. Email communication with staff regarding deficits on the reports was provided for the review. The COO regularly checks NetMIS to identify areas to be addressed.

Exceptions:

No peer record reviews have been conducted since October 2017 which signifies that there has not yet been a review of cases that were closed during the first and second quarters of FY 2017-2018.

The provider's P&P states PQI meetings will be held quarterly. The last two PQI meetings were held on 10/26/17 and 1/31/18. A review of the meetings held revealed there is no agenda for the meetings and the meetings are recorded but the minutes were not transcribed for the majority of meetings held. Four SORT staff meeting agendas/minutes were reviewed for the review period. One of the meetings discussed care days and one census; however, there were no discussions or evidence that staff are informed about patterns and trends identified and are involved in the process.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program's policy was reviewed and found that it addresses all of the requirements of the standard. The program has a policy in place which guarantees the safe use and responsible maintenance of the agency vehicles for Capital City Youth Services. Only staff properly licensed, insured, and approved by insurance company and agency administration may operate CCYS vehicles. The policies and procedures were approved by the COO in April 2018.

All CCYS staff are approved agency drivers. The agency staff is required to be screened through their insurance underwriter and must be approved in order to be added to the agency's auto insurance. This is a job requirement. The Program Director was able to provide a list from the insurance company with all eligible drivers. Alternatively, he was also able to provide emails where a person was not able to be added to the insurance and the result of which was end of employment.

The agency vehicle log was reviewed and found to be detailed. Timelines appear to align with logbook entries. The log records date, time, beginning odometer, driver, number of passengers, supervisor or on-call consultant required, destination, ending odometer, end time, gas level, 1st aid kit/Fire Ext., damages and locked. It was confirmed by the shelter director that all shelter staff, including interns, are approved to be a third party ride along if needed.

Exception:

Although it is documented as a yes or a no in the vehicle log, there is no further evidence or documentation that a supervisor is aware prior to transport that a single driver is driving a single client.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There was no specific policy provided related to Outreach Services. The program has developed an outreach plan for FY 2017-2018 which contains Capital City Youth Services vision and goals for outreach.

The Agency's Outreach plan provides an outline to increase name recognition and community awareness, educate youth/families, law enforcement and schools about CCYS, establish and maintain partnerships, oversee and maintain Safe Place and insure that it remains a beneficial outreach tool, and to increase and diversify funding sources to ensure long term stability and sustainability. Their outreach material consists of brochures, Safe Place hand out cards, stickers and newsletters. They also utilize their website, Facebook page and Twitter account.

It is recorded in NetMIS that from July 1, 2017 to January 31, 2018 CCYS had entered 125 events that had reached 1,789 youth and 302 adults.

It is evident that the Agency is represented at DJJ board and council meetings as well as other relevant community meetings. The Agency was able to provide minutes and agenda's to show participation and/or attendance at the DJJ 2nd Circuit Advisory Quarterly Board Meetings, JAC Steering Committee Meetings, notes from a Truancy Workgroup meeting and agenda's from a Wakulla County Coalition for Youth meeting.

CCYS participates in a Juvenile Justice Interagency Agreement for Leon County which includes Department of Juvenile Justice, DISC Village, Leon County Circuit Court, Juvenile Division and/or Leon County Clerk of the Circuit Court, Leon County School Board, Leon County Sheriff's Office, State Attorney for the Second Judicial Circuit, Public Defender of the Second Judicial Circuit, Tallahassee Police Department, Department of Children and Families, Florida State University Police Department and the Palmer Munroe Teen Center. CCYS also has 23 formalized partnerships and MOUs. Some of the partnerships are, but not limited to, 211 Big Bend, Disc Village, Kearney Center and Refuge House.

Exception:

The provider does not have a specific policy and procedures to address the requirement of Indicator 1.07.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Capital City Youth Services (CCYS) agency provides residential and non-residential services to youth ages 6 - 17. The Some Place Else Youth Shelter residential facility is located in Tallahassee. The non-residential program provide services to the following counties: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla.

The Non-Residential program is under the direct supervision of a Licensed Mental Health Counselor (LMHC). The Non-Residential LMHC supervises a counseling team comprised of 8 fulltime Counselors and 3 interns. The Non-Residential program services client needs across several counties. Several of these counties are in rural and outer-lying areas. The agency provides several services. The referrals for services are received from parents, school, counselors, the court system, the youth themselves and other sources. The services provided by CCYS include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home/community. Youth also receive referrals for substance abuse and mental health services.

The Residential program is under the direct supervision of a Licensed Clinical Social Worker (LCSW). The agency’s LCSW supervises a team comprised of 4 staff members including 2 fulltime counselors, 1 Program Support Specialist, 1 Shelter Support Specialist, and 2 interns.

A CINS/FINS screening is conducted on each youth prior to their entry into the facility to determine if they are appropriate for the program. Trained staff are available to determine the needs of the family and youth. A needs assessment is then conducted on each youth to ascertain what services they will need to be provided. The youth and family participate in a face-to-face session in order for the staff to assess their individual needs and develop an individualized plan of services to accomplish specified goals. After completion of the needs assessment a case/service plan is created to address these issues. Residential counseling services including individual, family, and group therapy are provided. In addition, case management and substance abuse prevention services are offered in non-residential settings. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, financial assistance, housing assistance, and educational assistance.

