



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

Review of Youth Crisis Center

on 04/24/2013

## 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 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 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 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	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 D. Carr, Lead Reviewer Quality Improvement, Florida Network of Youth of Family Services/Forefront LLC

Mark Shearon, Shelter Program Manager, Arnette House, Inc

Cynthia Starling Regional Coordinator CDS Family and Behavioral Health Services Inc.

Benittia Hall, Program Manager, Wayman Community Development Corporation

Becky Linn, Prevention Specialist, Florida Department of Juvenile Justice

**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 5 Case Managers          | 4 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor                 | 4 Clinical Staff         | 5 Program Supervisors   |
| <input type="checkbox"/> DHA or designee             | 2 Food Service Personnel | 4 Other                 |
| <input type="checkbox"/> DMHA or designee            | 0 Health Care Staff      |                         |

**Documents Reviewed**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Accreditation Reports                   | <input type="checkbox"/> Fire Prevention Plan                        | <input type="checkbox"/> Vehicle Inspection Reports |
| <input type="checkbox"/> Affidavit of Good Moral Character       | <input type="checkbox"/> Grievance Process/Records                   | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports                  | <input type="checkbox"/> Key Control Log                             | <input type="checkbox"/> Youth Handbook             |
| <input type="checkbox"/> Confinement Reports                     | <input type="checkbox"/> Logbooks                                    | 8 Health Records                                    |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 14 MH/SA Records                                    |
| <input type="checkbox"/> Contract Monitoring Reports             | <input type="checkbox"/> PAR Reports                                 | 12 Personnel Records                                |
| <input checked="" type="checkbox"/> Contract Scope of Services   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 10 Training Records/CORE                            |
| <input type="checkbox"/> Egress Plans                            | <input checked="" type="checkbox"/> Program Schedules                | 0 Youth Records (Closed)                            |
| <input type="checkbox"/> Escape Notification/Logs                | <input type="checkbox"/> Sick Call Logs                              | 0 Youth Records (Open)                              |
| <input type="checkbox"/> Exposure Control Plan                   | <input type="checkbox"/> Supplemental Contracts                      | 0 Other   |
| <input type="checkbox"/> Fire Drill Log                          | <input type="checkbox"/> Table of Organization                       |   |
| <input type="checkbox"/> Fire Inspection Report                  | <input type="checkbox"/> Telephone Logs                              |   |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 9 Youth | 4 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

**Observations During Review**

- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> Admissions     | <input type="checkbox"/> Posting of Abuse Hotline       | <input type="checkbox"/> Staff Supervision of Youth       |
| <input type="checkbox"/> Confinement               | <input type="checkbox"/> Program Activities             | <input type="checkbox"/> Tool Inventory and Storage       |
| <input type="checkbox"/> Facility and Grounds      | <input type="checkbox"/> Recreation                     | <input type="checkbox"/> Toxic Item Inventory and Storage |
| <input type="checkbox"/> First Aid Kit(s)          | <input type="checkbox"/> Searches                       | <input type="checkbox"/> Transition/Exit Conferences      |
| <input type="checkbox"/> Group                     | <input 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 type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts        |
| <input type="checkbox"/> Medication Administration | <input type="checkbox"/> Staff Interactions with Youth  |   |

**Comments**

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

Rating Narrative

The agency was well prepared for the Quality Improvement review. All staff were professional and very cooperative.

## **Strengths and Innovative Approaches**

### Rating Narrative

Youth Crisis Center (YCC) has begun the process of becoming nationally accredited through the Council on Accreditation. The initial submissions of information have been completed, with the remainder due June 3, 2013. A on site visit is planned for August 11, 2013.

YCC is one of the local agencies contracting with the Florida Network on behalf of DJJ in which youth are referred to a CINS/FINS respite program, rather than being sent to a detention facility, when arrested for domestic violence. The agency has begun providing services with 19 admissions to date. The average length of stay is ten (10) days.

The Department of Juvenile Justice has hired a new coordinator for the JDAI (Juvenile Detention Alternatives Initiative) for the northeast Florida area, and the program has become a lot more organized and active. Two (2) YCC staff members are participating on committees of JDAI.

YCC has partnered with a local Boy Scout who needed to perform a capstone project to earn his Eagle Scout badge. The youth planned, raised money for, constructed, and installed a swing set on YCC property.

