Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth Crisis Center

on 03/13/2019

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
2.08 Sexual Orientation, Gender Identity/Expression	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	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

Standard 4: Mental Health/Health Services

Indicator	Rating
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:

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

<u>Members</u>

Ashley Davies, Lead Reviewer/Consultant, Forefront LLC

Andy Coble, Senior Director of Community Based Programs, Family Resources

Angel Colon, Senior Case Manager, Hillsborough County Childrens Services

Cayse Houston, Program Manager, YFA Rap House

Persons Interviewed

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

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

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [x] Logbooks
- [ ] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [x] Fire Inspection Report
- [ ] Exposure Control Plan
- [ ] 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
- [ ] Supplemental Contracts
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

5 # Health Records
5 # MH/SA Records
18 # Personnel Records
9 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
0 # Other

Surveys

7 Youth
5 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [ ] 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

The agency signed the visual arts agreement with Cathedral Arts Project (CAP) for males and females to receive weekly one-hour visual art classes for the school year. This is an opportunity that is funded by the Jim Moran Foundation.

Promoted Ashton Crawford from Lead Residential therapist to CINS/FINS Program Manager.

Expanded the opportunity for master's and bachelor's level students to intern at YCC in residential and non-residential.

Began implementing the Adolescent Domestic Battery Typology Tool (ADBTT) for youth involved with domestic violence (piloting this for the FL Network).

Increased community volunteering opportunities, specifically for residential during the holidays.

The agency is partnering with Feeding Northeast FL to receive food for the programs, especially in residential. They have also opened an onsite food pantry. Produce, bakery, and dairy items are at no cost. This has assisted in lowering costs for the food budget as well as provides more nutritious meals with fresh foods as opposed to canned.

The program has three new teachers from the Duval County Public Schools who are providing academic instruction onsite to all residential youth.

A new Director of Human Resources, Kristen Wendle, after the former HR Director retired.

The agency eliminated the QA Director and Data Entry Specialist positions. They will be hiring two part time grant writers in this place. The functions of the above positions have been absorbed by program leadership or designated individuals, which included the expansion of the Crisis Intervention Specialist.

Ashton Crawford, LMHC received certification in TF-CBT (Trauma-Focused Cognitive Behavioral Therapy).

Upon receiving a grant from the Lowes Foundation, the program added perimeter fencing, fencing around the retention ponds, and an electronic gate system to the campus for additional security. This was at the recommendation from the local law enforcement agency (JSO).

The Board of Directors developed a CEO Succession Plan (for emergency purposes).

The agency hired an additional nurse (RN) for residential after receiving a grant from Baptist Health.

The agency participated in an active shooter training that was facilitated by Jacksonville Sheriff's Office.

Participated in First Coast Connect radio show to discuss the utilization of domestic violence respite beds.

The residential youth participated in several GAAP (Gaining Appreciation by Adjusting Perspectives) discussions where they can share openly about myths and concerns as it pertains to youth's relationship with law enforcement.

Participated in a Cox Media Radio phone interview where information was shared about referral process, needs of Baker County Community, and concerns as it pertains to mental health.

Participated in the Duval County Behavioral Health Consortium where mental health needs of the community are addressed and identify programs that have experience in addressing mental health concerns.

Participated in the Circuit 4 Advisory Board's Youth Success Day, where one of the residential youth was recognized for outstanding achievement.

Standard 1: Management Accountability

Overview

Narrative

The program Youth Crisis Center (YCC) operates a thirty bed residential shelter and non-residential CINS/FINS program. The program has more than sixty full-time, part-time, and on-call staff members. The agency has a detailed background screening process that is completed by their Human Resources department. The agency has a comprehensive training plan that requires all staff members to complete a broad array of core training topics. The agency has an active self-reporting incident reporting process. The agency completes monthly reporting of its risk management, quality improvement, service delivery, and outreach data reports.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Background Screening of Employees and Volunteers to address the requirements of this indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

All staff, interns and applicable volunteers and mentors will sign a Criminal History Acknowledgment form and an Affidavit of Good Moral Character form.

All staff, applicable volunteers and interns and mentors will undergo a series of background screenings, assessments, records search, and receive an eligible rating prior to an offer of employment or prior to being accepted into the volunteer/mentoring program at the Youth Crisis Center. The screenings/assessments/record search will include:

- A Motor Vehicle Records Check to review the applicant's driving record

- Local Law Enforcement Record Check,

- Pre-employment Drug Screening,

- Live Scan Background Screening Check, including fingerprinting,

- 911 Record Call log request for every address resided at for the last five (5) years,

- Civil Records Search for every County resided at for the last five (5) years,

- Abuse/Neglect Registry search for every State resided at for the last five (5) years,

- State Sex Offender Registry Search for every State resided at for the last five (5) years,

- Completion of Berke Assessment for select positions.

Background screenings must be completed prior to making an offer of employment to an applicant. No applicant may be hired, nor may the services of any volunteer, intern, mentor, subcontractor staff, or service provider be utilized until the background screening has been completed and the applicant has received an eligible background screening rating.

YCC will receive confirmation from DJJ for eligibility to hire under Section C of the Request for Live Scan Background Screening form. Eligibility to hire through DCF Abuse Registry is also required, prior to any new hire's start date. The Youth Crisis Center will use its discretion to hire, even if both DJJ and DCF state candidate is eligible, if the other screenings produce unfavorable information.

If the DJJ screening indicates an ineligible rating, the Human Resources Department will notify applicant and the applicant must contact the screener to determine what specific charges require disposition. If the ineligible rating is due to a criminal history the reason for the rating and an explanation of their option to seek exemption will be provided at the home address on the applicant's fingerprint forms. Charges must be at least three (3) years old and the information must be received by the Background Screening Unit Supervisor within 45 calendar days from the date of written notification. DJJ Office of Inspector General will review the information to determine if they will Grant or Deny your Request for Exemption from Ineligibility.

Live Scan Background Screening Check, including fingerprinting Re-screenings will be completed every five years after the date of the initial screening.

Human Resources Department will complete Annually each January an Annual Affidavit of Compliance with Good Moral Character Standards (Form IG/BSU-006) and send to the DJJ Background Screening Unit by January 31st on all staff who were actually working during the calendar year.

Human Resources Department will complete Annually following initial employment the following screenings/assessments/record search:

- A Motor Vehicle Records Check to review the applicant's driving record,

- Local Law Enforcement Record Check,

- 911 Record Call log request for every address resided at for the last year,

- Civil Records Search for every county resided at for the last year,

- Abuse/Neglect Registry search for every state resided at for the last year,

- State Sex Offender Registry Search.

The program has hired eighteen new staff members since the last on-site quality improvement review. All eighteen staff received a background screening with an eligible rating prior to hire. There were new interns at the program requiring a background screening and all six had a screening before beginning their internship at the program. In addition to the Clearinghouse Background Screening completed a public records search was completed, a local law enforcement records check was completed, a national sex offender search was completed, and a driver's license check was completed on each applicant. There were no staff requiring a five-year re-screen during this review period.

The Annual Affidavit of Compliance with Level 2 Screening Standards is required to be submitted to the DJJ Background Screening Unit on or before January 31st each year. Documentation provided showed the Annual Affidavit was submitted on February 20, 2019 which is after the January 31st requirement.