CCYS leads and 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 may include representatives from the school district, DJJ or CINS/FINS provider, State Attorney's Office, Mental Health and Substance Abuse organizations, law enforcement and DCF. The Case Staffing Committee meets monthly and can also recommend a CINS Petition be filed to court-order participation with treatment services.

The Residential and Non-residential Programs are meeting the requirements of this standard. There were a total of ten files reviewed: two open and three closed files from shelter and two open and three closed files from non-residential services.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy and procedure for screening and intake was last updated in January of 2017 and was approved by the COO. The policy includes the required elements of 24/7 access to services, screening by trained staff, and need for screening within 7 calendar days of referral.

Screenings for shelter services are conducted 24/7 and are completed by all trained staff. Screenings can be conducted by phone or in person and are recorded on the CCYS Screening Form. For shelter services, the screening form is considered the referral for services.

For Non-Residential services, a screening is conducted in response to written referrals, by phone or in person. Once a written referral is received, a counselor will attempt to contact the family within 48 hours to arrange an intake appointment. If the family cannot be reached a letter will be sent offering services.

During a shelter intake a client is given a Client Informed Consent Form, Rights & Responsibilities Form, and a CINS/FINS Brochure, which contains available service options. The Intake procedure for clients is considered initiated with the completion of the Intake and Assessment Form.

Two open and 3 closed residential files, including 1 probation respite file, was reviewed. All 5 files contained documentation supporting the practices noted in the policies and procedures and included all the required elements. The shelter intake documentation is inclusive of all the elements required to meet the standard, including client rights and responsibilities, written information about service options, grievance procedures and acknowledgment from parents that they received the Parent/Guardian Brochure.

Two open and 3 closed non-residential files, including 1 Case Staffing Case file, was reviewed. All 5 files contained documentation supporting practices, noted in the policy and procedures and included all the required elements. Interview with Non-Residential Clinical Director and two Non-Residential Counselors confirm the practice for counselors to take three sessions to complete the intake process and develop the Plan of Service. During the first intake session, the Informed Consent Agreement, Family Place Rights & Responsibilities, and Releases of Information are signed and the parents are provided a copy of the CINS/FINS Brochure outlining available services.

Exception:

The current policy notes "the accurate and thorough completion of the Intake process documents… provides crucial opportunity for staff to explain behavior expectations and to emphasize the program's core values." The Policy and Procedure does not mention the specific requirements for the youth and parent to receive written availability of service options, rights and responsibilities, possible actions through CINS/FINS services or grievance procedures. The Procedure notes the review of client rights and the grievance procedure, as well as a review of program goals and services available.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policy and procedure was last updated and approved by COO on February 2017. The policy does not include mention of the Needs Assessment (NA) being initiated within 72 hours of admission (for youth in shelter care); however, the policy does note the NA is considered initiated when a staff member begins completing the Intake and Assessment form, which is completed immediately upon a youth's arrival to shelter.

The Needs Assessment (NA) consists of three parts: Someplace Else Intake & Assessment Form; The Needs Assessment Form; and the Needs Assessment Summary. For shelter youth, the Intake Form is completed upon arrival and the full Needs Assessment is turned in to the Clinical Director within 7 calendar days of the youth's intake for signature.

For both residential and non-residential services, if the NA indicates an elevated risk for suicide, an Assessment of Suicide Risk is conducted and is reviewed by a LMHC.

All 10 files reviewed included the required documentation. In all 10 files the NA was completed the same day as admission to services, and was completed within 2 to 3 face-to-face sessions. All NAs were completed by Master's level counselors and were signed by a supervisor. Only one of the files had an elevated risk for suicide as a result of the NA and it had the required Suicide Risk Assessment completed and signed by a supervisor. The summary section of the NA is a comprehensive write-up and addresses current and past issues affecting the youth, his/her current level of suicide risk and reported strengths/likes and goals. The signatures on the Needs Assessment denote the counselor's degree level and supervisory review.

Exception:

The current policy does not include requirement that the Needs Assessment be completed by Bachelor's or Master's level staff and is signed by a supervisor.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedure for Service Plan Development was last updated February 2017 and was approved by the COO. The policy notes all the required elements except mention of actual completion dates and the date the plan was initiated.

Plans of Service (POS) are developed within 7 working days of the Needs Assessment. POS are individualized based on issues identified at screening. POS forms include service type, frequency, location, persons responsible, target dates, completion dates and signatures of youth, counselor, parent and supervisor. The form also includes space for documentation of the date the plan was initiated.

All 10 files reviewed met the requirements for this standard except one of the closed residential files did not have the completion dates noted. Instead of parent signature, 6 of 10 files noted the Plan of Service was discussed via telephone. For the residential files, the POS was difficult to read due to the poor copy of the form. This was not an issue for the non-res files.

The form used to verify the standard was the Plan of Service. The form was designed to capture the required elements of Type of Service,

Frequency, Location and Person Responsible. All files reviewed included individualized goals and had the necessary signatures.

Exceptions:

The policy notes all the required elements except mention of actual completion dates and the date the plan was initiated.

One of the closed residential files did not have the completion dates noted.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Requirements for this indicator are covered under two separate policies: 1) Case Supervision, which was updated during the review April 2018, and was approved by the COO and, 2) CINS/FINS Case Staffing Committee policy which was last updated February 2017 and was approved by COO.

