



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Youth Crisis Center

on 06/26/2014

## 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

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

**Standard 3: Shelter Care**

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

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

**Standard 2: Intervention and Case Management**

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	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:100.00%  
Percent of indicators rated Limited:0.00%  
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 LLC/Florida Network of Youth and Family Services

Cindy Starling, Regional Coordinator, CDS Family and Behavioral Health Service, Inc.

Teresa Clove, Executive Director, Thaise Educational and Exposure Tours, Inc.



## Quality Improvement Review

Youth Crisis Center - 06/26/2014

Lead Reviewer: Keith Carr

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Kevin Greaney, QI Reviewer, Florida Department of Juvenile Justice

Tom Popadak, Training Director, Diversified Consulting, Inc./FNYFS

Heather Prince, Program Director, Stewart Marchman ACT

### Persons Interviewed

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 4 Case Managers          | 2 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor      | 1 Clinical Staff         | 3 Program Supervisors   |
| <input type="checkbox"/> DHA or designee             | 3 Food Service Personnel | 7 Other                 |
| <input type="checkbox"/> DMHA or designee            | 0 Health Care Staff      |                         |

### Documents Reviewed

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs                       |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook             |
| <input checked="" type="checkbox"/> 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 | 2 MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 10 Personnel Records   |
| <input checked="" type="checkbox"/> Contract Scope of Services        | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 8 Training Records/CORE  |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 14 Youth Records (Closed)                                      |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 6 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

- |          |                     |         |
|----------|---------------------|---------|
| 10 Youth | 6 Direct Care Staff | 0 Other |
|----------|---------------------|---------|

### Observations During Review

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Admissions                | <input checked="" type="checkbox"/> Posting of Abuse Hotline       | <input checked="" type="checkbox"/> Staff Supervision of Youth       |
| <input type="checkbox"/> Confinement                          | <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 type="checkbox"/> Transition/Exit Conferences                 |
| <input checked="" type="checkbox"/> Group                     | <input checked="" type="checkbox"/> Security Video Tapes           | <input type="checkbox"/> Treatment Team Meetings                     |
| <input type="checkbox"/> Meals                                | <input type="checkbox"/> Sick Call                                 | <input type="checkbox"/> Use of Mechanical Restraints                |
| <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

All Youth Crisis Center (YCC) leadership team members, executive, management, supervisory and direct care staff for its residential and non-residential programs were very professional and responsive to all request made by the QI review team.

## Strengths and Innovative Approaches

### Rating Narrative

The Youth Crisis Center, Inc. (YCC) is a major local service provider of children and family services located in Jacksonville, Florida. The agency has service offerings that are aimed at addressing different needs of children and families in crisis. At the time of this review, the agency serves both male and female youth between the ages of ten to seventeen (10-17) years of age that are primarily defined as Status Offenders (runaway, ungovernable, locked out and/or truant) and homeless, abused, neglected or general at-risk youth. YCC's approach includes emergency shelter, residential and non-residential counseling and transition housing. YCC's focus is to offer programs that keep at-risk youth safely off the streets, providing options for a better future.

Youth Crisis Center offers an array of programs that includes CINS/FINS residential and non-residential services, Family Link Program and Project Safe Place to children and families throughout Clay, Duval and Nassau Counties. YCC is nationally recognized as setting a standard in youth services. YCC is accredited by the Council On Accreditation (COA). YCC has been ranked as one of the top five programs in the United States by the Youth Policy Institute in Washington DC. In addition, YCC programs have been honored with Commendations for Excellence and received numerous state honors awards by the State of Florida and other state, new press/media and national funding sources.

Since the last onsite Quality Improvement program review in 2013, YCC received full accreditation for all services our organization provides by the Council on Accreditation (COA) as of September, 2013. Further, YCC is a fully authorized Medicaid provider for outpatient behavioral healthcare, effective March, 2011 and has started an outpatient behavioral health program. Per a decision passed by their governing Board of Directors, the Board approved the closing of YCC's foster care group home program, effective April 15. Future plans involve YCC re-locating its current Residential Shelter to the previous group home building on or about July 1, 2014 to effectively care for the increasing demand for CINS/FINS, Domestic Violence and DCF Respite contracts services. With this move, YCC's immediate bed capacity will increase from 24 to 30 beds, evenly distributed between male and female clients. The agency's Board will give future consideration regarding re-opening the current Residential Shelter building in the future as both demand and funding determine. With the closing of the foster care group home, re-organization occurred including the elimination of the Chief Operating Officer's position.

The agency continues to be a Magellan Medicaid provider of Mental Health Counseling Services. Further, the agency maintains two (2) licensed clinicians on staff serving the CINS/FINS programs.

## Standard 1: Management Accountability

### Overview

#### Narrative

Youth Crisis Center, Inc. provides shelter and non-residential services for youth and their families in Clay, Duval and Nassau Counties. All YCC residential and non-residential programs operate from the agency's central office site located at 3015 Parental Home Road, Jacksonville, Florida. The agency is lead by Greg Steele, President and CEO. Other Management Team members include Kim Sirdevan, LCSW and VP of Clinical Services, Angie Srock, Chief Financial Officer, Susan Spinella, Vice President of Quality Assurance, Joyce Farhat, Vice President of Human Resources, Tracy Deadman, Vice President of Finance, Jim Smith, Vice President of Facilities and Elaine Peete, Director of Development. The management of the agency's major residential and non-residential service components are lead by Darryl Matthews, Director of Residential Services and Stacy Sechrist, Program Manager-Family Link.