The agency uses the Berke Assessment as their pre-employment screening tool. They currently have Job Fit Assessments in place for the Youth Care Specialist Position and the Registered Nurse Position. The Berke Assessment has been completed on any new hires in these two positions. The assessment places the candidate in the Low, Medium, or High Impact range. It was reported the agency is looking for candidates who fall in the High Impact category. The Berke Assessments reviewed for current employees document the employees fell in the High Impact range.

The Annual Affidavit of Compliance with Level 2 Screening Standards is required to be submitted to the DJJ Background Screening Unit on or before January 31st each year. Documentation provided showed the Annual Affidavit was submitted on February 20, 2019 which is after the January 31st requirement.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Provision of an Abuse Free Environment that addresses the requirements of this indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

All employees are required by law to report to the Child Abuse Registry when there is reasonable cause to know or suspect that a child is being abused or neglected. Clients are free to file their own abuse reports and may not be denied phone privileges to do so. Youth are made aware of the toll-free number 1-800-96 ABUSE at intake. The abuse hotline number is to be prominently displayed in the Residential living area.

Staff/interns are to be adhere to a code of conduct that forbids the use of physical abuse, profanity, threats, intimidation, and inappropriate language around sensitive areas such as LGBTQ and cultural differences. Management will be responsible for monitoring and addressing violations of the standards of conduct. YCC Management will take immediate action to address founded incidents of physical, emotional and/or psychological abuse and incidents of verbal intimidation, use of profanity, and/or excessive use of force. The staff member will not be paid for the time that they are away from the facility.

Clients will be informed of the grievance process during orientation to the program. Information on the grievance process is also made available in the Client Orientation Handbook and is posted in the shelter. Client Grievance forms are to be readily available for the client to access. Accommodations will be made for youth who cannot read or write. Staff shall assist clients in filing a grievance, but only if asked.

Clients should take the following steps to seek resolution for a grievance once it is determined that the situation cannot be resolved between the parties:

Informal Phase:

- Verbally present their problem to staffs that are on duty at the time of the situation.

Supervisor/designee Phase:

- If not satisfied with their resolution, the grievance should be made in writing on the Client Grievance form.

- The written grievance can be given to the supervisor/designee on duty or it can be placed in the locked box found in Residential.

- The Shift Supervisor/YCS II/Director of Residential Services will check the box shift to shift.

- The Shift Supervisor/YCS II/Director of Residential Services will review the grievance and investigate the facts of the grievance and render a decision within 72 hours of receiving the grievance.

- The staff involved in the grievance process has the option to write his/her comments in the grievance form.

- The client involved in the grievance process has the option to write his/her comments in the grievance form.

- If the supervisor/designee agrees with the grievance, action will be taken.

- The supervisor/designee will document all information on the Client Grievance form or will attach the information to the Client Grievance form.

Director of Residential Services/Director of Program Services Phase:

- If the supervisor/designee was unable to resolve the grievance to the client's satisfaction, the Director of Residential Services/Director of Program Services shall review the grievance and issue a decision within 72 hours.

All Client Grievance forms should be signed by staff and the client. If the client did not sign, staff should document the reason why (i.e. client was released from the program prior to resolution, client refused to sign, etc.).

During the prescreening process all staff are required to review and sign acknowledgement forms relating to reporting child abuse, neglect, and abandonment, mandatory reporting, and guidelines to prevent abuse. Upon hire staff are then required to sign and review acknowledge forms relating to the whistleblower policy and the operations manual. Staff are then given a copy of the Provision of an Abuse Free Environment policy. Staff are also required to sign a confidentiality statement.

The program has postings of the Florida Abuse Hotline number located in numerous areas throughout the shelter including boys dayroom, boys dorm, girls dayroom, girls dorm, staff work area, and visitor entrance. All postings are in English and Spanish both.

Any abuse calls made in the shelter are documented on an incident report if revealed during the youth's stay or on the Admission Form if revealed during the admission process. In both cases, the call is also documented on the Risk Allegations Log in the youth's file. There was one example of this process available for review. The abuse was revealed during admission and documented on the Admission Form and on the Risk Allegations Log. Any abuse that comes up during an individual and/or family session with the youth and counselor is reported to the abuse hotline and documented on the Needs Assessment and in a chronological note in the youth's file. There were three files reviewed to confirm this practice. All three files documented the abuse on the Needs Assessment and then a more thorough explanation in the chronological notes.

A review of a sample of nine staff training files documented all staff were trained on abuse reporting procedures. This training is part of first year training requirements for all staff.

The program has not had any instances of management addressing staff concerning inappropriate conduct relating to the provision of an abuse free environment.

The program has two grievance boxes, one located on the male side and one located on the female side. During the review the boxes were observed locked with grievance forms readily available next to the box. Both boxes were empty when checked. The Assistant Residential Director is responsible for checking both boxes each day. There have not been any grievances since the last on-site review.

There were seven youth surveyed. All seven youth reported they are aware of the abuse hotline and they know where the number is located. However, all seven reported they have never requested to call the abuse hotline. All seven reported staff treat the youth professionally and with respect and they have never heard staff use inappropriate language. Al seven reported they have never heard a staff threaten another youth and they feel safe in the shelter.

There were five staff surveyed. Two staff reported working conditions at the shelter are very good, two staff reported good, and one staff reported fair. All five staff reported they have been trained on the abuse hotline procedures and knew to report any knowledge of abuse to the hotline. All five staff reported they have never heard another staff member deny a youth access to the abuse hotline. All five staff also reported they have never heard a co-worker using profanity, threats, intimidation, or humiliation when speaking to the youth.

There are no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Incident Reporting that addresses the requirements of this indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

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/Incident Report form and funders incident reporting form. The CCC must be notified as soon as possible, but no later than two (2) hours after any reportable incident occurs, or within two (2) hours of YCC learning of the incident even if you learn of an incident when you are off work or at home, etc. If an incident was called in to the CCC then the CCC section on the Internal Accident/Incident Report form needs to be completed regardless of whether or not the report was accepted. If the incident involved a client, the parent/legal guardian should be contacted.

The program has had twenty-five CCC reports in the last six months. Out of the twenty-five reports, twenty-three involved a youth being transported off-site for some type of emergency medical care. The remaining two reports were a youth abscond and a staff arrest. All reports were reported to the CCC within the two-hour time frame. An internal incident report was maintained for each incident. The reports document all notifications made, a detailed description of the incident, and any discharge/follow-up instructions. All CCC reports were closed out successfully with the CCC.

The program also maintains a binder with all incidents that were not reportable to the CCC. Incident reports were completed for each incident and documented all parties notified and also documented detailed description of the event. All reports were filled out in their entirety.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Staff Training that addresses the requirements of this indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

Staff members at YCC receive training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions. During their first full year of employment, direct care staff (to include full-time, part-time, and on-call) receive 80 hours of training.

Following the first full year of employment, direct care staff receives at least 40 hours of job-related training annually, which includes refresher training on the use of available fire safety equipment, training necessary to maintain current CPR, first aid certification, crisis intervention, and suicide prevention.

Non-Licensed mental health clinical staff working in shelter under the supervision of a licensed mental health clinical staff person completing Assessments of Suicide Risk must have 20 documented hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The non-licensed mental health clinical staff person's training hours must include administration of, at a minimum, five one-to-one assessments of suicide risk or crisis assessments individually conducted on-site in the physical presence of a licensed mental health professional. The training must be documented and maintained in the non-licensed mental health clinical staff person's personnel file using the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk Form.