The Jacksonville chapter of the Kappa Alpha Psi Fraternity has just recognized YCC at its annual banquet with its Building Communities Award.

YCC has developed an in-house Ethics and Boundaries training which all direct care staff are required to take. Other staff may also receive the training. This practical course gives guidance to youth workers of appropriate/inappropriate behavior including contact via social networking media.

## 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 out of their multi-program location that is located at 3015 Parental Home Road, Jacksonville, Florida. The agency's is lead by Greg Steele, President and CEO. The agency's Management team consists of Butch Sims, Chief Operating Officer, Angie Srock, Chief Financial Officer, Kim Sirdevan, Vice President of Clinical Services, Tracy Deadman, Vice President of Finance, Joyce Farhat, Vice President of Human Resources, Susan Spinella, Vice President of Quality Assurance, Jim Smith, Vice President of Facilities, Darryl Matthews, Vice President of Residential Services, Linda Wilson, Clinical Manager, and Stacy Sechrist, Program Manager.

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 reports having (1) vacant fulltime Youth Care staff vacant position at this location. There were no vacancies reported in the Family Link Non-residential program. The Department of Children and Families has licensed YCC as an emergency runaway shelter, with the current license in effect until April 21, 2014.

The agency manages all personnel functions through its Human Resources division. The agency's Human Resources Department processes all state and local background screenings. The agency delivers Orientation training to both residential and non-residential personnel following screening and reference checks.

Training is also provided by a combination of training methods provided by the Florida Network trainer, interagency training delivered by the agency and outside 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 is 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 2012-2013. Further, the agency's Vice President of Facilities oversees weekly safety and physical plant checks.

### 1.01 Background Screening

Satisfactory                       Limited                       Failed

#### Rating Narrative

Review included a total of twenty (20) employee files. Each file reviewed included a satisfactory background screen prior to hire. Of the files reviewed, two (2) of these required a five (5) year rescreen. Rescreens were completed in compliance with Background Screening requirements.

The Annual Affidavit of Compliance was completed and submitted on January 4, 2013. Of the files reviewed it was noted that seventeen (17) of these were hires between the dates of 08/6/12 thru 04/8/13.

### 1.02 Provision of an Abuse Free Environment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has formal policies to address the requirements of this indicator. The agency has a detailed Code of Conduct system to ensure that staff members are familiar with the provisions that require them to report any and all abuse. In addition, the agency has established a new social media policy and training that have been delivered in the last six months. The agency also states that all youth are informed of the Abuse Hotline number when they are admitted to the program. At the time of this on site program review no graffiti or negative writing or words were visible or detected.

A total of one (1) youth Grievance was submitted by the agency for review. This grievance was reviewed to assess the system used by the agency to provide a method for participants to report general issues concerning their shelter stay. This system was reviewed on site to determine their adherence to agency policy. These documented grievance encompassed reports citing client issues regarding their dissatisfaction with the agency's daily schedule and general rules. The process for resolving grievances involves the agency policy that requires a response to a submitted grievance by a resident within seventy-two (72) hours of receiving the written resident grievance. Abuse hotline is posted in the day room area of each girls and boys day room in open and plain view. The current daily activity schedule and egress facility layout is also posted.

A this time of this onsite QI Review, a total of nine (9) CINS/FINS youth were available to complete an online QI youth survey. Of these completed surveys, eight (8) out of nine (9) surveys reported that they felt safe in the youth survey. Seven (7) out of 9 reported that they knew about the Abuse Hotline, the abuse hotline number and that it was available for them to report abuse. Nine (9) out of 9 youth surveyed reported

that they have not heard any adults threaten them or other youth. Eight (8) out of 9 youth reported that adults were respectful when talking with them or other youth.

A total of four (4) randomly selected Direct Care staff members across all work shifts were selected to complete the Florida Network online Quality Improvement survey. Of these completed surveys, four (4) out of 4 surveys reported that they never witnessed youth ever being sent to their room or an isolation room for punishment. Staff report that they never observed a co-worker telling a youth that they could not call the Abuse Hotline or ever seen a youth being sent to their room or an isolation room for punishment. In addition, staff reported that they never observed a co-worker using profanity when speaking to youth or observed a co-worker using threats, intimidation, or humiliation when interacting with the youth.