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

At the time of the quality improvement review, the agency's organizational chart reports having (1) vacant fiscal assistant position. The Department of Children and Families has licensed YCC as an emergency runaway shelter, with the current license in effect until April 2015.

The agency manages all personnel functions through its centralized Human Resources division located onsite. The agency's Human Resources Department is responsible for processing all state and local background screenings and documentation of training records. The agency delivers Orientation training to both residential and non-residential personnel following screening and background screening results and reference checks. Trainings are also provided by a combination of delivery methods for training that includes training provided by the Florida Network trainer, in-house training delivered by the agency, external subject matter experts and on-line training resources. The agency maintains an individual training file on each staff member that includes a training plan and copies of documentation for training received. Annual training logs for individual staff members are tracked according to the Fiscal year of July 1 through June 30.

The Florida Network approved the program's emergency response plan and hurricane plan for FY 2013-2014. The agency's Vice President of Facilities is responsible for all facility issues and oversees weekly safety and physical plant checks.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The Youth Crisis Center (YCC) has a comprehensive background screening policy that meets and addresses all major requirements of DJJ Background Policy. It was last revised and reviewed in June 2013. YCC's human resources department conducts all initial background and 5 year screenings through the Background Screening Unit for all prospective and current staff members. YCC policy is to also conduct a series of screening for all staff, applicable volunteers, and interns. The series includes records checks for motor vehicle record and local law enforcement records.

A total of ten eligible staff members files were selected to determine the agency's adherence to this indicator. All ten staff member files reviewed were organized in a standardized format. All had the required information and meet all requirements for this indicator.

Background screening is completed prior to the hire date for each employee. Four newly hired employees and three recently transferred employees from the group home were reviewed. All seven employees had their background screening completed prior to their hire or start date.

Three employee records were reviewed for five year rescreening. All three of these employees had their five-year rescreening completed within the required time period.

The Annual Affidavit of Good Moral Character Standards was completed by YCC and submitted to the DJJ Background Screening Unit before the January 31, 2014 deadline.

No exceptions noted for this indicator.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

A review of Youth Crisis Center Operations Manual revealed that it is in adherence with the all requirements for Indicator 1.02 Provision of an Abuse Free Environment. YCC's current policy 1.09, Provision of an Abuse Free Environment was last reviewed and revised in June 2013. The reviewer assessed a total of twenty-nine internal YCC incidents; ten of those were also a DJJ CCC Incidents. A review of ten DJJ CCC incidents



agency uses an annual performance and Development review process to evaluate staff member work performance. YCC provided all inter-agency written discipline reports that occurred since the last review. These forms were contained in the staff members' employee record and included work performance and disciplinary reports and staff evaluations. A review of agency written disciplinary action reports was conducted and a total of three reports were reviewed. The Notice of Disciplinary Action resulted in a termination of one male staff member for violation of the employee handbook rules. A female staff member had two unrelated written Notice of Disciplinary Action forms in the employee record. Both were written with a plan for a ninety day review.

Grievances were requested to verify or confirm any existence of inappropriate staff member demeanor, attitude and negative temperance toward program residents. All three youth grievances filed since the last QI review were reviewed. One of the grievances concerned food portions. The other two grievances concerned ae staff member who was named in both grievances that were about staff.

During the tour the monitor found that all grievance report boxes were accessible to residents and full with forms for residents to submit when needed.

Exceptions are noted for this indicator.

- Two of ten youth did not know that the abuse hotline was available to report abuse at the shelter.;
- Four of ten youth survey cannot show or tell others where the number to the abuse line is located.;
- Two of ten youth surveyed reported that all staff is not respectful when talking to youth. Both youth commented that some of the staff is respectful but some are not.;
- Three of ten youth surveyed report that they have heard adults using curse words when speaking to youth. One responded that they had heard a visitor use curse words and the other two youth reported that they have heard staff using curse words.;
- Four of ten youth surveyed report they have heard adults threaten youth. Two youth comments concerned the same staff member, one was an argument with a youth and the other a general statement that the staff members "threatens us all the time".;
- One of ten youth surveyed does not feel safe at the shelter. The youth's commented that "the staff threatens you and some of the girls bully and threaten you."

YCC provided inter-agency written reports that were contained in staff employee records. A female staff member had two Notice of Disciplinary Action forms in the employee record. Both were written with a plan for a ninety day review. The first one was written in August 2013 and the second was dated in October 2013 with a ninety day follow-up. The record of the ninety day review was not found. There was no documented counseling or disciplinary actions for this staff member concerning the two resolved grievances.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

YCC has a comprehensive incident reporting policy and procedures that addresses Incident Reporting. The current policy was last reviewed and revised in June 2013. YCC policy specifies that the agency notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident. The agency has a protocol that reviews the practice and execution of each documented incident.

Whenever an incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident. Twenty-nine (29) incidents were reviewed and all twenty-nine were documented to have been reported to the CCC within two hours. Reports are written legibly and clearly describe the incident for all twenty-nine incidents. Twenty-four (24) of these incidents were initially deemed non-reportable by the CCC. Four (4) were later changed to reportable after youth returned from the medical facilities with diagnosed injuries. A query of the DJJ CCC database by the DJJ QI program review team member confirmed a total of ten (10) official incidents documented in the system at the program over the last six months and given a CCC incident number. The 10 incidents include three medication errors, one medical incident,

four injuries, one medical other, and one was for contraband.