Training is scheduled throughout the year, and may be provided by the Florida Network, local community resources, and various local provider personnel approved or certified to deliver training.

The program maintains an individual training file for each staff member, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training program attended.

There were nine employee training files reviewed. Two of the files were reviewed only for training completed during the employs first 120 days of employment. Both staff received all required trainings with the exception of one staff who did not receive one training in Universal Precautions.

There were three staff training files reviewed for training completed during the first year of employment. The first staff documented 79 hours with one and a half months left to receive the additional one hour of training to meet the 80-hour requirement. This staff has already competed all trainings required during the first year of employment. The second staff documented 79.5 hours of training with two and a half months left to receive the additional half hour of training to meet the 80-hour requirement. This staff has received all required trainings already except for training in fire safety equipment. The third staff documented 66.5 hours of training with two and a half months left to receive the additional hours. This staff still had seven additional required trainings to completed; however, was on track to receive all required trainings and hours.

There were four staff training files reviewed for annual training requirements. The program tracks annual training by fiscal year. For the purposes of this review, the current fiscal year was reviewed, from July 1, 2018 until the first day of the on-site review. All four staff still had three and a half months to complete the training cycle. The four staff documented 34.5, 27, 63, and 23.5 hours of training so far. All staff had already

documented all required trainings except for one staff who still needed suicide prevention part 1 and 2.

The program maintains an individual training file for each staff that included a DJJ SkillPro printout documenting all trainings completed and total number of hours, and any supporting documentation such as certificates, certifications, agendas, tests, and/or sign-in sheets. The program also has an annual training plan that list all required trainings for each staffing position in the program. There is also a calendar attached that documents all trainings, and the days they will be offered, broken down by month.

There are no exceptions to this indicator.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Risk Management that addresses the requirements of this indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

Managers will review all Internal Accident/Incident Report forms and funders' incident reporting forms, if applicable, for their department, and ensure that appropriate action is/was taken. If the incident involved physical and/or psychological abuse or was an incident of verbal intimidation, use of profanity, and/or excessive use of force immediate action must be taken to address the incident.

The Director of Quality Assurance or designee will review all Internal Accident/Incident Report forms, funders' incident reporting forms, and Incident Report Follow Up forms, when applicable, and investigate the accident/incident, if necessary, to determine the root causes, patterns, and/or assist the applicable manager in determining the actions that need to take place to prevent reoccurrence.

The non-residential program reviews a sample of cases from each counselor/intern each month. These reviews are documented on the Clinical Case File Review form. Findings from these reviews are documented on the forms. These reviews are also discussed at the monthly staff meetings where any corrective actions or improvements are implemented. The residential program reviews all open cases each month. The reviews are also documented on the Clinical Case File Review form and discussed at the monthly staff meetings.

Incidents, accidents, and grievances are discussed during the quarterly management team meetings. A print-out of all incidents, accidents, and grievances for the quarter is provided. The print-out documents the incident type, date, time, staff involved, and brief description. These are discussed during the meeting and if any corrective actions need to be implemented, they are done so at that time. This information was reviewed for the last quarter completed.

A monthly review of NetMIS data reports is conducted by the Director of Program Services. Any changes needed, errors, or corrections needing to be made are emailed out to staff. Staff then review the information, make any changes needed then notify the Director of Program Services who will then review NetMIS data one more time to ensure changes have been made and information is accurate.

The last annual review of customer satisfaction data was completed in November 2018. A documentation of the review was provided in the management team meeting minutes. The Director of Program Services enters the customer satisfaction data in the database as they come in. If there are any comments either negative or positive, they are reviewed with staff at that time instead of waiting for the annual review.

The last annual review of outcome data was completed during the management team meeting in August 2018. Meeting minutes were reviewed that showed a print-out of the annual data and any comments, concerns, or questions from staff. Emails were provided to show a discussion of the annual outcome data between upper management staff and the Florida Network prior to the management team meeting in August. The information from the emails was then discussed in the management team meeting.

There were no exceptions to this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Client Transportation to address the requirements of this indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

Approved agency drivers are documented as having a valid Florida driver's license and are covered under the company insurance policy.

There are procedures in place to have a third party present in the vehicle while transporting a single youth. If a third party cannot be obtained, the clients history, evaluation, and recent behavior is considered. The approved drivers work performance and history indicates no inappropriate behavior is likely to occur. If driver is transporting a single client there is evidence the supervisor is aware and consent is documented.

Documentation of use of vehicle notes name of driver, date and time, mileage, number of passengers, purpose of travel, and location.

Any person hired by the program in the Youth Care Specialist position or a supervisory position must be eligible to transport youth. Prior to being hired and being offered the position, a drivers license check is completed. If the check comes back with issues the individual is required to clear them up prior to preceding with the hiring process and finally being offered the position. All job descriptions for the Youth Care Specialist and supervisory positions include the requirement to be able to transport youth if necessary, this includes having a valid Florida drivers license. All drivers are covered under the agency's insurance policy.

There have been approximately sixty-five single client transports in the last six months. All transports were documented on the Transportation Authorization Log, on the Vehicle Mileage Logs, and in the prolog. The Transportation Authorization Log documents the date, the time, staff, youth, reason, person authorizing, the date and the time of the authorization, and the page number the approval was documented on in the prolog. This log was filled out in its entirety for each transport for the last six months. Documentation reviewed in the prolog also showed the approval for the single client transport and documented who gave the approval.

The Vehicle Mileage Logs documented the date, time, mileage, driver and staff, number of passengers, destination, gas level, and a safety check. This log was completed for each transport conducted, including all single client transports. Logs reviewed were filled out in their entirety for the last six months.

There were no exceptions to this indicator.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Interagency Agreements and Outreach Services to address the requirements of this indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

Chief Executive Officer/designee regularly meets with other individual agencies and groups of agencies to establish informal linkages and written agreements. Written agreements will be forwarded to the Chief Executive Officer/designee for maintenance.

YCC uses both staff and materials to increase public awareness and provide information about agency programs and services to youths and adults in the targeted communities (refer to the Targeted Outreach Plan for site-specific locations of outreach services). Program personnel have been formally assigned this responsibility in their job description. Staff makes regular presentations to schools, youth groups, community groups (such as civic clubs, churches, neighborhood associations, PTAs, etc.), administrators and staff at other agencies, and at special community events. Presentations will be documented on the Outreach Events form and forwarded to the Administrative Assistant. YCC staff distributes a wide variety of promotional materials at regular outlets (through the Safe Place program), to organizations (such as schools, faith based and libraries) and to the entire community through local media outlets.

The agency has current interagency agreements in place with twenty-four community groups including: Jacksonville Sheriffs Office, Florida State University, University of North Florida, Duval County Full Service Schools, School Board of Clay County, Nassau County Multi-Agency, Baker County School District, St. Johns County Multi-Agency, JASMYN, JASMYN and Changing Homelessness, Feeding Northeast Florida, Florida Network of Youth and Family Services, DCF/FSS, DCF/Family Integrity Respite Services, Yoga4Change, Cathedral Arts, National Safe Place, Changing Homelessness, Thaise Educational and Exposure Tours, University of Florida IFAS Extension, Independent Living Resource Center, SALTech Charter High School, Police Athletic League, and Kids First of Florida.

