



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth Crisis Center

on 05/04/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory: 83.33%
 Percent of indicators rated Limited: 16.67%
 Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory: 85.71%
 Percent of indicators rated Limited: 14.29%
 Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 92.00%
 Percent of indicators rated Limited: 8.00%
 Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer FOREFRONT/FNYFS Oversight, Compliance and Quality Improvement

Felicia Wells, Program Director, Youth Advocate Program

Kevin Greaney, Regional Monitor, Florida Department of Juvenile Justice

Crystal Westman, LMHC, Clinical Supervisor, Arnette House

Shawn Block, Program Administrator, Anchorage Children's Home

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 2 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 11 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 8 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 27 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 20 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 9 Youth Records (Closed) |
| <input checked="" type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 8 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|----------|---------------------|---------|
| 12 Youth | 6 Direct Care Staff | 0 Other |
|----------|---------------------|---------|

Observations During Review

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

Comments

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

Rating Narrative

The agency has not received any referrals for Domestic Minor Sex Trafficking, Probation Respite and Staff Secure for more than a year. The agency has had minimal case staff referrals. The agency has had numerous Domestic Violence Referrals.

Strengths and Innovative Approaches

Rating Narrative

The Youth Crisis Center (YCC) is a large spacious campus. The campus has a modern, well-designed residential youth shelter, transitional living program and administrative office buildings.

Youth Crisis Center's (YCC) Chief Executive Officer hired new Dr. Steve Barsky as Clinical Director and Cecelia Stalnaker-Cauwenberghs as Program Director.

YCC finalized the behavior management system for the residential program. This process included receiving feedback from clients, direct care staff, therapists, and program management.

The agency purchased 3 Automated External Defibrillators (**AED**). An AED is a portable electronic device that automatically diagnoses the life-threatening cardiac arrhythmia events. The agency will be training on how to utilize the AED as part of their on-going CPR/First Aid training for all staff.

YCC also purchased six (6) 2-way radios to be used by direct care staff members to enhance on-going communication for the residential program. Further, the agency's Residential Director created a radio training for all direct care staff to use 10-codes to speak to each other (similar to systems in detention programs).

The agency partnered with several local community-based organizations. YCC connected with Yoga 4 Change, a local non-profit. Yoga 4 Change collaborated with YCC to provide yoga classes each Wednesday to the females in the shelter program. In addition, the agency partnered with Cathedral Arts Project. This agency now provides weekly visual art classes each Saturday to males in the residential program. YCC also partners with JASMYN, a local LGBTQ support organization who have provided LGBTQ sensitivity training to therapists and youth care staff.

The agency now has two (2) Registered Nurses that oversee medication storage, inventory and medication administration to YCC residents.

The agency has contracted with another mental health agency to pay for four (4) hours of time per week for a child psychiatrist. She has provided psychiatric evaluations for some of the CINS/FINS youth in the residential and Family Link programs.

YCC now has 4 part-time Duval County Public School teachers that provide academic instruction to the youth in the residential program.

YCC also instituted a new uniform protocol. All direct care staff in the residential shelter are transitioning to wear uniforms. Direct care staff were surveyed regarding their thoughts on going to uniforms as the dress code, as well as input on colors of shirts. All supervisors wear red and staff wear navy blue shirts. All staff members wear khaki pants with their respective shirt. YCC paid for 3 sets of clothes.

The agency conducted and completed one series of training for the Certification on Youth Care professionalism. A second series of this training will begin the week of May 9, 2016.

YCC's Board of Directors went through a Board development training in November to enhance knowledge around governance, fundraising, and policy.

Standard 1: Management Accountability

Overview

Narrative

The program Youth Crisis Center (YCC) operates a thirty (30) bed residential shelter and non-residential CINS/FINS program. The program has more than sixty (60) 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. To evaluate this standard, a total of more than thirty (30) employee files were reviewed. The agency has an active self-reporting incident reporting process. As of the date of this on site program review twenty-four (24) incident reports were accepted by DJJ in the last six (6) months. The agency has activated a new Client Transportation policy and process for 2015-2016. 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 Youth Crisis Center has a policy established to complete a series of background screenings prior to an offer of employment or prior to being accepted into the volunteer program. The policy also states that all staff will be re-screened every five years after the date of the initial screening.

The program maintains records pertaining to these background screenings in each individual employee's file. The files were found in an organized and secure manner and were neat and orderly.

There have been seven new staff members added to the program since the last Florida Network review on June 22, 2015. All seven employee files contained evidence of background screenings that had been performed prior to each employees' respective start date.

All employees are to be rescreened every five (5) years of their initial hire date. 100% of the program's employee files that met this requirement were reviewed and all four employees and one volunteer completed a five year rescreen prior to their five year anniversary.

The Annual Affidavit of Compliance with Good Moral Character Standards was sent to DJJ on January 8, 2016. The program presented a copy of the affidavit.