For shelter clients, counselors are assigned to a youth following admission to shelter. For non-residential services, counselors are assigned to a case in response to screenings. As part of the assessment process counselors establish a Plan of Service and immediately begin coordinating services to meet client needs. The POS form and Chronological record is used to document client needs and efforts made to engage and support youth and families. At discharge from services, an Aftercare Planning & Referral Form is completed and provided to families.

When warranted a referral to the Case Staffing Committee is made and the Committee is convened to assist the youth and family.

Follow-ups are completed for all cases at 30 and 60 days following case closure.

All ten files reviewed included the required documentation to support this standard. The POS was compared to the Needs Assessment and Screening Form to track inclusion of client issues on each form. The Clinical Director of Residential Services explained that the shelter chooses from a list of 10 Basic Target Skills to help youth better manage their problem behaviors. Reference to this list is noted via “Mastery of Target Skills” on the POS.

The POS and subsequent reviews, along with the Chronological Records were reviewed to confirm the practice to monitor and support youth and families' progress and need for referrals. All closed files reviewed included a very nice Aftercare Planning & Referral Form, which is provided to the family, and a Discharge Plan, which summarizes the services and referrals made.

No exceptions noted for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Requirements for this standard are covered under three separate policies: 1) the policy for Service Modality & Intervention Policy was last reviewed on February 2017; 2) The Chronological Records & Case Notes Policy; and, 3) The Group policy. All 3 policies were revised during the QI review in April 2018, and were approved by the COO.

Master's level counselors and/or interns utilize The Needs Assessment, Plan of Service, and Plan of Service Reviews to address youths' presenting problems. Chronological Notes are used to document client activities, sessions, phone calls, and collateral interventions. SOAP notes are used to document individual and family sessions. The primary service modality is individual counseling; however, family counseling is available if a family requests it.

The Group Log is used to document group activities. Groups are conducted 5 days a week and last at least 30 minutes. Groups can be conducted by youth care staff, volunteers, interns or counselors.

All 10 files included completed Needs Assessments, Plans of Service and Reviews, as appropriate. Signatures of licensed supervisors throughout the records and interviews with counselors, supports internal process of clinical reviews and weekly supervision.

All 10 files reviewed showed efforts to engage the families in services in accordance with their POS. The files reflected individual and family

chronological notes. The youth's presenting problems were consistently addressed in the Needs Assessments, POS and POS reviews. Chronological notes reflected client activities, and all interactions and/or efforts to interact with clients, parents/guardians, and other collateral contacts.

The Group Activity Log was reviewed for indication of groups being provided 5 days a week for the shelter clients.

Exception:

Two of the residential files reviewed were from October so the October log was reviewed. This log was found to be missing 10 group entries and additionally had 12 entries missing notation of the length of group and 11 entries missing notation of the facilitator. Subsequent logs reflected for the open files contained a revised form, with space for the group topic, facilitator name and length of group. The new form seems to have helped with the recording of this required information.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Requirements for this standard are covered under two policies. The policy for CINS/FINS Case Staffing Committee Policy, was last reviewed February 2017 and approved by the COO, and the Case Supervision Policy, which was approved during the review, April 2018 was approved by the COO.

A Case Staffing Committee is convened in response to a referral. The Non-Residential Clinical Director coordinates the meetings with the assigned counselor. Parents/Guardians and Committee members are notified no less than 5 days prior to the Case Staffing Committee. The meetings are documented using the Case Staffing Committee Recommendation Form, which is signed by all parties present and includes recommendations and plans for the family. Prior to the end of each meeting the form is copied and provided to the family being reviewed. The Chronological Record shows documentation of all the contacts for this process, including support for the family and referrals made.

One file was reviewed for this standard. The referral to the Case Staffing Committee was made by the Residential Counseling Team. Documentation on the Chronological Record and the Case Staffing Committee Recommendation Form was used to verify the family and committee was notified no less than 5 working days prior to the staffing. As a result of the Case Staffing Meetings, recommendations were made that included continuing the current POS and referring to additional services. A copy of the recommendations was signed and provided to the family following each meeting, well within the 7 day timeframe. The file showed consistent documentation supporting the CINS/FINS Case Staffing Process.

Additionally, the Clinical Director of Non-Residential services explained that the committee meets only as needed.

No exceptions noted for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This indicator is covered under two policies: 1) Confidentiality of Client Information and, 2) Record Retention Policy. Both policies were reviewed in February 2018 and were approved by the COO. The confidentiality policy states the program complies with all applicable federal and state statues and codes with regard to confidentiality of records. The policy further explains that all files are marked confidential and outlines details of when and how information is released. The record retention policy states client records will be maintained in a confidential manner and accessible only to authorized CCYS staff. The policy also states records are to be secured in lockable filing cabinets when not in use.

Each youth admitted to a program is given an individual client file, marked confidential and maintained in a specific and consistent manner. Each record is unique to that client and contains only his/her name and information. The records are maintained in a room marked confidential, in file cabinets also marked confidential. Only designated staff have access to the locked files. When files are transported, they are maintained in opaque lock boxes, marked confidential.

All ten files reviewed were marked confidential and were maintained in a neat and orderly manner. The open files were maintained in folders with separate tabs for ease of access. The file room and file cabinets were marked "confidential" and the lock boxes used for transporting files

were also marked "confidential".

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The SPE shelter provides short-term respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program as well as for youth from the Department of Children and Families DCF. The SPE youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services and other special populations. Specifically, this shelter is designated by the Florida Network to provide staff secure services, Domestic Violence (DV) respite, Probation Respite, and Domestic Minor Sex Trafficking.