The agency has conducted 112 outreach events in the last six months. Some outreach activities include attending local elementary schools, board meetings, and community meetings/events. During each one of the outreach activities the staff give a presentation and hand out cards and brochures detailing the different services provided by the agency. Each event is documented on an Outreach Event form documenting all the details of the event. There was documentation provided that staff attended the Circuit 4 DJJ meetings for the last two quarters.

There were no exceptions to 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 two residential therapists and five interns under the supervision of the Program Manager. The Family Link program is also under the direction of the Program Manager and has five Therapists, a Lead Therapist, a Case Manager, a Case Staffing Coordinator, and two vacant Therapists positions. In addition, the program was utilizing two interns. 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 agency has a written Operations Manual that addresses the key elements of the QI indicator for Screening and Intake. This indicator is addressed in section 2.05 and 2.06 of the manual. The Operations Manual was last approved on 08/01/18 and was signed by the agencies President/CEO.

The provider conducts an initial eligibility. The screening may be completed by phone of face to face and is to begin no later than seven (7) working days from the date of the youth is being referred. The screening is available to families twenty four hours a day which includes the presenting problems, immediate needs and determining if a youth is eligible for CINS/FINS services which is documented on the intake screening form. If a crisis or substance abuse service is determined there is support staff available and an on call supervisor to assist. There is also procedures in the manual in the event that youth/parent answers that the youth is currently suicidal or homicidal. There is a procedure that outlines service eligibility for non-residential programs during after-hours calls as well as if a family requires assistance with translation of languages.

There were ten files reviewed, five residential and five non-residential.

A total of three residential files, five non-residential files and two Case Staffing files were reviewed. All files covered all service options, Rights and Responsibilities forms were sign by parent and the child. The grievance procedures and outline of services are also provided to the child and the parent. All files had their screenings completed within seven calendar days. All files reflected the required signatures and included documentation of sufficient attempts or verbal consent by phone. Out of the ten files total, two were Case Staffing recommended and one file was recommended by the Case Staffing committee for filing of a petition due to the lack of progress and cooperation.

There were no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Operations Manual that addresses the key elements of the QI indicator for Needs Assessment. This indicator is addressed in section 2.08 of the manual. The Operations Manual was last approved on 08/01/18 and was signed by the agencies President/CEO.

The Operations Manual addresses the Needs Assessments and provides a baseline measurement for the effectiveness of services and the family's ability to implement skills learned through interventions. The needs assessment is completed within 24 hours of admission into the residential program and signed by the Director of Program Services or designee for signature within 72 hours of completion. For non-residential completion of the Needs Assessment shall be completed no later than three face to face contacts following the initial intake if the youth is receiving nonresidential services. Needs Assessment are completed by a Bachelors or Master's level staff and signed by supervisor. If a suicide risk is required as a result of the suicide risk, a license clinical supervisor signs and date the assessment.

There were ten files reviewed, five residential and five non-residential.

All files reviewed contained documentation of the Needs Assessment being initiated within the 72 hours of admission. All files reviewed were completed within the two to three face to face contacts following the initial intake. The Needs Assessments were completed by a Master's or Bachelor's level staff and signed by the supervisor. Out of the ten files reviewed there was three identified with an elevated risk of suicide. These three youth were placed on supervision until seen and assessed by a licensed counselor.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Operations Manual that addresses the key elements of the QI indicator for Case/Service Plan. This indicator is addressed in section 2.09 of the manual. The Operations Manual was last approved on 08/01/18 and was signed by the agencies President/CEO.

The Operations Manual meets the requirements for the Standard 2.03. Case plans are individualized utilizing strengths and limitations identified by the youth and family. The Case plans used by the agency includes the identified needs, type, frequency and location of services. Person responsible, target dates for completion, actual completion dates, signatures of youth, parent/guardian, counselor and supervisor. The case plans is to be developed with the youth and family within 24hours of meeting with the residential therapist and by no later than the third (3rd) face to face session following the completion of the assessment. If the Case plan cannot be signed due to the parent or youth unavailability, the counselor will document the reason the Case plan was not signed and efforts to obtain a signature are to be made. Case plans goals are monitored and formally reviewed at a minimum by the counselor/therapist and parent/guardian if available every thirty (30) days for the first three (3) months and every six (6) months thereafter for progress in achieving goals and objectives. Reviews are documented in the youth's file. The counselor documents all efforts to engage the youth and family in review process.

There were ten files reviewed, five residential and five non-residential.

All ten files documented a Case Plan was completed within seven working days of the Needs Assessment. All ten Case Plans included: individualized and prioritized goals, service type, frequency, and location, persons responsible, target dates for completion, actual completion dates, signature of the youth, parent, counselor, and supervisor, and date the plan was initiated.

Nine out of ten files were applicable for thirty-day reviews of the plan. Two of the files were applicable for one review, two files were applicable for two reviews, and the remaining five files were applicable for three reviews. All thirty-day reviews were completed as required.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Operations Manual that addresses the key elements of the QI indicator for Case Management and Service Delivery. This indicator is addressed in section 2.11 of the manual. The Operations Manual was last approved on 08/01/18 and was signed by the agencies President/CEO.

The agency Operations Manual address the process of Case Management and Service Delivery. Each youth is assigned a counselor who follows the youth's case and ensure delivery of services through direct provision or referral. Services are strength base and are in partnership with the family. The counselor utilize diligent efforts to engage the family in solution of the youth's issues which lead to the referral of Residential or Non-Residential services. Efforts may require school or home visits and collateral contacts. Procedure indicates the coordination and monitoring of goals, progress, referrals to the case staffing committee, court interventions, court hearings and related appointments.

There were ten files reviewed, five residential and five non-residential.

All ten files documented a counselor was assigned to the case. All files documented the counselor established referral needs, coordinated referrals to services, and monitored out-of-home placements as needed. All ten files documented the counselor coordinated service plan implementation, monitored the youth's/family's progress in services, and provided support for families. Two files were referred to the case staffing committee and referrals addressed problems and needs of the youth/family. Two applicable files documented referrals for additional services for the youth and family.

The five closed files documented case termination notes were completed. All five files also documented thirty and sixty day follow ups were completed as required.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Operations Manual that addresses the key elements of the QI indicator for Counseling Services. This indicator is addressed in section 2.10 of the manual. The Operations Manual was last approved on 08/01/18 and was signed by the agencies President/CEO.

Youth and families receive counseling services in accordance with the youth's case plan to address needs identified during the assessment process. Shelter programs provide individual and family counseling as well as group counseling. Non Residential programs provide therapeutic community based services designed to provide intervention necessary to stabilize the family in the event of a crisis, out of home placement, after care services for the youth returning to the home from any placement. For residential the assessment is completed within 24 hours of admission. For non-residential the youth and parent/guardian receives an assigned therapist and the assessment is completed no later than the third face to face contact following initial intake.

There were ten files reviewed, five residential and five non-residential.

All ten files reviewed documented the youth's presenting problems were addressed in the Needs Assessment, initial Service Plan, and Service Plan reviews. All ten files reviewed documented case notes were maintained for all counseling services provided and documented the youth's progress. All ten files documented the youth and families received services in accordance with the Service Plan. Individual and family counseling was provided by the program. All ten files documented on going clinical reviews of the case and staff performance.