No exceptions are noted.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. Staff adheres to a code of conduct which prohibits physical abuse, profanity, threats, and/or intimidation. Youth are never deprived of their basic needs. The program has "Workplace Policies", found in section "C" of the Employee Handbook that outlines "rules of conduct that will protect the interest and safety of all youth, employees, and the organization." The program has an established "Abuse Free Environment" policy (1.09) that ensures that both youth and staff feel safe and free from abuse, harm or harassment. The policy defines what constitutes abuse, neglect or threatened harm, but also establishes systemic procedures all staff must follow in reporting known or suspected abuse or neglect. All youth and staff have the right and sometimes the requirement to contact the abuse registry.

The program requires each newly hired employee to acknowledge their mandatory obligation to report known or suspected abuse of a child, as required by sec. 415.1034, F.S. All ten records reviewed contained a couple of documents signed by the employee that acknowledges they will abide by the program's guidelines to prevent abuse. All program new-hires acknowledge that they have read and received a copy of the employee handbook. They also sign their acknowledgement to the responsibility to complete a review of the program's operations manual. All staff acknowledge on a separate form that they will be responsible for complying with the contents of the program's operations manual.

There has been no allegations of child abuse or potential child abuse made towards the program since the last Quality Improvement review.

Twelve (12) youth were surveyed with their responses being, overwhelmingly positive toward staff and the practices of the shelter. All youth reported they felt safe at the facility. All except two youth reported that they knew about the abuse hotline being available to them and four of the twelve knew where it was posted in the shelter. All the youth did report that they have not wanted to make a call to the abuse registry and that they were not stopped from making a call. Eleven of the twelve responded that they know about the grievance process. Four responses of the twelve youth have heard staff, three being youth care workers and one was counseling staff, use profanity or threats toward youth.

All twelve youth reported feeling safe in the shelter. They all knew how to use the grievance process. Four reported that the grievance process was very good, three responded good, and four responding fair. When asked how they rate the provider, eight said very good, two responded good, and one said they were fair.

No exceptions are noted.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed Incident Reporting policy that meets the requirements of the indicator. Whenever a reportable incident occurs, the program notifies the Department's Central Communication Center (CCC). A total of twenty-four (24) calls were made from the program to the DJJ CCC since the last review. All 24 calls were made within two (2) hours of the incident or within 2 hours of becoming aware of the incident.

The program's policies (1.09 and 1.11) requires the reporting of incidents that occur with youth in the program. The program also completes follow-up communication tasks as required by the CCC in order to close the case and to assure that the incident had been fully examined.

No exceptions noted for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a written agency training plan in place. They have a training plan that is reviewed and updated annually. All full time employees are required to obtain a minimum of 80 hours the first year and 40 hours annually after that.

A total of 10 (ten) training files were reviewed. Of the 10 (ten) files, 5 (five) were Therapists; 4 (four) were Youth Care Specialists and 1 (one) was a Transitional Living Coordinator.

A total of 5 (five) files were reviewed for the first year of training. All 5 (five) files reflected each staff member having more than the required 80 training hours with 104.25, 101.5, 93, 122.75 and 82. However, 1 (one) of the files (B.N.)

did not show to have completed CINS/FINS Core Training or Fire Safety Equipment Training.

A total of 5 (five) files were reviewed for the annual training. All 5 (five) files reflected each staff member having more than the required forty (40) training hours with 47.75, 42, 63, 49, and 41. Of the 5 files, all of the files documented all the required trainings have been met via dates listed as completed on the "my learning point" form. This form listed all online, classroom and other courses the staff has completed or needs to complete in the future.

The agency's training files are very organized and easy to navigate through. This reviewer found that the training report forms were very helpful and beneficial with making this process easy to find documented trainings, completion dates and total hours for the staff. This form also listed an expiration date that would allow for the staff to have an understanding of when they would need to complete the course.

No exceptions were noted for this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

There is an established Quality Improvement process at the program. This process allows management to compile and communicate information on a broad array of topics for analysis of trends and outcomes. The quarterly held committee meeting compiles documentation from each area within the program including Quality Assurance, Data entry reporting, human resources, facilities, finance, residential, clinical, and development. The data is compiled and provides a summary data report of their status to the management team. These reports also includes quarterly case record reviews, reviews of incidents, accidents, and grievances, customer satisfaction data, outcome data, and monthly review of NetMIS data.

The program provided reports of aggregated data and meeting minutes compiled into a QIC notebook. When there are improvements or changes needed, there is evidence of corrective action being taken in the form of retraining or modification of processes.

The program does review medication management practices. At the time of this on site QI program review, the agency is not utilizing the Knowledge Portal or Pyxis Med-Station Reports.