One youth's incident report dated January 23, 2014 was non-reportable according to the CCC at 1912. On the youth returned from Wolfson Children's Hospital the following day, he had a diagnosed closed fracture. This was reported and the call accepted by the CCC. The incident report was not changed and placed in the other notebook to reflect the change.

#### 1.04 Training Requirements

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has detailed training policies and procedures. The agency has a full-service Human Resources department and an automated training topics and records management system. A total of eight (8) employee files were reviewed onsite. Of these, four (4) are new hires training records that had completed a year and 4 were ongoing training records. As it relates to first year training files, 3 out of 4 met the required 80 hours. The files that were short of hours did complete 73 out of 80 hours. Regarding new hire training records, several files were missing CINS/FINS Core, Title IV-E and Signs and Symptoms of Substance Abuse.

The ongoing training records were reviewed for 07/2012 - 06/2013. Four (4) files were reviewed. Out of these files, 3 out of 4 files met the 40 hour training requirement. The training file that was short of hours, did complete 37 hours. None of the files had Mental Health and substance abuse for the said training year. Additionally, several topics are recommended, but are not deemed as required. For example no files reviewed had Cultural Competency.

The agency meet the requirements for this indicator with limited exceptions.

#### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

##### Rating Narrative

The agency meets all aspects of this standard with no exceptions. The agency has a detailed Quality Improvement Plan that covers long term strategic goals, management and operational performance, program results and service delivery quality, client and program outcomes.

The agency has a quarterly Quality Improvement Committee Meeting that is attended by the heads of each department. This meeting reviews the data regarding incidents such as how many, what time and trends. There is also a review of NETMIS incomplete forms that are submitted. There are reports in regards to the trainings year to date and upcoming and which staff have trainings due. Each department has QIC measures for their program and this data is also reviewed. There is also a report quarterly in regards to peer reviews of files and the compliance in both residential and non residential and what the challenges are if applicable.

There are no exceptions noted for this indicator.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

The non-residential team members include the Vice President of Clinical Services, one (1) Program Manager, five (5) Therapist and three (3) Case Managers.

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

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

The counselors are responsible for providing case management services and linking youth and families to community services. The agency also provides limited case management and substance abuse prevention education referrals. The Family Link program coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court as needed.

### 2.01 Screening and Intake

Satisfactory
  Limited
  Failed

#### Rating Narrative

The provider has a written policy and procedure in place. The files were in compliance with the 2.01 Screening and Intake Standard. There were a total of 8 files reviewed, three (3) Residential and Five (5) Non-Residential, three (3) opened Residential and two (2) open and three (3) closed Non-Residential. The screening were completed and initiated within the 7 day period. The parents and family received the Client Rights, Grievance Procedures, Organization Brochure, Available service options, Rights and responsibilities of youth and parents/guardians; and Possible actions occurring through involvement with CINS/FINS services (i.e. case staffing committee, CINS petition, CINS adjudication).

There was one incident on a client #28052 screening form. The Screening and Intake Forms were completed 5/9/14 but the Staff and Supervisor signed and dated it 5/8/14. The Intake form was signed and dated before the client was admitted. This was an error and was corrected immediately.

The Residential files had a separate Intake and a separated Screening form but the Non-Residential files did not. It was confusing in determining which dates were the Screening and which dates were the Intake dates. Florida Network has had a standard practice of utilizing two forms, one for the screening and one for the intake. It is recommended that if the agency continues to use its present form, that they consider using separate lines to indicate the Screening and the Intake dates. The best practice would be to utilize separate forms.

### 2.02 Psychosocial Assessment

Satisfactory
  Limited
  Failed

#### Rating Narrative

The provider has a written policy and procedure in place. The files were in compliance with the 2.02 Psychosocial Assessment indicator. The Master's and Bachelor's level staff initiated the Psychosocial Assessment face to face within 72 hours of Intake. The assessments were signed by the staff and reviewed by the Licensed Clinical Supervisor. There was one suicide risk indicated and this document was reviewed and signed by the Licensed Clinical Supervisor. There were a total of eight (8) files reviewed. Of these files three (3) are Residential and Five (5) Non-Residential.

There are no exceptions documented for this indicator.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedure in place. There were a total of 8 files reviewed. Files reviewed included three (3) Residential and Five (5) Non-Residential, three (3) opened Residential and two (2) open and three (3) closed Non-Residential. The files were in compliance with the 2.03 Case/Service Plan Standard. The Case Service Plans were developed within 7 days as required by the standard. It included the identified needs and goals, frequency, type and location, person responsible, target date and the date of the plans. There were completion dates on the ones that were completed. All case plans were signed by the counselor, client and supervisor.

There are exceptions noted for this indicator. One case file did not have a parent signature on the Case Service Plan.

The standard states that the case/service plan is to be reviewed by the counselor and parent/guardian every 30 days for the first three (3) months and every six months thereafter for progress in achieving goals. The case/service plans were being reviewed monthly, but there was no evidence of who the case plans were being reviewed with on 5 out of 7 of the files. One file was recently opened so no review was needed. The Residential Case /Service Plan had an area for the participants to initial after reviewing the Case/Service Plans, but the Non-Residential files did not. One Non-Residential file had a 30 day review with the client and noted it in the case notes. This particular case was opened for 11 months. There was no other evidence of documentation in the case notes or signatures stating any other reviews were done with the client or the parent. On the back of the Non-Residential case/service plan was an area for Objective Review Dates, but no area for signatures confirming that the reviews were being completed. Documentation indicated a date and what objective was reviewed, but nothing indicated who it was reviewed with. There were no notes in the case notes addressing that a review was done and there was no place for the client, parent or staff to sign indicating that a 30, 60, and 90 day review was completed. The program Manager reported that she has change the case plan sheet to add the initials of the participants after the review takes place.