The five applicable residential files documented group counseling was provided at least five days each week. All groups reviewed were at least thirty minutes in length, documented a clear leader, documented a clear and relevant topic, and provided an opportunity for youth engagement.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Operations Manual that addresses the key elements of the QI indicator for Adjudication/Petition Process. This indicator is addressed in section 2.11 of the manual. The Operations Manual was last approved on 08/01/18 and was signed by the agencies President/CEO.

The Case Staffing may convened for individual cases or maintained as a standing committee but the composition of the case staffing committee are based on the needs of the youth and families. Families are contacted and reminded of the case staffing within five (5) working days by certified mail or hand delivered letter with the date and place of the Case Staffing and will be requested to attend with their child. The case staffing meeting is scheduled to review the case of any youth or family that the program determines is in need of services if youth is not in agreement with services and no participation in the services selected. Should a parent request a case staffing in writing, the committee shall convene within seven (7) days. The agency is responsible for contacting appropriate Case Staffing Committee members. Copies of letters mailed to family are to be filed in the youth's record. The agencies Case Staffing Coordinator is responsible to prepared all pre-dispositional reports and court orders.

There were two files reviewed. In both of the files the CINS/FINS counselor initiated the case staffing. Families were notified within the required time frame. One file had court involvement with pending adjudication date. Copies of all letters mailed to the family were filed. CINS/FINS counselor prepared all legal documentation (PDR's, Petition, and Affidavit). The youth and family were provided a revised plan for services. A written report was given to the parent/guardian within seven days of the staffing outlining recommendations. Case Staffing meetings appear to be convenient and centrally located to the families and participants.

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Operations Manual that addresses the key elements of the QI indicator for Youth Records. This indicator is addressed in section 2 of the manual. The Operations Manual was last approved on 08/01/18 and was signed by the agencies President/CEO.

Operations Manual reflects that each file is maintained in a neat and organized format. All files are marked confidential and in a secured room with controlled access. Transported files are to be locked inside a carrying case and labeled confidential. Records are purged on a quarterly basis and only those with no entry for seven (7) years are to be destroyed.

A total of ten files were reviewed. All files reviewed were observed to be secured in a locked storage room with controlled access and marked confidential. All files were stamped with a confidential notice. During an interview with staff, it was reported and observed that files transported offsite are locked in a carrying briefcase with a combination lock and a confidential labeled. All files were maintained in a neat and orderly manner.

There were no exceptions to this indicator.

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of the indicator. The operations manual was last reviewed and approved by the President/CEO on August 1, 2018.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging

in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender

expression. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy. Areas in which

youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual

orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred

name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific

documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments,

and clothing that affirms their gender identity or gender expression.

The shelter has copies of the Zine located in the main lobby, the visitor entrance, on the boys and girls dorms, and staff office area, for staff and

visitors to take and read. A review of a sample of training files revealed that most staff have received training on the SOGIE policy. This training

is included on the programs annual training plan. There is also a training that is provided for all interns and is also included on the intern training

plan.

The shelter has signage located throughout the shelter including in the hallways, staff offices, lobby area, visitor entrance, and the boys and girls

dayroom, indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender

expression.

There were no exceptions to 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 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 levels on each side. The building is equipped with two school classrooms, 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. The agency has emergency equipment such as fire extinguishers, knife for life, first aid kits, wire cutters, and 2-way radios.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the indicator.The policy was reviewed and approved August 1, 2018.

The agency policy states that the program including the attached buildings and the grounds are clean, landscaped and well maintained. Furnishings are in good repair. To provide a sense of ownership by involving staff in the identification of physical property needs. The policy states the Fire Prevention Plan will consist of the availability, the maintenance, quarterly testing and inspection of all fire protection equipment/supplies and the posting of evacuation egress plans. The policy states the program will post a residential daily schedule, in areas accessible to shelter clients. The schedule will include specialized treatment services, therapeutic groups, life and social skill training activities, leisure, educational programming, structured outdoor/indoor activities that teach social skills and sportsmanship. All residential clients will be provided the opportunity to participate in a variety of faith and community based services/activities. Participation is voluntary and non-punitive activities are provided for youth who choose not to participate. The policy states the program will provide group sessions in the residential program based on established group process principles that are conducted a minimum of five days per week as permissible and documented in the client's file. Youth who are assessed as needing specialized skill training, are provided skill training in social and planning skills, skills for dealing with feelings, positive alternatives to aggressive behavior, skills for responding effectively to stress response skills, and life skills, among others. The program provides health education to youth in the residential program. It states the program will maintain strict control of flammable, toxic, and poisonous chemicals. It is written that program staff will assist in identifying despair and/or unsanitary conditions in regards to: furnishings, insect infestations, grounds being landscaped, bathrooms and showers being functional, graffiti, adequate lighting, and bed coverings. Staff may correct the conditions and/or notify the facilities department by completing a maintenance request form. It is written that all chemicals used will have a Materials Safety Data Sheet (MSDS) that is kept in the designated log in the staff station. Inventories will be maintained monthly by the day shift. It is written that staff will check vehicles to ensure it is equipped with: a first aid kit, blood borne pathogen kit, fire extinguisher, and safety triangles. It is written that staff must lock all vehicles when not in use. It is written that the schedule will be posted for all clients to access it. The purpose is to provide a structured environment for the clients. The daily schedule is to include: at least one hour of physical activity daily; time allotted for homework and study; and faith-based programming opportunities.

A walk through of the residential building was conducted to include: dorm rooms, bathrooms, laundry room, kitchen, dining room, staff areas, library, classrooms, and common areas. Each dorm room had a bed with all bedding and linens neatly made. All furnishing were in good shape with no signs of graffiti. The building showed no signs of any insect infestation. All bathrooms and showers were extremely clean and were functional. All lighting was adequate and working. All necessary doors were secured with limited access to staff. Detailed map with egress charts, DCF child care license, client rules, grievance access, abuse hotline, and the DJJ incident reporting number were all available. There was no signs of contraband, and there was adequate storage for youth to lock up their personal items. Washers and dryers were well maintained. MSDS is counted monthly in accordance to the program's policy. Each chemical on the MSDS sheets has a picture, description and is counted. All food was properly stored, marked and labeled properly, and all areas were clean. Refrigerator and freezer were all clean and held required temperatures. There were four vans checked, both were locked upon viewing and were properly equipped with all necessary items.

The program is in compliance with needing a minimum of one fire drill completed each month, each month had additional fire drills that were completed in a timely manner. There were multiple mock drills completed each month for each shift, which is above being in compliance of one per shift per quarter. The drills were very detailed.

The program had the documented annual fire inspection that was completed on September 13, 2018 and was in compliance with their local fire marshal and fire safety code within their jurisdiction. There was documented annual fire safety equipment inspections for all necessary items: fire alarm, sprinklers and extinguishers were completed on January 24, 2019; kitchen overhead hood was completed March 8, 2019. The program has a current health inspection completed on March 12, 2019 by the department of health that was satisfactory. The program food menus are posted and were signed and stamped by a licensed dietician on March 1, 2019.

A daily schedule for each month was provided which was very structured. It included time for: spirituality weekly, an hour of physical activities, education, and social skills groups. Groups are documented in each client's individual files. Idle time is minimal. Daily activity schedule is available for all staff and youth.

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the indicator. The policy was reviewed and approved August 1, 2018.