No exceptions are noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a transportation policy concerning agency vehicles. It includes bi-weekly safety checks, vehicle mileage log, prior to every use safety inspections, vehicle use, and accidents. All new employees are screened in order to ascertain the status of their driver's license. There is a spreadsheet that lists when their license will expire. There is a list of approved drivers maintained. Documentation of the use of the vehicle is maintained separate from the bi-weekly safety checks. The vehicle log lists the name of the driver, date and time, mileage, number of passengers, destination, and gas level. There is a 3rd party requirement listed in the client transportation and maintenance of ratio portion of Staffing and Youth Supervision (3.10) procedure. The 3rd party can be staff, volunteer, or other youth with gender considered.

Exceptions are noted for this indicator. If the driver is transporting a single client in the vehicle the program supervisor is aware prior to the transportation and gives their consent, but consent is not documented.

The program requires YCC staff driving the vehicle to conduct a safety check with every use of the vehicle. Review

of transportation documentation on site was reviewed. The vehicle transportation safety checks are not consistently logged.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program participates in local and circuit level meetings convened by the Department of Juvenile Justice representing CINS/FINS. YCC also participates in the local DJJ Advisory Board meetings to ensure that CINS/FINS services are represented in a coordinated approach to reducing juvenile delinquency through effective prevention, intervention, and treatment services. The CEO sits on the DJJ Advisory Board, on St. Johns Juvenile Justice Board, United Way Area Director's Association, and member of National Association of Social Workers. The Director of Residential Services attends DJJ Provider's monthly meeting as the representative. This representative advocates for the effective use of CINS/FINS services and gives updates to services provided. Minutes are produced at this meeting by DJJ staff and they send an electronic copy to each of the attendees.

No exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Youth Crisis Center (YCC) operates residential and non-residential services to provide CINS/FINS services. The youth shelter has residential therapists under the supervision of the Clinical Director. The Family Link program has eight (8) Non-Residential Therapists and three (3) Residential Therapists. 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 program has a policy and process for centralized intake services including screening for eligibility, crisis counseling and information and referral. The process ensures that screening for eligibility for potential clients is done within seven (7) calendar days of referral to the program. In addition, on page 47 of the revised Operation Manual (2016) the Intake Procedure (Non-Residential) states that the agency provides youth and parents/legal guardians with brochure about service options and information pertaining to CINS/FINS services, etc.

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

Seven (7) files provided documentation that the agency completed each eligibility screening within 7 calendar days of referral. One (1) file shows a faxed date of 11/19/15 at 13:29 hours and the first documented attempt to contact family was dated 12/9/15 beyond the 7 calendar days.

Program has the parent/guardian and youth sign their "Consent to Services" which includes:

1. Service programs offered including information regarding case staffing meeting;
2. Client rights and Responsibilities as a Client
3. Grievance Procedures
4. Parents Responsibilities as a Parent/Legal Guardian, etc.

All eight (8) files had evidence that the form was signed-- "Consent to Services".

No exceptions are noted for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

This program has a written policy and procedure in place to ensure the Needs Assessment is initiated within 72

hours of admission (for youth in shelter care) and done within 2 to 3 face-to-face contacts after the initial intake (for youth in non-residential care). Needs Assessments are signed off by a Clinical Director or Program Director.

A total of eight (8) files were reviewed for this indicator. The client case files reviewed include four (4) Residential and (4) Non-Residential files.

All four (4) of the Residential files had a Needs Assessment initiated within 72 hours of youth admissions; three (3) were initiated with 24 hours and one (1) initiated within 48 hours.

All four (4) Non-Residential Needs Assessments were done within 2 to 3 face-to-face contacts; two (2) completed within the second contact and two (2) completed within the 3rd contact.

All file's Needs Assessments were completed by a Bachelor's or Master's staff and each assessment had been signed off by a supervisor.

One (1) residential youth was identified with an elevated risk of suicide. The youth was then referred for an assessment of Suicide Risk completed by a registered mental health Counselor Intern and Reviewed by a Licensed Clinical Social Worker.

There were no exceptions in this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

This program has a written policy and procedure in place to ensure Case/Service Plans are developed within 24 hours for residential clients and within the third face to face session. The Goal Plan has individualized and prioritized needs and goal(s) identified by the Needs Assessment as well as service type, frequency, location, persons responsible, date when plan was initiated, target date for completion and actual completion date, signatures of the youth, parent/guardian, counselor and supervisor.

A total of eight (8) files were reviewed for this indicator. The client case files reviewed include four (4) Residential and (4) Non-Residential files.

None of the residential files had signatures for the parents; however, the parent/guardian had signed other authorizations. One (1) file had documentation where a client's mother gave consent over the phone.

All of the non-residential files had signatures of all participants.

There were three (3) files that were closed. Two (2) files did not have a completion date documented on the Goal Plan.

There were no exceptions noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

This program has a written policy in place for this indicator that includes time line for implementation, review and revision of Goal Plan (pg. 53-54 of Operations Manual Revised 2016). The Goal Plan is reviewed every 30 days for the first three (3) months and every six (6) months thereafter for non-residential clients. Case Management and Service Delivery include establishing referral needs and coordinating referrals, monitoring youths'/family's progress, case termination with follow-up.