The shelter program management team is comprised of a Residential Shelter Manager and two (2) Residential Supervisors. Each shift also has YCS that is the designated team leader. An organization chart dated 3/1/2018 shows a total of 12 full time and 5 part time Youth Care Specialist positions in the shelter program. There are also two (2) residential counseling positions.

The CCYS SPE youth shelter building includes a large day room, individual girls' and boys' sleeping rooms, individual bath rooms, kitchen, laundry, residential and counseling staff offices. The exterior of the office includes a large outside basketball and recreation area. During the Quality Improvement review, the shelter was found to be in clean and good condition. The furnishings are in adequate condition and the rooms and common areas were clean. The bathroom floors are tiled and the plumbing appeared functional. The sleeping rooms houses two - three (3) youth each. The sleeping room is equipped with individual beds, bed coverings and pillows. The windows are equipped for privacy for the youth.

The program has policies and procedures in place for its Shelter Care programming. The Direct Care workers are responsible for completing all applicable admission paperwork conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the staff. The facility has a part-time Registered Nurse (RN) as required by the CINS/FINS Contract. Oversight of clinical services is provided by both the residential and non-residential Licensed Clinicians.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Wellness Plan-Last reviewed on 2/2017 by the COO. The policy addresses: nutrition education; physical activity; food safety/security; other program based activities; and snacks. However, it does not address all of the items required by the indicator.

The agency is to provide a clean, well-maintained program. The youth shall be provided an individual bed and clean coverings. The lighting is to be adequate. A safe shall be provided to keep personal belongings, if requested. The youth will be offered a variety of activities that include faith-based activities and activities to keep them active and involved which includes opportunities for physical, mental, and social maturity through exposure.

A schedule shall be posted publicly and accessible to youth and staff. Records of a current health and fire safety inspection were reviewed. Physical activity, food safety/security, program based activities, nutrition guidelines, and snacks are implemented in the program. The agency utilizes direct care staff to prepare and serve food. Training is provided regarding health and nutrition. Youth participate in creating menus for cultural studies. Special dietary needs are addressed upon intake. The USDA National School Lunch Program is followed.

The shelter is located on a nice wooded and well-kept campus in a residential neighborhood. The shelter is licensed for 18 youth; their DCF license is located in the lobby as well as the agency's COA certificate. At the entrance of the shelter there is a fully enclosed front porch area as well as a lobby area which are used for intakes and activities for the youth. The shelter has a total of eight bedrooms with a maximum of three beds per room. The shelter can change the number of beds in a given room to accommodate for different needs of the youth they serve. Upon inspection of each room there were no identified safety concerns; all the rooms appear to be clean and maintained. All the beds were made which included linens, comforters and pillows and all appear to be clean.

The shelter has four single use bathrooms which all appeared to be clean and fully functional with no major concerns. The bathroom, located by bedroom five, sink was not attached to the wall; however, this was fixed before the review was completed. All the bathrooms are accessible to all youth regardless of their gender identity.

The living room areas of the shelter are maintained and furnished; the shelter has two new sofas and several new chairs. In the living areas there is a TV, games, and books available for the youth to use. The kitchen and dining room area appeared to be clean and maintained; the shelter recently purchased new tables and chairs for the dining room. The shelter has a total of four refrigerators/freezers with two freezers being located in the laundry room and a refrigerator and freezer being located in the kitchen; all appeared to be clear and operating correctly. The dry storage area appeared clean and organized; no concerns were noticed. The shelter has two washers and two dryers; all appear to be maintained and operating correctly.

The facility was free of noticeable graffiti. There were no indicators of insect infestation. The facility is maintained with no noticeable structural or safety concerns and the grounds are landscaped and appear to be maintained. The facility doors are all locked from the outside not allowing public entry into the facility but allowing youth to exit without restriction. All staff have a key fob which allows them access to the building. The shelter keys are locked on a bracket and the staff has the tool needed to get the keys off but the entire bracket is placed in an unlocked drawer.

The windows all appear to be secured and have alarms located on the outside to notify staff if a youth was to open a window.

The shelter completes fire drills once per month based on their monthly fire drill records; all drills noted they were completed within two minutes. Based on the CCYS Emergency Drill Sheets, the shelter conducts emergency drills once a month versus once a quarter. The chemicals used in the shelter are locked up in a utility closet; there is a chemical logbook kept by the shelter regarding chemical inventory. Based on the logbook, the chemicals are for the most part inventoried daily with few exceptions. The MSDS sheets are located in two binders and kept on the shelf with the chemicals. Their shelter has a Health Inspection which expires on 9/30/2018 and a Fire Inspection which expires on 4/14/2018. The shelter had a fire system inspection by Fotia Services on 2/6/2018; there did not appear to be any areas of concern based on the paperwork.

The shelter has a system in order to maintain items in safe keeping for youth in the shelter who have something valuable and/or important to them and they wish to place somewhere safe. The shelter offers to keep these item in a cabinet located behind the staff desk; however, the cabinet is not locked.

The shelter's daily schedules are posted in two different areas in the shelter; at the staff desk area and the kitchen door. The schedules are detailed and provide a good breakdown of how the day will generally flow including wakeup, meals, and activities such as study/homework time, physical activities, community service, social skills, down/quiet time, groups and bedtime. The schedule does not provide time for school/learning if a youth is not enrolled in school off site or participating in on-line classes. The schedule also does not specify faith-based activities, however, according to staff if a youth wants to participate in a faith-based activity staff ensure the youth's participation. According to staff, the shelter currently does not have anyone coming in to provide faith-based services although this has been done in the past.