**2.04 Case Management and Service Delivery**

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedure in place. The files were in compliance with the 2.04 Case Management and Service Delivery. Files reviewed included three (3) Residential and Five (5) Non-Residential, three (3) opened Residential and two (2) open and three (3) closed Non-Residential.

All case files were assigned a counselor/case manager who followed the youth and ensured services delivery throughout the case. The case files indicated that the families were being referred as needed for additional services, that the families were receiving counseling and support services, that the clients are being referred to the case staffing team as needed. The case notes are documented in all files and relates back to their case/service plan. The cases that were closed contained a discharge summary with recommendations. No court cases were noted or judicial intervention.

No exceptions documented for this indicator.

**2.05 Counseling Services**

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedure in place. Files reviewed included three (3) Residential and Five (5) Non-Residential, three (3) opened Residential and two (2) open and three (3) closed Non-Residential. The files were in compliance with the 2.05 Counseling Services. The youth and parent are being offered counseling and case management services on a regularly basis. The case notes are being maintained in chronological order, stating the client progress and indicating that the client and parent are being served. All case files are being maintained and are adhering to all laws regarding confidentiality. All 8 files reviewed have Confidentiality on the front and back of the case file. Youth Crisis Center is maintaining an on-going internal process which is addressed in their Youth Crisis Center Quality Improvement Plan 2014.

No exceptions documented for this indicator.

**2.06 Adjudication/Petition Process**

Satisfactory

Limited

Failed

## Rating Narrative

The agency has a policy that addresses the general requirements of this indicator to include the procedures for the Case Staffing Committee, Case Staffing Report, Case Staffing Requests, and the CINS Petition Process. The program meets the requirements for establishing policies related to Case Staffing and CINS petition. The program has an established case staffing committee in Duval County with regular scheduled meetings every first and third Tuesday of the each month. Other counties served by the YCC are staffed as requested either by the parent or schools.

During this review, six (6) non-residential file were reviewed for compliance with this standard. Of the files reviewed, none were requests for Case Staffing by the parents. Four (4) of the six (6) files were referrals by the schools for habitual truancy and two (2) of the participants were receiving non-residential services relative to ungovernable behaviors. When the ungovernable issues were not successfully resolved during counseling/case management services, the two cases were referred to the Case Staffing Committee by the Case Manager. Of the six (6) non-residential files, only one proceeded to Court and the youth was adjudicated a Child In Need of Services on 12/3/13.

All of the six (6) files reviewed had verification of notification to the family no less than five (5) working days prior to the case staffing that was scheduled. Each of the files had copies of the letters to the parents/guardian of the youth. The case manager reported that the practice is to send all notification of case staffings by certified mail. All cases had verification of the letter being sent by certified mail. The case manager maintains a separate Case Staffing Committee logbook which contains all of the letters to committee members. This is to ensure confidentiality when more than one case is scheduled on the same day. All of the six (6) files reviewed had letters of notification to the committee members within the required time frame of no less than five (5) working days prior to the staffing. The case manager reports that the letters are sent via e-mail to the committee members. The agency had the required members on the committee meeting in all six (6) files. In fact, the agency has very good representation on their case staffing committee to include: DJJ attorney, local school representative, CINS/FINS case manager, State Attorney's Office, Department of Children and Families, and Law Enforcement. If the youth has an agency therapist, the therapist attends the meeting also. The letters that are sent to the parent/guardian also offers the family the option of inviting anyone that they feel may be important to the process.

Five of the six files contained a new or revised plan of services and provided documentation that a copy was either mailed to the parent/guardian of given to the parent at the time of the review. In the one other case, a plan for service was not made due to the youth already having involvement in the delinquency system. The Department of Juvenile Justice Attorney recommended that the case be closed.

Only one of the six cases had been referred to the Court for CINS/FINS adjudication. The file contained a pre-disposition report and a judicial summary.

No exceptions are noted for the indicator.

## 2.07 Youth Records

Satisfactory

Limited

Failed

## Rating Narrative

The agency has policies and procedures that address the requirements of this indicator. There were a total of eight (8) records (four residential and four non-residential) reviewed. All records reviewed were marked with a "Confidential and Privileged Information" stamp. All closed CINS/FINS (residential and non-residential) files are stored in a locked room and records are kept in file cabinets. Open residential records are kept in locked file cabinets in the staff work area. A locked cabinet is maintained for the female records and another locked cabinet secures the open male records. Open non-residential records are kept in either a locked file cabinet or locked brief cases when staff are transporting records. The 8 records reviewed were maintained in a neat and orderly manner.

All records reviewed were marked with a "Confidential" stamp. All closed CINS/FINS records (residential and non-residential) are maintained in a secure room. Open residential records are kept in locked file cabinets in the staff work area. Open non-residential records are kept in a locked file cabinet or locked brief cases when transporting records. The records reviewed were maintained in a neat and orderly manner.