A total of eight (8) files were reviewed for this indicator; four (4) residential and four (4) non-residential. All eight (8) files had Counselor/Case Managers assigned, referrals were established, service plan implemented, youth/family progress was monitored, and support was provided to families.

Five (5) youth/families were referred for additional services. One (1) file was referred to the Case Staffing Committee.

There were no exceptions for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place for this indicator (pg. 164 of the Operations Manual Revised 2016). The policy ensures youth and families receive counseling services in accordance with their Goal Plan to address needs identified during the assessment process. Non-residential programs provide intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter, etc.

A total of eight (8) files were reviewed for this indicator; four (4) residential and four (4) non-residential.

Seven (7) files (youth and families) received counseling services in accordance with the Goal Plan.

One (1) client file has a Goal Plan stating youth will receive BCT/BM one time per week at school. Youth plan was developed or objectives started on 10/30/2015. Since 10/30/2015 until discharge on 4/26/16 the client received 15 weekly sessions at school. The reviewer documents that for the aforementioned time period there are a total of 21 weeks that the youth was available for school sessions excluding 4 weeks (Thanksgiving, Christmas, and Spring Break) of school. There is no documentation that there was an attempt to provide services to the client in school for the missing sessions.

There were no exceptions noted.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

This program has a written policy in place for this indicator (Case Staffing Committee meeting schedule). The program has staff that is the Chairperson for the Case Staffing Committee. The Case Staffing Committee meets two (2) times per month. Members of the committee are notified/reminded prior to Case Staffing Committee meetings.

One (1) file was reviewed for this indicator. Family was sent notice on 2/5/16 and meeting was scheduled for 2/16/16. Committee members in attendance were representatives from School District, DJJ, State Attorney's Office and Law Enforcement. Staff advised they are attempting to obtain a new member to represent and meet Mental Health. The previous member is no longer with the committee.

There were no exceptions for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

This program has a written policy in place for this indicator. The program maintains confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program.

Kim Sirdevan, President and CEO, reported that each non-residential counselor/case manager has a large rolling double combination lock box. In addition, each counselor also maintains an office at the program facility where they have access to locked file cabinets.

A total of eight (8) files were reviewed for this indicator. Of these files, four (4) were residential and four (4) non-residential. All client files reviewed were marked "confidential". All file records were maintained in a neat and orderly manner.

There were no exceptions for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Youth Crisis Center is a large modern residential group care facility. The shelter has the capability to service more than thirty (30) beds. The shelter is well staffed and maintains proper staff to youth supervision ratio. The residential facility has separate male and female quarters with two (2) levels on each side. The building is equipped with 2 school class rooms, library, common areas, cafeteria and an intake room. The agency has recently revised its behavior management system (bms). There are daily activity calendars posted in the shelter and they include social, educational, spiritual and recreational activities. At the time of this on site quality improvement program review, the agency has emergency equipment such as fire extinguishers, knife for life, first aid kits, wire cutters and 2-way radios.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The program fully met all the requirements for this indicator. The facility is fairly new and is located on an attractive campus. The facility is nicely painted inside and out, landscaped, and decorated. The facility appears to be well maintained with no areas of concern identified; including facility security.

All the required licenses are up-to-date; CCA is good through April 2017 and the annual Health Department is good through February 2017. All required inspections were up-to-date which included, fire, fire alarm, sprinkler and range hood; based on the documentation there were no concerns or discrepancy.

The program is licensed for thirty-four (34) youth; the facility has plenty of room to accommodate for this number of youth. The facility is setup with two separate units; one is female and the other is male. Each unit has two wings. This allows the program to keep younger youth and older youth separated; ten to thirteen and fourteen to seventeen. One wing is made up of single person rooms while the other wing is made up of two person rooms. This also allows the program to make needed adjustments depending on the need of the youth.

The program additionally has two observation rooms located within the staff office area which provides the ability for youth to be observed more closely when needed. The bedrooms, bathrooms, and living areas (common areas) were neat and very clean looking; no graffiti was noticed at the facility. In the living areas there are poster boards that have the activities calendar and other required information for the youth, including abuse reporting information. In each unit there is a grievance box with forms. The bathrooms all appeared to be fully functioning; running water and flushing toilets. The beds were made with full linens. The rooms have an area for the youth to store their clothing and personal belongings. The rooms are numbered and in the two person rooms there are nicely painted picture indicating bed A or B.

There is a staff office area which is centrally located between the female and male units with direct access to both areas. The staff office area has a board indicating which youth are in the program, as well as their room and bed assignments. This office area is also contains primary emergency equipment such as the knife for life, wire cutters and first aid kit. In the locked medication room are the biohazardous and sharps containers. This area also has a locked store room which contains all their chemicals. They currently review/inspect their chemicals monthly (best practice would be weekly). The laundry room was clean and all the washers and dryers appeared to be in working order. The kitchen and dining areas appeared to be clean and well maintained. The kitchen was neat and there were no concerns regarding the storage of food; including dry and refrigerated. The equipment in the kitchen also appeared to be clean and in working condition. The facility is designed with multiple classrooms. The residents in the program also attend school on site. The program partners with the local Duval County school board to provide instructors that teaches on site. The facility also has a library room. The program has four vans; all appear to be in good condition and all had the required equipment and paperwork.