The agency policy states the program is to provide orientation to youth immediately upon admission to the program or no later than 24 hours from admission. It is written that upon admission the program staff will offer the client a client orientation handbook and will review it together. This orientation handbook includes: disaster preparedness instructions, the search policy, list of contraband items, identification of key staff and roles, abuse reporting, youth rights, center rules and consequences, medical/dental/mental health access, dress code, personal hygiene, activity schedule, room assignment, facility tour, confidentiality guidelines, school attendance, explanation of individual/group/family therapy, program services, grievance procedures, suggestion box, visitation policy, telephone guidelines, correspondence policy, and suicide prevention awareness. It states both staff and youth will sign the client orientation form.

There were six files reviewed, four open and two closed. All six files reviewed completed the client orientation on the same day as intake. All six client orientations reviewed had both the staff's and the youth's signatures. All required items were included in the orientation, which included: disaster preparedness instructions, the search policy, list of contraband items, identification of key staff and roles, abuse reporting, youth rights, center rules and consequences, medical/dental/mental health access, dress code, personal hygiene, activity schedule, room assignment, facility tour, confidentiality guidelines, school attendance, explanation of individual/group/family therapy, program services, grievance procedures, suggestion box, visitation policy, telephone guidelines, correspondence policy, and suicide prevention awareness.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the indicator. The policy was reviewed and approved August 1, 2018.

The agency policy states the program demonstrates the goal to protect youth through a classification system that ensures the most appropriate unit assignment and sleeping room assignment. It is written that the youth will be interviewed upon admission to determine the most appropriate sleeping arrangement and to increase staff awareness of classification issues. Factors include: physical characteristics, initial contact and initial observations of youth, age differences, aggressive behaviors, susceptibility of victimization, presence of medical, mental or physical disabilities, suicide risk, sexual aggression, gang affiliation, current and/or alleged offenses, and attitude at admission.

There were six files reviewed, four open and two closed. All six files had completed the client's room assignment on the day of admission. All necessary information was captured and documented, which included: physical characteristics, initial contact and initial observations of youth, age differences, aggressive behaviors, susceptibility of victimization, presence of medical, mental or physical disabilities, suicide risk, sexual aggression, gang affiliation, current and/or alleged offenses, and attitude at admission.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the indicator. The policy was reviewed and approved August 1, 2018.

The agency policy states residential programs are to maintain a permanently bound log book with sequentially numbers pages to chronologically record the program events. The professional log is used to record routine information, emergency situations and any incidents, especially those that affect the safety and security of the program. All residential staff, including shift supervisor/designees will review the log entries prior to coming on shift. All entries are to be brief and legibly written in black ink and should include: date and time of incident, event or activity; name of all youth involved, name of staff involved; a brief statement providing pertinent information; the name of the person making the entry with the date, time of entry and signature. All recording errors will be struck through with one single line and "VOID" written above the error, the staff must sign and date the correction. The use of whiteout, or any erasure is prohibited. Logbook will be retained for a period of three years. It is written that program staff are to write their own entries, unless there is an emergency. Staff are to enter the date and time in the first column, on separate lines ideally. Staff are to enter the contact code in the second column, there is a key of the codes in the back of the log book. An explanation narrative is to be written in the third column. All late entries are to be documented by using the date and time of that the staff are physically writing the entry, then write LE and the date and time that the late entry should have been recorded. Staff must authorize all entries

with their signature and title or credentials.

There were three log books reviewed. All three log books contained very thorough documentation of daily activities in the shelter. All safety and security issues were documented. All entries were written legibly and in ink with no evidence of erasures or use of white-out. All entries included the date, time, youth and staff involved, and a signature of the staff completing the entry. Supervisory reviews are completed at a minimum of one time a week, with most weeks having more than one documented entry of a supervisor reviewing the log book. Great documentation of all staff reviewing the log book of the previous shifts. Supervision and resident counts are documented consistently and in real time. All visitations and home visits are documented consistently. The program uses color coded highlights for specific entries such as drills, medications, incidents and other important entries. The program uses a contact key code to make it easier to find specific entries. There were four recording errors reviewed that were not struck through with a single clear line with staff initial and the date. All four recording errors reviewed had “VOID” written through the entry with no staff initial and no date. All other recording errors observed were documented correctly.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the indicator. The policy was reviewed and approved August 1, 2018.

The agency policy states the program will utilize the point system to foster accountability and compliance with the program rules, expectations and consequences. This method provides the youth with on-going feedback concerning their behavior. The behavior management system is clearly described in the written client’s orientation handbook that is provided to youth upon admission to the residential program. The program will also utilize consequences and sanctions that are directly related to the seriousness of the inappropriate behavior exhibited. These consequences are to be applied immediately when the inappropriate behavior is displayed. It states the program is to have behavioral interventions that utilize the least amount of force necessary to address the situation and basic rights of the youth. It states it is the policy of not to permit certain disciplinary measures and not to deny youth certain rights regardless of their behavior. No youth or group of youth is to be given the authority to impose disciplinary sanctions over other youth. It is policy that staff use behavioral interventions that utilize the least amount of force necessary to address the situation and basic rights of youth. It is written that the program’s point system is based on points a youth earns for activities or events they are expected to participate in each day. Points earned per activity can be between 0-2. There are very detailed examples of how youth can earn points. Youth have the opportunity to earn up to 104 points per day. The number of points earned each day will determine the level they earned for the following day. Level I = 0-61 points; Level II = 62-74 points; Level III = 75-104 points. The level the youth earns determines the daily rewards the youth has earned. The points are used to assess and monitor a youth’s overall behavior and compliance in the program. Therefore, the points are able to be used in a youth’s goal planning. Consequences are evaluated on an individual basis.

It is written that only program staff are to discipline youth. Group discipline is not to be imposed. Appropriate interventions would include: counseling, verbal interventions, physical interventions approved by Florida Network, and referring to the behavior management system. The following are forbidden behavioral interventions: corporal punishment, ridicule, intimidation, verbal abuse, punitive work, withholding or distributing medication, deprivation of the youth’s rights, chemical or mechanical restraints, painful behavioral modification, or room restriction. No youth are to impose sanctions over another youth.

The program has a detailed written description of their behavior management point system that both staff and youth can follow. The point system is explained at orientation and is used daily with the youth to assist in gaining compliance with the program rules and to help influence positive behavior while increasing accountability. The youth can earn points for activities or events they are expected to participate in each day. Points earned per activity can be between 0-2. There are very detailed examples of how youth can earn points: doing chores, participating in group, completing school work, waking up and going to bed when told, along with many others. Youth have the opportunity to earn up to 104 points per day. The number of points earned each day will determine the level they earned for the following day. Level I = 0-61 points; Level II = 62-74 points; Level III = 75-104 points. The level the youth earns determines the daily rewards the youth has earned. the levels are displayed for the youth to see. the points pages are kept in the youths' files. There are very detailed examples of what the youth can earn based on the level they earned. The point system utilized encourages youth to meet behavior expectations and is used when needed in their personalized goal setting. Consequences are evaluated on an individual basis and are connected to the behavior. Youth are not permitted to impose discipline over other youth. Some consequences include: brief time-outs, brief work assignments, room changes, loss of temporary release or off-site outings, and removal or arrest from the program. All staff were trained in the theory and practice of administering the program’s behavior management system. There is a protocol for providing feedback and evaluation of staff regarding their use of the behavior management system. The supervisors discuss the feedback in their monthly meetings, one-on-one meetings, and as needed. Supervisors are trained to monitor the use of rewards and consequences by their staff.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the CQI indicator. The policy was reviewed and approved August 1, 2018.