A total of eight (8) DJJ CCC incidents were documented in the DJJ CCC database over the last six (6) months. Of these incidents none contained evidence of events related to program participants being subjected threat, intimidation, humiliation or abuse. Incidents are specifically related to medication errors and items located during searches and program disruption issues and contraband and search issues.

The agency reported that eight (8) cases of agency staff personnel action reports were documented over the last six (6) months. Of these reports, four (4) are current disciplinary administrative reports and 4 are terminations/resignations related to employee work performance. None of the reports contain evidence of threats, harm intimidation or humiliation towards youth.

Three (3) out of nine (9) youth reported that they heard adults use curse words when speaking to them or other youth. Four (4) out of nine (9) youth reported that they have not been instructed on what to do in case of a fire. Four (4) out of 5 youth reported that they did not know about the grievance process. Many of the youth surveyed had been residents in the shelter for more than seven (7) days. This indicates that the agency program orientation process is not consistent in terms of informing youth of Abuse Hotline and Grievance process.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The Operations Manual was reviewed. It includes Policy 1.11 which pertains to the procedures for Incident Reporting. This was reviewed/updated by management in April 2013.

The peer completed a review of the 2013 Incident Report Book. The following was noted:

Reports included in Incident Report Book binder are from 10/29/12 thru 4/12/13. A total of thirty three (33) reports are included. These reports were reviewed and compared to the listing provided by the Florida Network. Dates and times were consistent. Additionally, reports reviewed were legible, however it is recommended that in some cases greater detail be provided to create a history of the event.

Additional review included the Episodic Care Log - data in this log was compared to the Incident Report Binder - data was consistent.

Review also included the Staff and Youth Surveys completed at the QI review. Seven (7) youth were surveyed. 7 of the 7 youth reported that they were familiar with reporting procedures and requirements. Four (4) staff were surveyed. All staff surveyed indicated that they are familiar with reporting procedures and requirements.

CCC Reports generated from 12/1/12 thru 2/11/13 were reviewed. A total of seven (7) reports were reviewed. Two (2) of these created an Administrative Review (AR). Additionally Medication Errors resulted in two (2) staff being referred to Nurse Karen Jackson for follow up medication training. Additionally, written and oral reprimands were issued to staff responsible

Follow up with staff training found that one staff (Ron Haywood) has remedial training pending due to an incident which occurred on 4/09/13

Additionally, a medical incident occurring on 3/13/13 involving staff Yolanda McGee recommended follow up training with Nurse Jackson. Ms. McGee's training and personnel file were reviewed. Ms. McGee left the agency on 3/28/13 due to relocation. No action taken by the agency.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has a clear and precise Training Plan that mirrors the requirement of the Standards set forward by the Network. The training plan requires that all first year employees must receive 80 hours of training and after that all Residential employees must receive at least 40 hours of training even though the Network only requires 24 hours. There was 4 first year employee training files and 4 other employee files were reviewed.

Of the four (4) new employee files that were reviewed two (2) of the employees did not receive suicide training, 1 did not receive title IV-E training, two did not receive signs and symptoms, and two did not receive cultural competency. Of the 4 employee files that were older than the first year two of them are still working on their 40 hours of required training. None of the 4 employees had signs and symptoms training and none of them had cultural competency training.

### 1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

#### Rating Narrative

Peer reviewed the following Youth Crisis Center agency policies:

1.12 which pertains to Interagency Agreements and Outreach. Also, Policy 1.13 which covers agency Outreach Presentations. Policies were detailed and specific. These were reviewed and updated in April 2013.

The agency binder used to maintain the Interagency Agreements was reviewed. File review included 25 Inter-Agency agreements. These were current with only one file the St Johns Truancy dates incorrect on the file log reviewed. Should be 12/1/12 - 11/30/15.

As an additional observation of agency agreements, although many agreements are self renewing, it is recommended that many of these be updated even though they have automatic renewals on multiple agreements. Several of these include the previous President of YCC (Tom Patania) or on the part of the partner agency, staff signing are no longer in place, which may in-validate the agreement.