The agency has a detailed disaster plan which meets all specified requirements. The only thing to note is the need to update the Response Team regarding VP of Clinical Services/Clinical Director to reflect Steven Barsky. The program is carrying out fire drills monthly; averaging three per month. There were four fire drills over the six month period reviewed that did not have times recorded. The drills that had documented times recorded were all completed in less than two minutes. The program conducts other emergency drills that include first aid and other critical situations. Over the six months that was reviewed they ranged from six per month to thirteen per month covering all three shifts.

There are no exceptions for this area.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed Program Orientation policy that meets the general requirements of this indicator. The reviewer of this indicator conducted a total of eight (8) files, open and closed. All files had the required documentation for this indicator. The program has four main forms they use as part of the intake to help provide an orientation/overview of the program and services they provide to the parent and youth. This starts with the Consent to Services, Consent for Residential Care, and Residential Contract (these three forms involve the parent). The fourth form, Client Orientation, is specifically for the youth; which also includes the youth receiving a copy of the Youth Crisis Center Client Orientation Handbook (Residential Shelter). A combination these documents, along with the handbook, clearly provides the expectations and rules of the program. These documents, along with the intake process, cover the area of suicide prevention. The program reports at intake, as part of their packet, the parent is also given the CINS/ FINS pamphlet.

The Client Orientation Handbook, 17 pages, is very detailed and provides a complete overview for the youth regarding program expectations, rights, daily operations (a general schedule), grievance process and an example of the grievance form.

The program has recently started using a new form called Personal Safety Plan-Residential. This does not specifically talk about suicide prevention, but does discuss when the youth is upset what helps them calm down. This can be a tool in helping staff effectively intervene with a youth and prevent escalation of a situation and prevent feelings/threats of self-harm.

The program met the requirements for this indicator.

There are no exceptions for this area.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed Youth Room Assignment policy that meets the general requirements of this indicator. There were a total of seven (7) files reviewed. The program has a clear process for room assignment. The room placement process was demonstrated through a face to face meeting with the Shift Supervisor. The facility's physical layout and their operational system also play a big role in room assignments. The program has two (2) separate units—one for females and one for males. Each unit also has 2 wings that allows the program to separate youth by age. This includes level one being 10-13 and level two being 14-17.

There are also 2 observation rooms for youth that need to be placed on a greater level of supervision due to risk factors. There are three (3) main forms used by the program that also assists in room assignments. These forms include the NETMIS Screening, Youth Crisis Center Admission Form, and the Residential Progress Note. The last page of the Youth Crisis Center Admission Form is specific for room assignment. The combination of the answers

from the questions on these forms, as well as the program's system of operation provides the needed information and steps to safely assign youth to rooms.

The only thing to note for this area is the program does not ask the client for their sexual orientation. The program met the requirements for this indicator. There are no exceptions for this area.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed Log Book policy that meets the general requirements of this indicator. The program's log books capture the required information per policy and procedure. They have an outline guide on the front and back cover of the logbook which breaks down the documentation coding as well as what needs to be highlighted and in what color. Based on the review, the program is following their protocol regarding documentation for important/critical events and highlighting them accordingly. Entries are brief and are in ink. There were two entries observed where the information initially documented was incorrect and the staff used the correct procedure of crossing out the entry with a single line and initialing/signing. The Program Director conducts weekly reviews of the logbook; these are recorded in red ink so they are easily identified.

The reviewer observed limited findings related to the amount of logbook reviews conducted by all staff and supervisors at the start of their shift for the previous two (2) shifts. Based on the documentation in the log book there is a consistent lack of this being completed. There is a consistent pattern of direct care staff not reviewing the log book when they sign in on duty. This is also occurring with the shift supervisors. For this particular indicator, six (6) random days were picked—one for each of the 6 months under review. Based on the entries reviewed, there was no documentation of a logbook review for one out of the three supervisors for five of the six days.

The program met the requirements for this indicator. There are no exceptions for this area.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a "Behavior Management System" policy in place that states the shelter utilizes a "Behavior Management System". The agency also has a policy that utilizes the point system which helps to foster accountability and compliance with the rules, expectation and consequences of the program. The point system allows the clients to make choices in what and how they will perform their daily task. The behavior management system is based off of a point system that tracks points from 0 to 104 per day per youth tracking behaviors. The behavior management system explains the expectations of how to earn points during the day. Depending on how many points have been earned throughout the day will determine the level the youth is on for the next day. The behavior system has a total of 3 levels. Level 1 (0-61 points), Level 2 (62-74 points) and Level 3 (75-104 points). The points are displayed for the youth to see in both the male and female hallways. A monthly calendar is also displayed with activities the youth can achieve with gaining points during the week or month.