The agency policy states the program is to maintain a staff schedule to ensure staff coverage across shifts. The program maintains 24-hour awake supervision of residents, which includes a staff-to-client ratio of 1-to-6 during waking hours and community activities, and a ratio of 1-to-12 during sleeping hours. The program strives to exceed the minimum requirements for having at least one male and one female staff on duty when both male and female clients are housed in the program by maintaining a staff schedule that has a minimum of one male and one female on each shift. Staff observe youth at least every 15 minutes while they are in their sleeping rooms, either during the sleep period or at other times when the client is in their room, such as during illness, reading, writing, etc. staff will observe the youth every 10 minutes for youth who are on risk supervision. The nature of the program requires that the director of residential services/shift supervisor/designee be on-call on a 24-hour basis. It is written that the shift supervisor/designee will develop a staff schedule to ensure that the proper staff to client ratio in maintained. If an issue arises regarding coverage, the shift supervisor/designee will attempt to get coverage by calling the call list/staff roster. During sleeping hours, staff shall observe youth at least every 15 minutes, or every 10 minutes for a youth on risk supervision. Fifteen minute checks will be documented in the sleep log.

Program maintains minimum staff requirements of 1 staff to 6 youth during waking hours. Program maintains minimum staff requirements of 1 staff to 12 youth during sleeping hours, and always has a minimum of 2 staff on during the overnight shift. The program at times exceed the minimum to allow more support for the staff and youth. There is a roster of relief staff when additional coverage is needed. It was noted there were a few shifts that did not maintain at least one staff member on shift of the same gender as the youth, however, in reviewing additional documentation it revealed a relief staff of the gender needed came in to work to meet the requirement.

The agency is equipped with functioning surveillance cameras that are well positioned and has clear video. Tape is able to be retained for at least the last 30 days, in watching tapes, video retained was over the 30 days required. The following dates and times were reviewed: January 3, 2019, February 19, 2019, and March 1, 2019. In reviewing the documented times it was witnessed that staff observed youth every 15 minutes while in their dorm rooms on January 3,2019 and February 19, 2019. In reviewing tape on March 1, 2019 it was noted that between the 5:10am-6:01am there was only 1 bed check completed on the boy's dorm at 5:36am. However, in reviewing the written sleeping logs for March 1, 2019 the bed checks were documented being completed every 15 minutes during that time frame.

The following dates and times were reviewed: January 3, 2019, February 19, 2019, and March 1, 2019. In reviewing the documented times it was witnessed that staff observed youth every 15 minutes while in their dorm rooms on January 3,2019 and February 19, 2019. In reviewing tape on March 1, 2019 it was noted that between 5:10am-6:01am there was only 1 bed check completed on the boy's dorm at 5:36am. However, in reviewing the written sleeping logs for March 1, 2019 the bed checks were documented being completed every 15 minutes during that time frame. This was reported to the CCC as falsification of documentation.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the CQI indicator. The policy was reviewed and approved August 1, 2018.

The agency policy states the program will provide a higher level of security for staff secure clients. Strategies have been put in place, which work to reduce runaway incidents. It states the program will provide family/youth respite aftercare services to youth between the ages of 6 and 18 years of age referred following a domestic violence arrest on a household member and/or youth on probation regardless of adjudication status at risk violating. It states services are designed for youth referred by DJJ and are in need of more intense family stabilization. It is written that the intensive case management services are available for youth between the ages of 6-17 years old who are chronically truant/ungovernable, are court involved or likely to enter the petition process and may require more intensive and lengthy services. These services may be court ordered or referred through the local case staffing committee. These services are to connect youth and families to a coordinated, comprehensive array of services that meet their needs. There was no evidence of a policy and procedure written for domestic violence respite referrals, probation respite referrals or domestic minor sex trafficking respite referrals, however the program follows all the key elements in the CQI indicator.

In the time frame being reviewed there were no staff secured youth court ordered to the program.

There were two closed files reviewed for domestic violence (DV) referred youth. Both DV respite youth had a pending domestic violence charge and were screened by Jacksonville Sheriff's Office. Neither youth exceeded the 21 days in the DV respite placement. One youth had documented evidence that showed they had been switched from a DV respite bed to a community CINS/FINS bed after their 21 days. Both youth had case plans and goals that focused on aggression management and family coping skills to help reduce re-occurrence of violence in the home.

There were two closed files reviewed for probation respite referred youth. Both probation respite youth were referred by the youth's juvenile probation officer. Neither of the two youth exceeded the probation respite allotment of no more than 14 to 30 days. There is documented evidence that the case management and goals addressed were consistent with their current crisis.

There was one closed file reviewed for domestic minor sex trafficking approved youth. There was email approval from Florida Network to utilize the DMST respite bed, along with an approval for additional days outside of the standard seven days. There was further approval for increased supervision for the safety of the youth and the program in which the program utilized. All services provided to the youth were specifically tailored to serve and assist the youth.

There were two closed files reviewed for family/youth respite aftercare services referred youth. Both youth were referred by DJJ for a domestic violence arrest and was on probation. Both files had documented evidence of approval from the Florida Network office. Intake and initial assessments on both youth were face-to-face and included gathering family history and demographic information. Both youths' and their guardians' signatures were captured on the program's orientation. For one youth there was clear documentation of face-to-face sessions that were at a minimum of 60 minutes and focused on strengthening the family and identifying strengths and needs of each member to assist in improving family functioning. There were thirteen documented sessions with the youth and their family. The second youth reviewed there was great documentation that showed staff attempting to reach out to family to continue services after the initial assessment, with no response from the youth or guardian. This youth was closed out for family non-compliance after initial contact.

There were two open files reviewed for intensive case management services. Both files had documented evidence that the youth was referred by case staffing committee to the program. One file had documented evidence the youth and family had a minimum of 6 direct contacts and a minimum of 6 collateral contacts per month, or well documented evidence of continued efforts to meet with the youth but the youth would not show up for the session. The second file just opened services march 1st so there was not enough time to have 6 direct contacts and 6 collateral contacts. The child behavioral checklist and the self-report assessments were both completed at intake with both youth. One youth completed the self-report assessment again in less than the 90 days. The second youth started services March 1st so there has not been enough time to complete this. Both case plans demonstrate a strength-based and trauma-informed focus for the youth. The agency has evidence that the ICM has a strength-based perspective to help youth and families through: engaging with the youth and their families via sessions and phone calls; advocating for the youth in case staffing committees; initiating change agent activities with both the youth and their families; and helping to access supports within the community to further assist the youth.

There were no exceptions to this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the CQI indicator. The policy was reviewed and approved August 1, 2018.

The agency policy states the program will have a security camera system to monitor staff interactions with youth, activities, and events. It is written that the program has a security camera system to ensure and monitor staff interactions with youth, activities, events, and the safety of the facility. The camera system is to monitor in the youth care stations and other common areas in the facility except bedrooms and bathrooms. Signs are to be posted to alert visitors and clients of the presence of the security camera system. Videos are to be reviewed by the director of residential services, or designee, monthly or as needed based on any incidents. The system is able to retain information for a minimum of 30 days.