No exceptions are documented for this noted.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The Youth Crisis Center (YCC) operates its CINS/FINS shelter in an area that is primarily a residential area of the City of Jacksonville. The youth shelter's Department of Children and Families (DCF) license was increased from twenty-two to twenty-four (22-24) beds and it primarily serves youth from Duval County, as well as youth from neighboring counties. There are a total of 8 bedrooms with four (4) rooms on the male resident wing and 4 on the female resident wing of the facility. There are a total of thirteen (13) beds within the 4 male resident rooms, and a total of twelve (12) beds within the 4 female resident rooms.

At the time of the quality improvement review, the shelter was providing services to twenty-one (21) CINS/FINS youth during the days of the onsite program review. This YCC CINS/FINS shelter is designated by the Florida Network to serve all staff secure referrals. The agency has two (2) staff members onsite that are Licensed Clinicians and also employs a licensed outpatient therapist. The program also employs A Registered Nurse and several other licensed staff members.

A tour of the youth shelter was conducted by all members of the QI review team following the entrance interview. The review team member assigned to the facility inspection indicator conducted a detailed inspection for hygiene, safety and security requirements. All areas observed on the shelter inspection were found to be clean, in working order and all safety equipment in place. All major furnishings were in good order. The bedrooms were found to be clean. The facility grounds are surrounded by a perimeter fence and residents have access to open activity space, volley ball, a covered sitting area and an open basketball court.

The day to day operations of the residential program are the responsibility of Darryl Matthews, Director of Residential Services. Mr. Matthews is supported by three (3), Shift Supervisors, one (1) Integrated Services Specialist, one (1) part time Registered Nurse and more than twenty (20) Youth Care Specialists. Youth Care Specialists are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedure that addresses all of the key elements of this QI indicator. The policies are reviewed and signed by the agency's President/CEO on an annual basis. The last review occurred in June of 2013.

During the entrance interview the agency's President/CEO stated that the program is scheduled to move out of the existing facility which has housed the CINS/FINS program for many years and into a newer facility that was constructed in 2009. That facility was built to house a DCF group home program that recently lost funding and was closed. The move to the new facility in July of 2014 will enhance programs services, improve client safety and supervision and increase resident satisfaction with their living environment.

The current facility is an older building but is very clean, safe and well maintained. The agency has a VP for Facilities that does an excellent job in managing the agency's facilities and supervising a F/T facilities maintenance employee. During our site visit I had the opportunity to interview both of these employees about their responsibilities, the maintenance of the current facility and the highly anticipated move to the new building that is located at the rear of the property.

During our tour of the facility we observed all of the residential and administrative areas of the facility. The facility has appropriate furnishings that are in good repair and we did not observe any signs of physical damage or graffiti. The facility had a few areas (lobby, etc.) that were recently painted and/or redecorated. In addition a door was added to the intake office to enhance confidentiality during the intake/admission process.

The facility is located on a large campus with several adjacent buildings near the front of the property and a separate newer cluster of buildings near the rear of the property. The grounds are attractively landscaped, well maintained and free of any dangerous materials or debris. The facility has excellent exterior lighting for safety and security.

During the QI site visit the QI team observed youth engaged in a pro-active daily routine at the facility. Youth were actively involved in on-site educational services during our tour of the first day of the review. We also observed youth engaged in recreational activities, meals, chores, group counseling and social interactions with staff. Youth received effective supervision and support from staff during various activities we observed.

No exceptions were noted during this QI site review.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedure that addresses all of the key elements of this QI indicator. The policies are reviewed and signed by the agency's President/CEO on an annual basis. The last review occurred in June of 2013.

The program conducts a comprehensive new client orientation for each youth admitted to the shelter. This process is documented on the "Client Orientation" form located in each client's case file. The form lists 20 specific areas covered during orientation by the staff member performing the intake at the shelter. The areas covered are consistent with the requirements of this QI indicator.

A review of 5 client case files (3 open, 2 closed) revealed that in each case the Client Orientation form was completed, signed and dated by the staff, the youth and their parent at intake or admission to the shelter.

There were no exceptions identified during this onsite QI review.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedure that addresses all of the key elements of this QI indicator. The policies are reviewed and signed by the agency's President/CEO on an annual basis. The last review occurred in June of 2013. A total of five (5) cases were reviewed to verify the agency's adherence to this indicator. All residents files have evidence that the agency utilizes a classification system that focuses on youth age, size, current health and mental health conditions. All files indicate specific rooms and have been reviewed and signed by a supervisor.

There were no exceptions identified during this onsite QI program review.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedure that addresses all of the key elements of this QI indicator. The policies are reviewed and signed by the agency's President/CEO on an annual basis. The last review occurred in June of 2013.

The program maintains a "Pro-Log" program log book to document the daily activities of the program. A review of the program log book for the last 5 months (12/22/13-5/13/14) revealed that the practice is consistent with agency policy and satisfies all of the QI requirements. All entries written in ink and errors are corrected in accordance with policy. No white out or crossing out of entries was observed during this review. All entries contained the date and time of the entry and the signature of the staff making the entry.

Log book reviews by staff of the previous shifts were documented by direct care staff and shift supervisors signing in and out of the log book. Supervisory reviews were consistently conducted by the Director of Residential Services and Assistant Manager of Residential services. An interview with the Director of Residential Services confirmed that the agency policy and practice was consistently followed in accordance with QI requirements.

There are exceptions documented for this indicator.