Additionally, the Outreach Events file was reviewed. Months reviewed included: Sept 2012; Oct 2012; Nov 2012; Dec 2012; Jan 2013; Feb 2013 and March 2013. Files included extensive back-up documentation of community events and outreach activities. Activities reviewed were consistent with policy requirements.

The Safe Place Management file was additionally reviewed. This included the date, time, location, attendance and topics at varied events.

Daniel Memorial agreement is included in the Interagency Agreement binder. The agency agreement is dated and signed. The agreement references an attached agreement, however, agreement is not included in the agreement binder reviewed.

Agreements with Murray Hill and Lone Star School are included in the file. These are signed by management staff of YCC, however, the partnering agency has not signed. Agreements are dated December 12, 2011.

### 1.06 Disaster Planning

Satisfactory

Limited

Failed

#### Rating Narrative

Emergency Disaster Plan review – last revision 5/30/12 as indicated on foot-notes included on each page of document, however, plan cover includes a date of 2/15/12.

Additional review of this indicator found the following:

Procedures are established which define situations and procedures to be followed for specific disasters.

Transportation usage is defined with the staff chain of command include. Mode of transportation is included. Facility will use agency vehicles.

A specific evacuation facility (YCC-Gainesville) is identified. The location and contact information is included.

The disaster plan supplies are maintained in a central location accessible for timely use.

A process to Notify the Florida Network is defined on page 13 of the plan which includes Network Contact information.

### 1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has developed a policy to address the provisions of the requirements of this Quality Improvement indicator. The agency has a

Quality Improvement (QI) Committee. The primary areas that are addressed by this committee include Risk Management issues that include tracking of incidents, absconds, etc. (QA Table) by the fiscal year. The Vice President of Quality Assurance tracks this information on a monthly basis to determine trends and patterns. Serious incidents are reported immediately to be addressed according to agency procedures.

The agency's QA department tracks the accuracy and completion of NETMIS data entries. In this process the agency screens all NETMIS to catch errors prior to putting the information in the system. If necessary, the Vice President of QA meets with the data specialist to discuss errors, omissions, and to discuss issues related to data entry. The Florida Network's NETMIS Data Manager visited the Youth Crisis Center in January 2013 to review data entry forms, documents, data entry practice and provided updates on the new user issues and things that the agency can do with NETMIS. The agency produces a Quarterly NETMIS data report that track monthly data entered into the system every quarter.

The agency reviews facility related safety issues. The VP of facilities is the agency's safety officer and tracks the number of days it takes to address safety issues.

The agency reports on vacancy and attritions. The agency also tracks turnaround time on filling positions. They also track training completion. The agency tracks training hour achievement regarding annual training requirements for each staff member.

The VP of Clinical Services tracks compliance issues, programmatic and operations trends and patterns. The Family Link Program tracks the type of youth served, history of trauma, medication, referral trends, family counseling sessions provided in both non-residential and residential programs.

The director of Residential services tracks school attendance and any infractions/rule violations. The agency also tracks client satisfaction information upon discharge.

The agency collects minutes on QIC meetings for the current fiscal year. The agency provided minutes from July 2012, October 2012 and January 2013. The most recent meeting is scheduled for April 26, 2013.

The agency Executive Leadership Team is comprised of Chief Executive Officer, Chief Financial Officer, VP of Clinical Services, VP of Finance and COO. The agency transition plan for the financial department that began in 2013. The plan is to transition the VP of Finance Tracy Deadman to CFO by June 30, 2014. The agency bylaws dictate that the agency reconsider a new annual auditor every for four (4) years.

A review of agency Quality Improvement goals was conducted onsite. The agency did not make reference to the measure (amount, degree or percentage) of its effort to reduce certain risks or obtain the desired increase within an established time frame. For example, the agency could develop a plan to address the problem and set a target date to address the identified problem. At the time of this onsite review, the internal oversight process used by the agency demonstrates general awareness of issues. The agency should utilize focus on increasing its efforts to document the various interventions and strategies it uses to address a problem in more detail, as well test practice overtime to ensure the intervention achieves the desired outcome.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Youth Crisis Center provides Residential and Non-Residential services located in Jacksonville, Florida. The Non-residential services include Truancy, Group and Individual Counseling and Family Counseling. Centralized Intake Services are evidenced throughout all eight charts reviewed. The charts include four Non-residential charts, four Residential charts. Youth Crisis Center has included the "A Guide of CINS/FINS Services for Parents" brochure as part of their Intake process for Residential and Non-Residential programs. This provides the options and process through which parents can find the help needed for truant, runaway and/or ungovernable youth. Youth Crisis Center also distributes a client handbook to each parent/guardian or family. Youth Crisis Center has their Rights and Responsibilities, Grievance Policy, Consent to Treatment, and Discharge Policy clearly stated on their Intake form. The language used is appropriate for many levels of education parents might possess.