There is written notice posted in the lobby of the video surveillance being recorded. There are video surveillance cameras in the interior and exterior general locations where youth and staff congregate as well as where visitors enter and exit. All 16 cameras are visible and there were no hidden cameras. There were no cameras in the youths' bedroom or bathrooms. Systems can capture and retain video photographic images including facial recognition. The video surveillance system can record date, time, location and store video for a minimum of 30 days. Cameras have a back-up system that can operate during a power outage. There is a list of designated personal who can access the video surveillance system which includes 4 supervisory staff. In reviewing the supervisory review of video is conducted at a minimum of once every 14 days and noted in the log book. The reviews completed assess the activities of the facility and include random samples of the overnight shifts. The program has a process for third party review of video recordings after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.

There were no exceptions to this indicator.

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 addressing the screening of medical and health issues with youth admitted for intake.

The agency has procedures in addressing the evaluation and assessment of any medical or health needs of a youth admitted to the facility. In addition, there are procedures for conducting follow up referrals and notifications with guardians to ensure the health or medical issue has been or will be addressed.

Upon entering the facility and conducting intake, staff utilize the Admission Form which screens for any potential health or medical issues to include certain health condition such as asthma, hemophilia, diabetes, pregnancy, seizures, heart issues, tuberculosis, and head injuries. The form also addresses any chronic or acute issues as well as any observable behaviors or markings. The form also addresses any allergies, recent injuries or illnesses, and current medications. Five residential files were reviewed and each of the files had the form present and filled out upon intake. Each of the files addressed the areas noted in the standard and none of the files indicated any medical or health issues that required further follow up. In addition to this screening, the agency nurse reviews the form and addresses any further needs with the youth in her own progress notes.

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the process and scope of suicide risk screening and assessment.

The agency procedures for assessment of suicide risk-assessment cover both residential and non-residential services per the Florida Network Policy. The agency also has an Emergency Mental Health and Substance Abuse Services Plan which address the procedures for staff in conducting each of these services.

Three files were reviewed which had initial indications of suicide risk. Each of the files contained a designation of risk based on the admission screening form. Staff in each of these files noted after completing the intake that the youth was being placed on sight and sound. In one instance, the youth was placed on one to one supervision based on higher risk responses on the screening form. In each of the cases, a licensed mental health professional was not available so staff began observation logs and youth sign a personal safety plan. Within 24 hours on each of the files reviewed, youth on sight and sound were met with by a counselor under the supervision of a licensed professional or with a licensed professional themselves. In one case the youth was stepped down from one to one and placed on constant sight and sound. The same youth was subsequently reviewed again in 24 hours and placed on standard supervision. The other two files reviewed were met within 24 hours and stepped down to standard supervision. Progress notes for each file indicated that an assessment had taken place and was also reviewed by the clinical authority, all within required timelines. In looking at the observation logs, staff maintained logs while the youth were on elevated supervision per the requirements at 15 minute intervals during awake hours and 10 minute intervals during sleep hours. The observation logs detail each day and shift, and staff would initial after their observation.

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place which complies with the requirements of the Florida Network regarding the proper supervision and monitoring of medication.

The agency has procedures for the proper supervision and monitoring of medication that encompass OTC distribution, prescription medication distribution, training of staff, refusal of and missed medications, and medical resources available to clients in an emergency.

The agency has a separate medication room in the staff area that is secure at all times. There are two nurses on staff who are both RN's. The RN's complete the medication training for the agency for any new staff and ongoing. The list of approved staff for medication distribution is maintained and currently there are 24 staff on the list with the dates of their initial or most recent training. All medications are stored in the Pyxis machine on site in the medication room. OTC's are stored in the first drawer, prescription medications are stored in the subsequent drawers. At the time of this review, there were 5 youth on medications, 3 males and 2 females. The agency maintains MDL's on each youth in a separate log, one for males and one for females. The log contains photo identification of the youth along with prescription information. The MDL contains the distribution times, dosage, dates, perpetual count, and shift to shift counts for controlled substances. In addition, the MDL's also contain any known allergies and potential side effects. Verifications are completed on each medication and noted on the back of the MDL. Most of the verifications are done by the nurse and some are completed by contacting the pharmacy. In each youth's residential file in section 3 the agency maintains the consent to distribute medication along with a list of any known allergies, consent for OTC's, and any counter-indications noted by the guardian or physician. The agency has a total of 7 super users and the room also contains a refrigerator for storage of medication. The temperature of the refrigerator was 44 degrees which is within the required temperature range. The staff also receive training from the nurse on epi-pen use before being able to administer or assist in administration. OTC's are inventoried weekly by the nurse in a log stored in the medication room. The agency maintains 14 OTC's which are inventoried on a perpetual and weekly count. Youth needing and receiving OTC's are asked to sign along with staff. Outside of the medication room in the staff area a board is kept with all of the youth on medications currently along with any allergies they may have. Discrepancies in the Pyxis are cleared by the next shift and a report was generated showing past discrepancies for one week, all of which were cleared by the next shift and witnessed by staff. The RN also conducts monthly reviews of the Knowledge Portal and keeps binders with the documentation of the reviews.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place which addresses the components of alerting staff to any special needs of the youth when they enter the facility.

The agency has procedures which detail the process of alerting staff and notes that the alerts are placed in several locations which are the file, census board, the log, and the Alert Classification System binder.

During intake youth are screened for any special needs or risk and a subsequent alert process is put into motion to ensure all levels of staff are aware. The agency utilizes a color coded process to designate youth who are on Risk (green) and Medical/Special Needs (pink). Staff complete a form called Intake Alert Classification Form which designates any alerts on youth such as Medical, Risk, Allergies, Run Risk, Baker Act, Gang, and DMST. This form is signed by the staff, supervisor, and clinical authority. In addition, the sheet is scanned and e-mailed to all administrative, medical, therapeutic, and supervisory staff at the shelter. A copy of this form is then placed in the Alert Classification System binder which is accessible to all staff to ensure they are monitoring a youth's status. In addition, alerts are also noted for staff on the shift reports. The census boards are utilized to also indicate a youth's alert status and the corresponding colors noted above are used on the boards. Of the six residential files reviewed for alerts, one was placed on Risk when he entered the facility and was noted on the Intake Alert form, placed on the board and highlighted in the log. One file had a Special Needs indicated with possible DMST and this was noted on the form and in the log. The form was located in the other four files but no alert classification was necessary.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place which addresses the need for administering episodic care to youth in the program.

The agency has a procedure in place to address the steps to be taken by staff in the event of a youth's medical or mental health emergency. The procedures address each section of the standard and are in compliance with the Network policy and procedures. In review of staff training files, there was evidence that all of them had a training in Emergency Response through the agency.

There is a knife for life located behind the staff station along with wire cutters and is in a box with a zip lock that can be accessed when pulled. The agency has 3 AED machines located throughout the facility and all are in working order. There is a first aid kit in the staff station and one in each of the 4 vans. In reviewing the staff kit and 4 vans, all required items were located. The kits are checked monthly and there was evidence indicating checks on stickers in the kits. In addition, seat belt cutters and glass hammers were located in each van. The agency maintains an episodic log in the medication room that is completed when any medical or health issues are addressed with the youth. The log tracks the date, youth's name, client number, injury/emergency/illness, treatment rendered, staff initials, and referred to status. Of the 6 entries reviewed in the log, 3 of them required off site medical care. There were Internal Reports (IR's) corresponding to the off site medical care and notations in the log for both the medical issue and the incident; these were highlighted in yellow and pink respectively. There were notations made in the youth's progress notes corresponding to the episodic care given, as well.

There were no exceptions to this indicator.