It has been noted that staff tries to implement strategies for any youth that may be struggling with taking them for a walk outside, having the youth get some space. The staff also reported that they give out stress balls to the youth. The point system provides rewards, privileges, and natural/logical consequences. Each youth is provided a handbook at orientation that explains the behavior management system. Also at intake, the behavior management plan is explained in detail to every youth by staff. The behavior plan covers bed-time to wake-up, chores, table manners, school participation, respectful language, and shower time/hygiene. A binder for both the males and females was reviewed regarding daily points for the youth on-site, the point sheets are also placed in the youth charts which was reviewed for 3 (three) closed charts.

It was reported that the staff is actively trying to obtain products for a points or token store. This is something the staff and agency are working towards implementing in the future.

No exceptions noted.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure (Operations Manual) for staffing and youth supervision with a ratio of 1:6 during the day and 1:12 at night. There is a male and female staff on-site at all times at a minimum per shift. The schedule also reported that 6 (six) out of the 7 (seven) days there is either an integrated specialist or a crisis interventionist on site to help with intakes, crisis intervention and to provide any extra staff if needed. The schedule also noted on each shift there was a shift supervisor and an assistant shift supervisor, not including the direct care workers on each shift which totaled 6 (six) staff on both shifts 7-3 and 3-11, and 4 (four) staff on the 11-7. It was reported that if at any time that more coverage is needed, a relief staff member is available for support or staff coverage. The director of residential services is available via phone calls after hours for any information, staff or schedule changes that may occur.

It was documented in the log book that every staff reviews and signs the log book as well as documents the number of clients onsite. Random selections of weekday and weekend log book entries were reviewed to ensure contracted youth to staff ratio is met. A review of the shift log book from November 2015 through April 2016 and the staff schedule verifies contracted ratio coverage. It was noted in the log book that each person uses either SI=sign in or SO=sign out next to the date and the staff entry. There is also a procedure key that lists all the acronyms being used in the log book, which was helpful in reviewing the log book. It was noted that the agency has 1 (one) log book documenting daily activities and 2 (two) separate log books one for males and 1 (one) for females for sleeping. It was noted in the sleep logs for both males and females that it was unclear about which hallway the staff was monitoring, as the program has 2 (two) hallways per side that could have clients sleeping.

A review of three (3) sections of video on April 11-12, 2016 from 10:23pm-3:16am; April 20-21 from 11:30pm-1:30am; 2016 and April 29-30, 2016 from 10:00pm-12:34am time frames were conducted. It was noted that on April 11-12, 2016; bed checks were listed as the following 10:34, 10:43, 11:01, 11:22. No more bed checks were completed from April 11, 2016 at 11:22 p.m. until April 12 at 12:27a.m., 12:34, 12:47, 1:11a.m. These were the last bed checks documented by the video until 1:33 when the staff walked half way down the female hall to the bathroom on the right and back to the front without completing bed checks. The videos show that 2:06 was the next actual bed check. At 3:16, it was noted that the staff went half way down the hall to the bathroom on the right and back to the front without completing bed checks. We discontinued watching the video at 3:16.

The Director of Residential Services Stepheny was also viewing the video at this time and witnessed the above information on video, after reviewing the sleep log book it was noted that the staff on April 11-12, 2016 reported in the log book to have completed bed checks every 15 minutes starting at 10:30. The reviewers notified Keith Carr (lead peer reviewer of the QI team) and the YCC Director of Residential Services, Stepheny Durham, who reported that he would be calling in a reportable incident to the DJJ CCC. On May 5, 2016 the Incident report was completed with Melaney from the DJJ CCC and the report number is 201602619.

Around 3:00pm the QI program review team and Kim Sirdevan, President/CEO met to talk about concerns and general findings from the video tape footage. It was also reported to Kim Sirdevan, President/CEO, that a DJJ CCC report had been completed and the number has been provided for the report. At 3:19p.m. a list of the 2 (two) female staff members that were working the night shift on April 11-12, 2016 was generated. The names of the female staff are Melody Satchell and Felicia Williams. Between 3:30 and 4:00pm it was reported from Kim Sirdevan, YCC President and CEO, that the agency is going to terminate the staff member caught falsifying the documentation in the log book and not completing bed checks as stated in the log book.

The 2 (two) other video sections that were reviewed showed the staff were completing the beds checks prior to the

15 minute policy. It was noted that the staff would check 1 (one) hallway and then immediately check the 2nd hall way. After reviewing the log books for April 20-21 and April 29-30 it was noted that all staff reporting in the log books were documenting checks being completed every 15 minutes instead of real time.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Special Population policy. The Domestic Violence Respite, as each youth had a current arrest for Domestic Violence. Three (3) charts were reviewed. Of these 3 cases, all cases were discharged from the Domestic Violence respite program and opened in the CINS/FINS program (which was reported as a common practice to provide longer term care to help obtain the goals). Of the 3 files reviewed, none exceeded a 14 day length of stay in Domestic Violence Respite. All three (3) cases included case plan goals targeted at reducing the re-occurrence of violence in the home. All three (3) cases are consistent with all other general CINS/FINS program requirements.