The shelter has posted the grievance process in two different areas; one is on the board located in the living area the other one is on the grievance box. The grievance box is located in the living room area at the staff desk. The shelter also has the Abuse Hotline reporting number on the board in the living area. This information is also provided to the youth at intake and is located in the shelter handbook which is placed on the door of each room.

A random check of the vehicles in the parking log did not find any doors unlocked. The shelter has two vehicles, SUVs, both appeared to be in good condition, clean and maintained. Each vehicle had a first aid kit, fire extinguisher, flashlight, and tool for breaking glass and cutting a seat belt.

Exceptions:

The agency's Wellness Plan policy which was provided for 3.01 does not cover all the areas identified in the QI Indicator 1.01. The Wellness policy under section 3, Food Safety/Security, does not address food storage. However, cold food not in their original packaging was not labeled or dated.

Based on the current shelter daily schedule it has physical activities daily but only four days for a full hour the other three only provide for a half hour, shy of the one full hour required daily. The schedule also does not specify faith-based activities and alternate activities for youth not participating in faith-based activities.

There were no air bag deflators in either agency vehicle.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place that addresses all aspects of the Indicator. The policy and procedure was last reviewed by the COO in February 2017.

The program uses several forms to support the completion of the orientation. The main form used is the Youth Orientation Checklist and Room Check-In, which is literally a check list of all the items covered and is signed by the youth and staff at the time of completion. The program also uses other forms such as Someplace Else Youth Contract and Someplace Else Program Overview and Guideline.

A total of three files were reviewed for this indicator which included two open cases and one closed case. In each of the case files reviewed, there was documentation which clearly demonstrated that a shelter staff member completed a program orientation with each youth at the time of their intake. The program uses several forms to support the completion of the orientation. A Youth Orientation Checklist and Room Check-In form was in each of the 3 files reviewed as well as the Someplace Else Youth Contract and Someplace Else Program Overview and Guideline.

No exceptions were noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place that was reviewed on 2/18 by the COO. The policy addresses the indicator and states an alert system legend is to be used in each file.

The shelter uses the information gathered on the Someplace Else Intake and Assessment Form to determine room assignment. The form covers all the required area to make an appropriate assessment as to which room a youth should be assigned up on their arrival at the shelter. The shelter also uses several forms to indicate any alerts, based on the CCYS Residential Alert System Sheet, a youth may have; these include the Someplace Else Intake and Assessment Form, Contact Authorization Form, File cover and Medication Schedule Overview.

A total of three files were reviewed for this indicator which included two open cases and one closed case. The shelter uses the information gathered on the Someplace Else Intake and Assessment Form to determine room assignment. The files contained all the required forms to indicate any alerts, based on the CCYS Residential Alert System Sheet, and the Someplace Else Intake and Assessment Form, Contact Authorization Form, File cover and Medication Schedule Overview.

The Someplace Else Intake and Assessment Form has a section specified as Observations, however, it was only seen used to identify any alerts the youth may have not to note any specific observations by the staff during their interaction with the youth during the intake process. However, there is a section that allows a staff to give a youth a rating based on their observations. This is a number rating scale used by the staff which is located at the end of the form just before the observation section. According to staff, collateral contacts can be found on the screening and intake progress note.

Exception:

The QI Indicator specifies the use of collateral contacts as part of room assignment; the Someplace Else Intake and Assessment Form which is the primary form used to make room assignments does not identify collateral contacts. The agency's policy also does not specify requiring collateral contacts in room assignment.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

An agency policy is in place that addresses Log Books. The policy and procedure meets all of the requirements of the indicator and was last reviewed on 4/2018 by the COO.

The shelter has a clear policy on what and how information should be noted in the log book. The different highlights used are: orange for youth behavior, yellow for parent/guardian, pink for medication, blue for Law Enforcement, purple for administrative, and green for safety. The shelter highlighted items related to safety and security. Reviews of the log are to be conducted by the program director or designee, oncoming supervisor and direct care staff in the unit indicating he/she have read and reviewed, dating each review.

The program only utilizes the electronic log book. The shelter staff appeared to be comfortable with the use of the e-logbook and appears to be using the log effectively. There were no reported issues for the staff or Administration regarding its operation. The shelter has a clear policy on what and how information should be noted in the log, which included highlighting certain information; however, there was nothing regarding the use of icons/symbols.

Based on the review of the log, staff appear to be following the shelter's policy as it is currently written as well as meeting the Network requirements; the notes conveyed the needed information which was brief, dated, and signed. The shelter does not use the e-logbook for bed check; instead they use a paper bed check log. The log is simple, including the youth name, date of check, time of check, and initial verifying check was completed. Based on the review of the bed check log there were no concerns.

Staff reported there is no highlighting or indicators of youth off sight just a note; this does make that information difficult to locate.

There were no exceptions noted for this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place that addresses Behavior Management Strategies. The policy and procedures was last reviewed in February 2017 by the COO.