1. Some entries were difficult to read (not legible / i.e. pg 52 at bottom).
2. Supervisory reviews were being conducted by the shift supervisors. However, reviews by the Assistant Manager and Residential Director were hard to identify or find.

#### Rating Narrative

The program has a written policy and procedure that addresses all of the key elements of this CQI indicator. The policies are reviewed and signed by the agency's President/CEO on an annual basis. The last review occurred in June of 2013. The program has a behavior management system that utilizes a token economy point system. The system has three levels that youth can achieve based on their daily point totals. Points earned per activity ranges from 0 to 4 and there are 25 activities each day for a maximum potential total of 100 points per day.

Each of the three levels (I, II and III) have various privileges or incentives associated with them. Some of the incentives include the use of the

Nintendo or Xbox game system, watching movies, skipping a day of chores and going on off site activities. An interview with the Residential Manager confirmed the active and consistent use of the behavior management system by staff. Staff receive behavior management training during their orientation training upon being hired. This training is documented in their individual training files.

The client handbook given to youth at intake explains the behavior management system and the privileges/consequences associated with each level. The handbook also explains clients rights, behavioral incentives and clearly outlines the program rules and behavior management system rewards and consequences related to rule compliance and/or violations.

No exceptions were identified during this QI site review.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedure that addresses all of the key elements of this QI indicator. The policies are reviewed and signed by the agency's President/CEO on an annual basis. The last review occurred in June of 2013.

The three (3) Shift Supervisors and the Assistant Manager and posts a weekly staff schedule that meets or exceeds the required ratio of 1 staff for every 6 youth during awake hours and 1:12 during sleeping hours. The schedule is posted in the bulletin board in the staff work station and the Supervisors office. Program information reviewed onsite indicate that there is at least one male and one female on each shift in accordance with CQI requirements. There are 3 shifts at the facility: 8 AM to 4 PM, 4 PM to 12 AM and 12 AM to 8 AM. Typically there are 5 staff on the morning shift, 5 staff on the afternoon shift and 3 staff on the overnight shift.

A detailed review of staff schedules for the previous 3 months indicated that there were no exceptions to the requirements of this CQI standard. An interview with the Residential Director also confirmed the staff scheduling and shift coverage policy and practice is consistent with QI requirements.

No exceptions were identified during this QI indicator.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a current policy and procedure for staff secure youth in shelter. Although, staff reports that there have been no staff secure youth referred to the shelter since the last onsite program review.

Upon review, the agency does not have a current policy and procedure for domestic violence respite. The agency has had multiple residents in the shelter for domestic violence respite stays. The agency has assigned bed days and does not need approval from the network for these youth.

A total of 4 files were reviewed of which 3 were open and 1 was closed. All youth admitted to DV Respite had a pending DV charge and have evidence of being screened by the JAC. The youth that were currently open did not exceed the 14 day time frame and the discharged file was closed at the 14 day mark. The case plan on all files reflected goals that focused on aggression management, family coping skills or other interventions designed to reduce the reoccurrence of violence in the home.

All other services provided to the Domestic Violence youth are consistent with the other general CINS/FINS program requirements.

The agency meets all requirements for the standard with one exception. The agency does not have policy-specific language regarding its methods and practices for serving Domestic Violence Respite youth referred to the agency.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The Youth Crisis Center CINS/FINS program provides health and mental health screening, counseling, general health services and mental health assessment services. The agency has staff members that are trained to screen, assess and notify all staff members of conditions of all youth admitted to the residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect the major risk of youth referred to their programs with mental health and health related risks.

Specifically, the agency utilizes screening and a screening and Intake forms to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The agency also uses an alert board to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The YCC program assists in the delivery of medications to all youth admitted to the Safe Place 2B youth shelter. The agency operates a detailed medication distribution system. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. The agency has three (3) staff members that are licensed clinicians. These staff members are involved in the review of all residential clients that screen positive for suicide risk.

The agency is fully staffed with both male and female staff members across all three (3) work shifts. Agency training files indicate that direct care staff members receive crisis intervention, first aid, CPR, suicide prevention and medication distribution training. During this onsite QI review, the agency provided an up to date list of twenty (20) agency staff members that have received medication distribution training and are authorized to assist in the delivery of medication to residential clients.

### 4.01 Healthcare Admission Screening

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency policy is 4.01 Health Care Admission Screening. The written procedures for this indicator address the Health Screening practice and Medical Health Follow-Up. A total of six (6) open residential files were reviewed for adherence to this requirement. A total of 6 client files were reviewed and all included evidence that the program performs a preliminary physical health screening for each youth at the time of admission to the shelter. All files contained a shelter admission form which is yellow and was filed consistently in all files completed. These documents all indicate that they were reviewed on the youths' admission date and are reviewed by a supervisor. The healthcare form addresses all FNYFS health screening requirements that include current medication; existing medical conditions; allergies; recent injuries or illnesses; presence of pain or physical distress; and difficulty moving. The screening process also screens for physical appearance/distinguishing features, or other skin markings (scars, tattoos, bruises and other markings).

There are no exceptions noted for this indicator.