Staff Secure - This writer asked for a list of clients for staff secure for the past 6 months. The agency reported that they did not have any clients for staff secure for the past 6 months. The agency was asked if they could check since the last audit and it was reported that the agency has not had any staff secure clients since 2014.

Probation Respite - This writer asked for a list of clients for probation respite for the past 6 months. The agency reported that they did not have any clients for probation respite for the past 6 months. The agency was asked if they could check since the last audit and it was reported that the agency has not had any probation respite clients since 2013.

Domestic Minor Sex Trafficking - This writer asked for a list of clients for domestic minor sex trafficking for the past 6 months. The agency reported that they did not have any clients for domestic minor sex trafficking for the past 6 months. The agency was asked if they could check since the last audit and it was reported that the agency has never had any clients for domestic minor sex trafficking.

No exceptions are noted for 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's Clinical Director is a Psychologist. 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 YCC has a written policy on Health Admission Screening. The current health screening admission process meets the general requirement of the indicator and includes an in-depth health screening completed on all youth deemed eligible to be served by the program. One of the main instruments utilized to complete this process is the FNYFS Intake Assessment form. The health screening form addresses and captures all major elements of the indicator: current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings.

The agency's practice indicates that residents have access to emergency care during their entire residential shelter stay. The procedures indicate if a major medical condition exists the youth will be immediately referred to emergency services. Additionally, the policy requires that YCC staff members contact the parent/legal guardian to inform them about any injury, illnesses, health status or medical/mental health condition issue sustained during the service delivery period.

A review of eight (8) randomly selected active and closed CINS/FINS client files were reviewed to assess their adherence to the requirements of this quality improvement indicator. All 8 cases contained documented evidence of meeting all general health screening requirements. All cases were screened upon admission and updated accordingly during the client's shelter stay.

No exceptions are noted for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The YCC has a detailed written policy on Suicide Assessment and Response. The agency's suicide assessment screening and response plan requires that each youth admitted to the shelter will be screened for suicidal risk by using the six (6) suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to any of the 6 questions, the youth care worker will immediately place the youth on elevated supervision status that includes Sight and Sound or One to One Supervision. In the event that a qualified mental health counselor is not available immediately, the youth remains on Constant Sight and Sound supervision until a full suicide assessment can be completed.

The monitor reviewed a total seven (7) client cases that were identified as being at risk of suicide prevention. All 7 files contained documentation that indicated the suicide screening results were reviewed and signed by the direct care staff member and the designated supervisor. Seven (7) of the 7 files were applicable for sight and sound supervision requirements. All youth were placed on the appropriate level of supervision based on the suicide risk screening results. In addition, all cases remained on elevated supervision status until the Assessment of Suicide Risk was completed by the assigned counselor. Further, each client file has evidence of a Suicide Assessment that is completed by a Master Level counselor/professional or non-licensed staff under the direct supervision of the licensed professional (LCSW or LMHC). The supervision level in the open cases were changed or reduced with evidence of the approved by a YCC licensed professional. The agency has a total of three (3) licensed mental health professionals on the roster of professional staff persons.

The agency uses a client observation sheet to document all counts. A documentation review of sample cases for 15 and 30 minute checks were conducted. All observation counts included evidence of these counts being conducted as required. Evidence of all youth being placed on a designated supervision status is confirmed in the log book. At the time of this on-site program review, all agency counselors have evidence of completing five (5) or more Comprehensive Family Assessments. These assessments are confirmed by the agency President.

Overall, the agency's plan and the random sample selected fully meet all elements of Indicator 4.02. In addition, the agency's suicide policy complies with the requirements outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

No exceptions are noted for this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Medication Storage, Access, Inventory, and Disposal policy that has been reviewed and revised since the quality improvement review. The agency has recently completed a full year of operating on the CareFusion Pyxis MedStation 4000 automated medication machine. The policy has been updated to include references to the agency use of the CareFusion Pyxis Med-Station 4000 and for medication inventory, distribution and storage. The shelter provided a list of staff members that are trained as Super or Regular Users to supervise the self-administration of medications. The agency has secured a second Registered Nurse to primarily work on the 2nd work shift. At the time of this on-site program, there are twenty-three (23) staff on that list.

The agency medication distribution process is overseen by two (2) part-time Registered Nurses. The assigned RNs are list as the primary staff members for distributing medications when they are on duty. In addition, the RNs provide training to direct care staff on the use of the Pyxis Med-Station, general medical/healthcare, and CPR/first aid. Direct care staff members are responsible for distributing medications when an RN is not on duty. At the time of the on-site program review, the shelter had been using the Pyxis Med-Station just over a year (April 2016). The YCC Registered Nurses and Super Users are designated to load new medications and clear discrepancies related to the Pyxis Med-Station. At the time of this on-site quality improvement program review, the agency does not have any un-cleared discrepancies listed in the Pyxis Med-Station. The RNs complete a weekly inventory of all medications on-site. In addition, trained staff members conduct shift-to-shift inventories of all controlled medications.