Screenings are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. A case plan is developed for each client. In addition, home visits are conducted on a case-by-case basis to offer support the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by Youth Crisis Center with shelter or residential care as an option for youth that need additional support services.

The non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist resolve issues faced by the youth and their family.

### 2.01 Screening and Intake

Satisfactory
  Limited
  Failed

#### Rating Narrative

YCC has an Intake policy that provides centralized intake services to families 24 hours a day. YCC also has a screening policy that conducts an initial eligibility screening within seven days of the client being referred. YCC's policies coordinates with CINS/FINS Standards and are clearly written to be understood by each staff member. A total of five (8) client charts were reviewed with four (4) Residential and four (4) Non-Residential charts. Seven charts reviewed had admission dates visible. Available service options are presented to each family through the consent packet.

During the review of eight client charts (four Residential and four Non-Res), the following results were observed:

- 1.) One non-res chart was referred to program on 12/4/12 and the Intake was completed on 2/22/13. Another Non-Res chart was referred to the program on 9/28/12 and the Intake was completed on 10/25/12.
- 2.) One non-res chart did not have a date on the referral form
- 3.) All charts did contain a consent form stating the available service options that are available to the client and parent/guardian. However, the CINS/FINS brochure was not a part of the Intake or Orientation packet. While on site, YCC did revise the consent form to state that the parent/guardian will receive the CINS/FINS brochure.

### 2.02 Psychosocial Assessment

Satisfactory
  Limited
  Failed

#### Rating Narrative

YCC provides Policy and Procedures for staff members to follow and complete the Psychosocial Assessment process. Three files from Non-residential had the psychosocial assessments completed at face-to-face meetings and were initiated and completed within the 72 hour window of admittance, and one was initiated with client's mother. All four files from Residential had their psychosocial assessments were initiated and completed within the 72 hour window of admittance. Seven psychosocial assessments were completed by Bachelor and/or Master level staff, and one psychosocial was initiated by a non-credentialed staff member. Seven of the eight reviewed assessments were reviewed and signed by a supervisor as evidenced by signatures at the end of the assessments. One of the eight assessments indicated a suicide risk; therefore, there

was not a Suicide Risk Screening completed. While one of these charts reviewed did not receive a Suicide Risk Screening, for their "Yes" risk questions; there is an agency policy with procedures and information stating if the suicide risk component of the assessment is required (as result of suicide risk screening), it must be reviewed (signed and dated) by a licensed clinical supervisor or written by licensed clinical staff.

During the review of eight charts (four Residential and four Non-Res), the following results were observed:

2.) One of the Non-Res Psycho-social assessments had two suicide indicators marked "yes". The notes in chart detailed the client's thoughts for the "Yes" answers. There was not an Assessment of Suicide Risk conducted, however the counselor reported that the Suicide Hotline number was given to the client and the guardian.

3. One of the non-res Psycho-social assessment was signed by the case manager on 10/25/12; and signed by the Clinical Reviewer on 11/26/12.

**2.03 Case/Service Plan**

Satisfactory
  Limited
  Failed

Rating Narrative

Both YCC Non-residential and Residential programs follow, as designated through chart review, the agency Policy and Procedures for Case/Service Plans. The said policy and procedure follows the CINS/FINS Quality Improvement Standards. Seven of eight charts had completed and individualized Case/Service Plans. Residential charts were completed within 24 hours of the Assessment. Seven of eight Case/Service Plans contained location and frequency of where services would be provided. Seven of eight Case Plans documented clearly what persons would be responsible, the target dates for each goal, signatures of the youth, parent/guardian, (consent was documented when parent not physically present for the development of the Plan). Seven of eight Plans contained signatures of the counselors and supervisors for documentation.