### 4.02 Suicide Prevention

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency has an active suicide 4.03 policy that addresses the requirements for the suicide prevention indicator. The current policy was last reviewed in June 2013. The current suicide policy has specific procedures that outline specific suicide prevention and response procedures. Samples of cases served in the last six (6) months were reviewed to determine the agency's adherence to the requirements of this indicator. All six (6) youth files were screened utilizing the agency's suicide risk questionnaire. All 6 indicated a positive response to 1 or more of the suicide risk screening questions. Residential direct care staff members use the NETMIS Screening process to assess the risk to self and risk to someone else. Overall, the majority of cases are being screened for suicide risk during the admission process. The agency uses an admission form. Specific suicide risk questions are listed on page 3. There are 3 levels that include Standard, Sight and Sound and 1 on 1 suicide risk status. Standard is normal supervision. Residents determined to be on Sight and Sound status can be placed in the general population, but have eyes on the youth at all times. The 1 on 1 status require a staff to be an additional assigned person within 5 feet. Both require ten (10) minute observation checks when they are awake and 15 minutes during sleeping hours. Both types of counts require documentation in the agency's mental health alert observation log.

The agency recently changed to a customized Suicide Risk Assessment tool that was approved by the FNYFS. Use of the new form started in

March 2014 by master level therapists. The new suicide risk screening form screens for suicide, violence and homicidal behavior and self-harm behavior using a risk assessment matrix. Once this phase is completed a summary is required and consultation with the licensed staff occurs prior to youth being stepped down. Licensed staff will reassess every 24 hours for behavior changes according to the respective risk (suicide, self-harm, violence and homicide). The agency then has a step down release process from the suicide status form called the Request for Discontinuation or Risk Level Supervision Precautions. No child is taken off sight or Sound or 1 on 1 status unless this form is completed and reviewed by the licensed staff person. After this the therapist will document in the program log that the child has been taken off or stepped down from their current level of supervision. Clients also use a Safety Plan. This plan includes giving the clients tools on how the client will use certain strategies to relieve and address stress.

A sample of five (5) client files of youth that were deemed positive for suicide risk was conducted on site. Of these, two (2) are open files and three (3) are closed files. All clients had documented Yellow Admission screening forms in their files that show that each file had been screened during the initial intake. Of these 5 youth, 2 were placed on constant Sight and Sound supervision and 3 were placed on 1 on 1 supervision. All five (5) youth files received an assessment of suicide risk which was completed by Masters Level Therapist. Each client file includes evidence that it has been reviewed by Licensed Mental Health Counselor for all assessments and follow up forms. All youth have file did contain a supervision log with documented ten counts.

Exceptions are noted for this indicator.

Some counts documented on the observation alert forms by direct care staff were missing initials that confirm a review by the shift lead or supervisor.

Three (3) out of 5 cases reviewed did not clearly document what staff person was assigned to the youth placed on One on One Supervision status is not clear.

The JSO was called to conduct a Baker ACT Assessment on a resident. The resident was initially designated to be placed on 1 on 1 supervision, but was mistakenly placed on Sight and Sound Supervision instead of 1 on 1 supervision Status.

The agency's Logbook documentation of the word "RISK" for the suicide status of youth placed on supervision are not consistent. The word RISK is supposed to be documented and the agency is documenting the letter "R".

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a detailed medication policy. The medication policy is numbered 4.06 Medications and is documented as being last reviewed in June 2013. The current policy addresses the requirements of the indicator including procedures that include safe and Medication storage, Access to Medication, Medication/Inventory, Emergency Procedures, Training, Non-Controlled Prescribed Medications, Over the Counter Medication, Prescribed Medications, Medication Disposal, Medication Supervision and Monitoring, and distribution of medication in accordance with the DJJ Health Services Manual.

When the nurse is not on duty all supervisors and lead staff conduct medication verification when they have a doubt about the integrity of the prescribed medication. The agency's nurse is funded on part time basis by a local grant funding source from the local hospital. The agency's nurse provided the training and remedial training for all staff. The agency has a list of staff that have been trained by the registered nurse and are authorized to distribute medication.

The agency uses a morning, afternoon and evening chart to inform staff what period during the day that certain youth are to be given medication. The shelter has implemented a process where two (2) employees are required to conduct medications counts to ensure accurate medication inventory of all controlled medication. The monitor assigned to the indicator observed two (2) medication shift count during the 2 day program and a found this process to be functioning according to its procedures.

All medications are stored in a separate locked medication and sharps storage room that is inaccessible to youth. In this room all prescribed medications are stored in a locked medication cabinet. The cabinet contains five (5) shelves that include 5 individual locking tackle boxes. The shelves are labeled controlled, prescription, topical, sprays and disposal. The agency has separate metal locking wall boxes designated for injectables and sharps. There were no syringes at the time of this review. The agency had a total of eight (8) scissors or sharps in the shelter. At the time of this review, there were no injectable medications on site. Additionally, there is a locking refrigerator designed for refrigerated medications. There were no medications that required refrigeration on site at the time of this review. All medication including over the counter medication brought in the shelter by a child admitted to the program are required to be prescribed by a medical doctor.

The actual medication is stored in small plastic baggies with the client's name and client number on the outside of the bag. Colored dots are affixed on the bag that corresponds with Red for controlled; Yellow for AM medication; and Blue for PM medication. These dots provide a color to indicate what time of day the medication is to be given to the resident.

A review of ten (10) client open and closed medication logs were reviewed to determine accuracy and completion. The agency maintains a

separate MDL binder for residents on medication. The medication administration logs contained the youths' name, allergies, and side effects. The medication log contained the youth admission date and time. The agency's controlled medication shift to shift counts were all accurate across all 10 files reviewed on site. The start and stop dates for medications were clearly documented on the medication log.