The agency uses at least three different behavior management strategies for addressing behavioral concerns which utilizes Collaborative Problem Solving, Managing Aggressive Behavior, Why Try, and Trauma Informed Care which appears to be working effectively for their program. Consequences are used on an as needed basis only. WHY TRY teaches through daily group activities (critical thinking). A trauma informed evidence based curriculum is used which is designed to promote resiliency (ability to overcome challenges, crisis) in the youth. Managing Aggressive Behavior teaches to the behavior as well, identifying why the youth is behaving as he/she does.

The shelter does not use a formal behavioral management/point system. The shelter has a method of addressing behavioral concerns which utilizes Collaborative Problem Solving, Managing Aggressive Behavior, Why Try and Trauma Informed Care. The staff report that they focus on problem solving the situation with the youth attempting to identify what need the youth is trying to get met. The shelter relies on natural consequences that result from the youth's behavior to also help resolve behavioral issues/concerns as well as serve as a leaning opportunity. The youth's behavior in and by itself does not determine if they can participate in an outing; however, if their behavior is a safety concern then this can affect their ability to participate in an outing.

The youth who was interviewed stated that when there is problem staff talks with the resident(s) involved in the situation and help them work it out. According to the youth, a resident does not just lose privileges but their behavior can affect their ability to participate in an outing. Two staff members were also interviewed, they were able to provide details as to how they address areas of concern and they were consistent with each other. The information provided by the youth who was interviewed also lined up with what the staff were saying.

Three staff training files were reviewed by the review team and all reflected training on Collaborative Problem Solving, Managing Aggressive Behavior, Why Try and Trauma Informed Care.

Exception:

The agency's policy does not provide an outline as to the method the shelters uses. The policy also makes reference to a handbook which the program does not have.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a policies and procedures to address the requirement of the indicator entitled Supervision of Clients and Staff Responsibility and Shift Scheduling. The policies and procedures were last reviewed in February 2017 by the COO.

The program's procedure meets general staffing ratio requirements in that a minimum staff ratio of 1:6 is required during wake hours and community events and 1:12 during sleep hours. All program staff ensures the safety and orderly conduct of clients through consistent use of standard procedures, policies and basic client supervision. Youth Care Specialists are responsible for the care and safety of all clients.

Formal and informal headcounts will be conducted on each shift. Bed checks are conducted every ten minutes between bedtime and wake time and recorded on the Bed Check log. Staff are required to have visual contact with all residents during waking hours. Formal headcounts are conducted at the beginning of each shift by duty staff and documented in the log book. Emergency headcounts refer to spontaneous counting procedure conducted after an unscheduled event/incident or fire drill. Staff are called in as needed when a hold over occurs.

The shelter uses a population board located in front of the staff desk area which provides the names of each youth/number of youth currently in the shelter. The shelter is licensed for a maximum of eighteen youth. Based on the review of the staff schedule the program maintained the required number of staff on each shift as required, 1 to 6 during awake hours and 1 to 12 during sleeping hours/overnight. The shelter's staff schedule is posted at the staff desk. There is not a "hold over/overtime roster"; however, the shelter does have a system in place to address situations like this in that a current staff member from the prior shift will stay over, the Supervisor is notified, other staff are contacted to cover the shift, and if that does not resolve the issue then there is an on-call system. This on-call system includes two Residential Supervisors, two Residential Counselors, two Non-Residential Counselors, and a TL mentor who is responsible to cover the shift. According to the Program Manager, there have been times the shelter has been short hand due to turnover. The Program Manager, also reported there has been challenges with finding qualified male staff. Based on the review of the schedule, there were always two staff scheduled for overnights. There

were two overnight shifts where there were only two male staff on shift; however, this was signed off on by a Supervisor. There were also seven shifts where there were only two female on staff; however each were signed off on by a Supervisor.

Staff complete bed checks during sleeping hours every ten minutes. This is documented on a Room Check Log. Based on the video review there was falsification of bed checks on 4/1/2018 at 3:10 a.m. on camera 16 as well as room checks completed at 3:20 a.m, for both cameras 13 and 16. There were no concerns regarding the reviews completed on 2/14/2018 from 1:10 a.m. to 1:30 a.m. for cameras 13 and 16. There were no concerns regarding the reviews completed on 3/18/2018, 2:00 a.m. to 2:20 a.m. for cameras 13 and 14.

The shelter is equipped with 16 cameras which cover both inside and outside the shelter. The camera system also allows staff to provide additional supervision and security as well as allows Administration oversight; however, the camera system was difficult for the agency to provide continuous feed to conduct full shift reviews. The video reviews had to be done viewing each camera separately. During the QI visit, the agency stated they are going to making improvements to their camera system the upcoming year.

Exceptions:

Neither of the two policies provided by the program had language regarding there being a male and female staff on each shift when youth of the same gender is present. There was also no language documented regarding the process if a shift was short a person and how that should be handled. However, the staff interviewed were able to describe the process used which is a staff form the current shift stays over until another staff member can be called in to cover the shift.

Based on the video review there was falsification of bed checks on 4/1/2018 at 3:10 a.m. on camera 16 as well as room checks completed at 3:20 a.m. for both cameras 13 and 16. The CCC was contacted by the reviewer and Program Manager at 2:29 pm. The report was accepted with assigned report number: 2018-01721.

There were nine situations where there was no male and female staff on the shifts. In seven of the nine instances, there were two female staff on an overnight shift and, in two situations, there were only two males on an overnight shift.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency had a policy that addressed all of the requirements for staff secure including in-depth orientation on admission, assessment and service planning, enhanced supervision, parental involvement and collaborative aftercare. It also includes the legal requirements outlined in Chapter 984.