All inventories of medications reviewed were completed as required by the agency policy. The shelter has access to a refrigerator for medications that require medication. At the time of this on site QI program review, there were no medications that required refrigeration during the time of review. Sharps are stored in a separate locked cabinet and are also inventoried on a weekly basis.

There were six (6) randomly selected files (3 open and 3 closed) reviewed on site to verify the agency's medication distribution process. The agency uses a Medication Distribution Log (MDL) that maintains all medication distribution and counting activity during the resident's stay. Following discharge all the MDL

information is kept in the resident's file after the shelter stay. The MDL includes the youth's name, a picture of the youth, date of birth, age, physician, allergies and side effects. The resident and the staff person assisting in the delivery of the medication's initials are documented on all MDLs reviewed on site. All MDRs reviewed on-site document that perpetual inventory counts with running balances are being maintained on each youth.

The shelter has had one CCC report relating to medication errors in the last six months. One documented medication error occurred in the last six months. This error involved a youth that did not receive a scheduled prescription medication as required. The incident was substantiated. The agency followed up this medication error with the staff member involved. The agency conducted a re-training with staff member and documented the error in their personnel file accordingly.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in their Operations Manual that states all clients have to complete a physical and mental health screening and/or follow-up or risk screening, substance abuse screening and/or behavior or other evaluation to indicate if the client has a physical, medical or mental health conditions (which requires an alert). During the screening process, risks are documented including suicidal or homicidal ideation on the form. Once the client has arrived for the intake the staff completes the admission forms with the children. The admission form documents information regarding the following areas; injuries, acute or chronic medical, dental or mental health concerns, medication, recent injuries or illnesses that require current medical care, allergies to food, general or medication, any dietary restrictions, nutritional concerns for fitness issues, with the clients that also lists and physical or mental health concerns and well as any allergies to food or medication, alcohol or drug use, asthma, bleeding disorder, heart conditions, diabetes, head injury, seizures/blackouts, tuberculosis, pregnancy, hepatitis and any homicidal or suicidal thoughts.

If a client answers yes to any of the above the staff will then place the client on alert. This process consists of documenting the clients name on a white board with Special Need (SN) next to their name (this information is also documented in the log book). If the youth is in need of consent sight and sound (CS&S) the client's name is also documented on a white board that state for CS&S. If the youth has any allergies to food that information can also be found in the kitchen on a board listing the allergies next to the client's name for the kitchen staff.

A total of 6 (six) files were reviewed. Of those 6 (six), all the clients' information was documented on the white board with SN next to their name. Out of the 6 (six) files, 1 (one) of the files listed the client to have allergies to aspirin and penicillin. This information was also noted in the log book. All the files reviewed were in compliance with the policy.

No exceptions are noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy called Episodic Emergency Care that was last reviewed and signed by the agency CEO in April 2016. This policy addresses the agency's protocol for responding to and documentation of all major events that require first aid and or episodic emergencies. The reviewer assessed the agency's documentation practices for these events by reviewing the Episodic Log, Program Log Book and related DJJ CCC documentation.

The reviewer found that a total of thirteen (13) episodic emergencies had occurred in the last six (6) months. Of the reported events, a total of 3 out of 13 were documented as required. The remaining ten (10) medical incidents that required hospitalization reported to the DJJ CCC were not documented in agency's Episodic Log. Documentation

of the aforementioned incidents were found in the agency's program log book. These events were located in the DJJ CCC data base as reported incidents that required hospitalization or off site medical care.

Jan 15, 2016 - lightheadedness; Jan 29, 2016 - Fracture Right Hand; February 18, 2016 - Pain in Ear; Feb 20, 2016 swimmer's ear; March 5, left knee sprain; March 13, 2016 chest pains; April 19, 2016 - Chest Pains; April 29, 2016 - back pain -infection; May 2, 2016 - Right Hip Pain; November 17, 2015 - fractured Left foot; November 26, 2015 - Intestinal Bacteria; November 27, 2015 - Chest Pains; and December 18, 2015 - Chest Pains.

The policy also addresses the agency's levels of readiness related to emergency training. This includes training in preparation for emergency events through conducting emergency drills. Fire drills are conducted on a monthly basis. The agency conducts an emergency Mock Drill on an average of 6-12 times a month. The agency has a total of six (6) first aid kits and emergency equipment.

Some documentation of Episodic Emergency events were not documented in chronological order in the binder.

Two (2) recent episodic emergency events were not found in the agency Episodic Emergency Binder.

The agency has documentation of Fire safety, CPR and First Aid, Blood Borne Pathogens, and Mock Emergency Medical drills completed by all direct care staff persons.

No exceptions are noted for this indicator.