The medication log clearly documented when a youth is off site for temporary release. The process was observed. The employees counted both the medications before giving the medications to the parent and clearly documented temporary release medications. Employees and resident both initial each dose of medication once distributed. The youths' pictures with their birth date are kept in the current month's medication log book.

The agency had no medications that had been left behind after youth are discharged from the residential program. The agency does employ a disposal process that is overseen by the nurse and required disposal from 2 persons.

The agency utilizes a weekly medication check process that uses the weekly prescription medication count to determine if the residents have 7 days or less medications in stock. If their medication stock is less than a 7 day supply then the program contacts the parent and or guardian to obtain a refill.

Exceptions are noted for this indicator.

At the time of this onsite review, the agency policy does clearly document medication of youth admitted in to the program. At the time of this onsite review, the agency policy does not include or outline that all medications are verified by a specific medication verification procedure that is documented. However, the agency employs a Registered Nurse that receives and verifies all youth admitted to the shelter on prescribed medications. The monitor did verify this practice by conducting an interview the agency's Registered Nurse.

The agency also houses razors in the in the shelter. Razors were not being counted due to the infrequent use by shelter residents.

There were a total of three (3) DJJ CCC reports regarding medication errors committed by the agency in the last 6 months. All 3 CCC reports were reported due to medication errors for not giving or missing the time in which to give these youth their medication. These incidents were all detected by other staff members identifying incorrect medications counts or a resident informing them that they did not receive their medication. Two (2) out of three (3) had documented evidence of a reprimand, counseling or retraining as a result of missing the scheduled time in which to give these youth their medications.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a detailed policy to ensure that staff are provided sufficient information and instructions that will allow them to recognize and respond to the need for emergency care and treatment. The specific procedure is also identified in the operations manual. Any alert is documented as a special need and contact coded "SN" in the professional log and the client's progress notes. The specific condition or special need should be noted as well and the entry is highlighted in the Professional Log. The shelter has a special needs column on the census board and if a client has a special need it is coded with a "Y" for yes and if there is no special need is indicated the column is coded "N" for no special need. If the special need is medication then the census board is coded with a red marker for that client. A green marker is used for all other client alerts. The census board directs staff to "see client file" for specific alert information. This process is utilized from intake and continues throughout the client's stay at the shelter.

At the time of this onsite review, the census board, five (5) client files, kitchen food allergy board and the program logbook entries were reviewed to ensure compliance with this standard and also to ensure that staff members are provided with sufficient information regarding the youth's medical or mental health condition to allow them to recognize and respond to the need for emergency care. Three of the five participants had a food allergy. All three were marked appropriately on the client board and in the client record but one participant's food allergy was not included on the Allergy Board in the kitchen area. Two of the five participants had seasonal allergies. Of the two participants with seasonal allergies, one file did not indicate the allergy on the Admission Form in the appropriate section "Physical and Mental Health Screening".

There are exceptions noted for this indicator:

Five open residential files were reviewed for this indicator. Three of the five participants had a food allergy (seafood, tomatoes, and shrimp). All three were marked appropriately on the client board and in the client record but one participant's food allergy was not included on the Allergy board located in the kitchen area. Two of the five participants had seasonal allergies. Of the two files reviewed with seasonal allergies, one file did not indicate the allergy on the Admission Form in the appropriate section: "Physical and Mental Health Screening".

It appears that there is a lack of consistency regarding the Medical/Mental Health Alert Process in the documentation across the file, client board, program logbook, and food allergy board. It is recommended that the agency consider implementing a "best practices" method that has been identified at other agencies during the QI process. Specifically, a more detailed medical/mental health alert system that includes a list of specific alerts and a color coding system in the program logbooks.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

YCC has an Emergency Disaster Plan Manual which contains all Emergency Plans including Duval County Emergency Directory (page 42-43). All information regarding procedures for Medical Emergencies/Universal Precautions to include procedures for Eyes, Nose Bleeds, Bleeding Wounds, Teeth, Choking, Broken Bones and Sprains, Head, Neck, and Spine Injuries, and Poison Emergencies (pages 44-49). Procedures for Mental Health and Substance Abuse Emergencies are listed in a step by step format (pages 50-51). Finally, procedures for Pandemic/Epidemic Infections are also provided with step by step instructions (pages 52-56).

Seven files were reviewed for this indicator. All seven had off site medical care. The parents/guardians were contacted or contact was attempted in all seven cases. There is an Episodic (First Aid/Emergency) Care Log that is maintained on a daily basis. The CCC and the Florida Network were contacted in a timely manner in all seven cases. In the cases where the youth was returned to the shelter, verification of medical clearance, discharge

instructions, and follow-up care was documented.

The Knife-for-Life and wire cutters are located in the "Suicide Intervention Kit" which is mounted on the wall in a metal box that requires a numeric code to open. Staff were able to open the Kit during the visit to show the items contained within. The First Aid kits are fully stocked and sealed with a plastic tie. The kit is located in the staff work station along with the bio-hazard spill kits. Both vans also have fully stocked first aid kits and bio-hazard spill kits. There is a bio-hazard receptacle in the medication room. Staff are properly trained in CPR/First Aid and Universal Precautions in all of the eight training files reviewed.

There are exceptions noted for this indicator. Two (2) of the seven (7) incidents reviewed were not documented in the Emergency Log Book.