There is also a policy for Domestic Violence (DV) and Probation Respite (PR) that address all of the indicator requirements.

Access to staff secure shelter services shall occur after other alternative, less restrictive remedies have been exhausted by the provider in cooperation with the case staffing committee as per Florida Statute 984.12. All youth receiving staff secure services will receive the same living arrangements as specified in temporary shelter placements. Staff secure youth should be clearly distinguished from other shelter youth including more comprehensive assessments and one-to-one supervision during awake hours for the youth during each shift to monitor the location and movement of the staff secure youth at all times.

Domestic Violence Respite Care Services shall be provided to both male and female youth ranging from 10 years of age and up to 17 years of age, who have been charged with an offense of domestic violence. Eligible youth shall include youth who have been charged with domestic violence as well as previously adjudicated on other charges besides domestic violence.

Probation Respite Care Services shall be provided to both male and female youth ranging from 10 years of age and up to 17 years of age, who are currently on probation regardless of adjudication status and referred by the Department’s Juvenile Probation Officer.

There were no staff secure or DMST youth to review within the last 6 months or since the last QI visit.

Two DV files were reviewed. Both had a pending DV charges and both had been screened by the JAC prior to admission. Also, both cases did not exceed 21 days. One case was less than a 24 hour stay. In the other case, the case plan reflected goals focusing an aggression management and family coping skills. Both cases aligned with all other CINS/FINS program requirements.

Two PR files were reviewed. In both cases the referrals came from DJJ probation and both youth were on probation with Adjudication Withheld, both cases were approved by the Florida Network prior to placement; neither case resulted in a stay longer than 14 days and there is evidence that all case management and counseling needs have been considered and addressed and all services are consistent with other general CINS/FINS program requirements.

Exception:

The Staff Secure policy and procedure does not clearly state that there will be one on one staff supervision on each shift nor the documentation

of the staff assigned to the youth in the log book as required by the indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency's policy and procedure for Alarm and Security System was last reviewed on 2/20/2018 by the COO. The policy is consistent with the QI Indicator.

The program has a video surveillance system that is in operation twenty-four hours a day, seven days a week. The system can capture and retain video photographic images for a minimum of thirty days. The cameras are located in general locations of the shelter where youth and staff congregate and where visitors enter and exit. The video surveillance system is only accessible to designated personnel in the facility. If requested by a third party (Law Enforcement or CCC) the video system is made available to them. The supervisors review and document review of video at minimum once every fourteen days.

There are a total of sixteen cameras at the shelter both inside and outside the facility. The cameras are located in all the major area where the youth spend time and are clearly visible. The only area without a direct camera but covered by the camera directed at the staff desk is the lobby. There is a notice posted in the lobby that there are security cameras in use at the facility. There are no cameras located in the bedrooms or bathrooms. A review of the system showed it is able to capture video with date and time stamp. In reviewing footage you were able to determine where the footage was taking place in the shelter and also identify the individuals on the camera. According to the Program Manager, the system can operate when there is no power and can store footage for up to thirty days.

In the interview with the Program Manager it was reported that he was the one who reviews the camera's footage and is the one who has primary access to camera footage. However, if needed other administrators can access the footage. The Program Manager reported that he was the one responsible for completing camera reviews; these reviews are random and include overnight footage. Based on a review of the camera review logs, the checks are being conducted and included random days and times which also includes overnights. The checks are being normally weekly but some involved greater time frames. The program also has a system in place so if there is a request for camera footage needed in an investigation by a third party the program is able to provide it.

No exceptions are noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The CCYS agency has detailed policies and procedures related to the screening, health admission screening, classification, assessment and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. All youth receive an initial assessment to determine the youth's risks, needs and issues. Based on this information, the youth is assigned a room which can change after further assessment.

All staff members are trained on risk screening methods that immediately identifies youth who are admitted with special needs and risks—such as risk of suicide, mental health, substance abuse, physical health (acute and chronic), or security risk factors. Once risks are identified through the screening and assessment process all staff and management are notified. The youth is placed on alert status. The agency takes steps to ensure that measures are taken to maintain a safe and secure placement; and supervision is provided by direct care staff during the resident's shelter stay. The agency maintains a program log, general alert system, pass down/shift exchange forms, and other notification systems. Youth admitted to the shelter with prescribed medications are also provided their medications during their shelter stay.

Staff members participate in routine mock emergency drills and receive orientation and annual training courses that include Universal Precautions, Safety and General Program Risk Management training. In addition, the agency's Shelter Manager is a certified Managing Aggressive Behavior (MAB) Trainer.

4.01 Healthcare Admission Screening

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy titled "Health Care Screening on Admission" applicable to residential programs. This policy was last reviewed and updated February 2017. This policy requires verification that all youth admitted to residential programs are not in need of medical attention. This policy also establishes protocol for responding to reported or observed acute or chronic medical concerns of the youth upon admission to the program.

All youth are expected to be screened for acute and chronic medical conditions initially on the screening form prior to intake, and more thoroughly during the Intake process. Staff completing intake assesses health status and needs by observation and interaction with the youth, interviewing the youth, and interviewing the parent or guardian if they are available. In the event that the youth has a health condition that requires monitoring or restricting of activities these conditions are noted by a color dot system knows the "Medical/Mental Health Alert System." These sticker dots are affixed to the spine of the client file and inside the file. All healthcare screenings are to be reviewed by the facility nurse.

In a review of 2 open and 1 closed files the healthcare admission screening process was followed according to policy. Medical conditions were noted in all three files with affixed alert indicators, documentation of prescriptions, and all required fields were documented as yes, no, or N/A with no fields left blank.

Exception:

During the review period, there was no evidence that was provided of Nurse reviewing physical health screening documentation in client files following intake.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Suicide Prevention applicable to Residential Services. This policy was last updated in February 2017. The policy addresses screening, identification, and response to youth at-risk of suicide.

The program assesses risk for suicide at multiple points in the process from screening for eligibility, intake foe services, and observations

throughout the length of stay. If youth indicates an affirmative answer to one or more screening questions they are placed under increased supervision which initiates a process for direct line of sight and sound monitoring. The youth remains on this status until a licensed counselor, or a non-licensed counselor under the direct supervision of a licensed counselor completes assessment and makes a determination that youth is not at-risk of harm. Each shift begins with a log entry that includes the number of youth in shelter, and specifically the number of youth on heightened supervision.

The documented practice observed in 3 files verified that the practice reflects the stated policy and procedure. All documentation of screening and assessment was completed and annotated by both direct care, and licensed staff. Two open files and 1 closed file were reviewed. Both open files contained indicated the youth were at-risk of suicide and subsequently were placed on sight and sound until the licensed staff could evaluate the youth and make a determination. Both youth were removed from heightened observation and all assessments and observation logs were signed by a supervisor. One closed file indicated that the youth was asked all 6 initial suicide screening questions and answered “no” indicating youth was not at risk of suicide.

No exceptions were noted for this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a global policy governing medications titled “Medication Policy” last updated April 2018. The policy is organized in sections pertaining to individual programs within the CCYS service continuum. The section titled “Someplace Else Shelter” provides guidance for assisting in the self-administration of medications, storage of medications, inventory of medications, recording and reporting the administration of medications, and verification of prescription medications.

The agency policy establishes practices for efficient management of youth medical and health care needs. An alert system for identifying specific indications and concerns is utilized to communicate and monitor the well-being of all youth. Health screening at intake and review of all screening forms by the nurse is required by policy. Preventative care is maintained through organized procedures for monitoring client hygiene, cleaning and maintenance duties. The agency also maintains an extensive guide for referral to medical professionals for acute, chronic, and prevention-based medical care.

The program is utilizing the Pyxis machine for the storage of all medications, prescription and OTC. When on-site, the nurse assumes responsibility for administering the medication management process as required in policy. The agency verifies all prescription medication by approved methods of contacting the pharmacy of origin, or verification by the nurse. All client files have a medication distribution log recording all medication transactions. Client files contain required information regarding side-effects and pharmacy-issued information on all prescription medications.

Exceptions:

Discrepancies are not being cleared per-shift. Discrepancies are not being cleared by the individual who created the discrepancy. The current practice reflects staff clearing discrepancies for each other as a means of distributing shift work load.

Shift-to-shift controlled medication counts are being witnessed and verified only in a written binder, and not by biometric confirmation in the Pyxis. At this time it is unclear if this is due to mis-classification of the medication when input into the Pyxis, or due to a parameter setting of the Pyxis interface.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy governing the use of medical and mental health alert processes and notifications titled “Medical’ and applicable to Residential programs. The policy is designed to inform all personnel of specific precautions for medical, mental health, behavioral, and supervision concerns for individual youth. These precautions are annotated by a “hot dot” system of color-coded stickers affixed to the spine of the client files, as well as within the file contents on both the medication distribution log and the client identification sheet.

The agency implements this policy throughout the screening and intake process, an on-going through the youth’s shelter stay if status changes. Guidance for response to emergency and non-emergency medical and health-related scenarios are included in the policy. Conditions requiring an alert indicator are identified at: Screening, Intake, Physical Health Screening, and Clinical Needs Assessment. Based on the alert indicated, the youth’s activities, room assignment, diet, and behavioral interventions may be modified for the safety of the youth.

The program follows their stated policy and procedure as described. In review of 3 closed files all 3 youth required notification for conditions both medical and behavioral. The alerts utilized were consistent with the key provided to this reviewer.

No exceptions were noted for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled First Aid and Emergency Care- On-site, last reviewed and updated February 2017. The policy establishes guidelines for on-site episodic care in the event of a medical emergency. First aid or emergency care provided by staff is dictated by the parameters of training provided by Red Cross.

The program requires all staff who have contact with clients to receive CPR and First Aid training within the first 120 days of hire. In the event that a client receives aid on-site or off-site and incident report is to be completed internally. Verification of medical clearance via discharge instructions and follow-up are to be present in the client file. Parent or guardian notification must be recorded and notation is the daily log book is required.

Four client files were reviewed related to incidents requiring on-site and off-site medical care. During the review period the program experienced physical injury and illness incidents requiring a first-aid response from staff and subsequent or simultaneous responses from medical professionals. In each instance the required elements of the policy were met. Entries in the log book coincide with the correct dates and times from the incident reports. All client files contained follow-up information from medical providers when required. Documentation of parent/guardian notification was verified for each of 4 incidents.

Knife-for-life, wire cutters, and first aid kit were readily available and presented upon request by staff on duty. First aid kit inventory checklist was completed and last reviewed and updated by staff on 4/8/2018.

No exceptions were noted for this indicator.