**2.04 Case Management and Service Delivery**

Satisfactory
  Limited
  Failed

Rating Narrative

As evidenced by documentation found in the files, YCC Non-residential and Residential programs have a consistent and regularly used method of establishing referral needs and providing referral information to family at the time of admission and time of discharge. The referral form includes the service recommended, the resources available for that recommendation and the agency names, address, phone numbers, and services provided. YCC also provides the family with the brochure "A Guide to CINS/FINS Services for Parents" with services offered, description of services, phone numbers and website information for internal Family Resources opportunities. All charts should provide documentation of the client/family's progress, interventions in cases of lack of progress toward goals, and support provided by staff to clients and/or families. Per staff report, YCC staff member may accompany the client/family at court, monitors the case and court documents if requested by family.

**2.05 Counseling Services**

Satisfactory
  Limited
  Failed

Rating Narrative

Both the Non-residential and the Residential programs at YCC coordinate counseling with the Service/Case Plan development per the agency Policy and Procedures. This was evidenced in the Case Notes from Youth Care Workers, Bachelor's level and Master's level staff. Throughout all eight client files reviewed, the issues identified at the Screening level were addressed in the Psycho-social and had goals set for those issues in the Service/Case Plan. Case notes written by non-credentialed, Bachelor level and Master level staff members are in all eight charts. These notes provided the issues of the youth, needs of the youth, and a additional areas of support upon discharge from both Non-residential and Residential programs, and referrals for after services. Non-residential and Residential case notes should encourage parents/guardian

participation in service completion.

During the review of eight charts (four Residential and four Non-Res), the following results were observed:

1.) Per staff, an internal on-going clinical review policy is not available for review. Per staff, a monthly chart review policy is currently in process. This process should ensure that all clinical records and staff performances are reviewed for accuracy.

## 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.

During this review, five (5) non-residential file were monitored for compliance with this standard. Of the files reviewed, none were parent referrals or requests for Case Staffing by parents. Four(4) of the five (5) files were referrals by the Duval County School Board for habitual truancy and one (1) file was referred by the State Attorney's Office for Ungovernable Issues.

Four (4) of the five (5) 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 four (4) files had copies of the letters to the parents/guardian of the youth. The case manager reported that the practice is to send all notifications of case staffings by certified mail. All four (4) files had verification of the letter being sent by certified mail. One (1) of the five (5) records reviewed did not notify the parent that a case staffing committee was scheduled. The case manager reported that a valid address was not available.

All five (5) of the five (5) records reviewed had coresponding letters which were sent to the Case Staffing Committee members within the required time frame of no less than five (5) working days prior to the staffing. A separate notebook for the committee notification letters was maintained by the case manager in order to ensure confidentiality when more than one case was scheduled on the same day. The agency has an excellent representation of various agencies on their standing Case Staffing Committee. In all five (5) cases, the mandatory local school district representative and the DJJ representative and/or CINS/FINS provider was present. In addition to these representatives, the agency had representation in most cases from the State Attorney's Office, Mental Health, Law Enforcement, and a Department of Children and Families representative. The letters that are sent to the parent/guardian also offers the family the option of inviting others that they feel may be important to the process.

Four (4) of the five (5) files reviewed, had a new or revised plan in each record. The plans were completed with goals and objectives for the youth and parent/guardian. The plans were signed by the case manager and all case staffing committee representatives who were present at the meeting. All four (4) case staffings had a written plans that was provided to the parent within seven (7) days of the meeting. Three (3) written plans were given to the parent at the meeting and one (1) was mailed to the parent within the required time frame. One (1) of the five (5) files reviewed was closed at the time of the case staffing meeting due to information that the youth/family had DCF involvement.

One (1) of the five (5) files reviewed contained a plan dated 4-16-13 that recommended filing a CINS petition. The case manager does complete pre-disposition reports on youth who are recommended to proceed to the circuit court for judicial intervention for the youth/family. The case manager also completes judicial summaries on youth who are adjudicated a Child In Need of Services. The agency has an established Case Staffing Committee with regular communication and meetings that can be convened twice a month when needed.

None Noted.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The agency has a policy that addresses the general requirements of this indicator. The policy addresses Procedure, Record Access, Retention of Records, Record Storage, Record Destruction and Evacuation.

A sample of twelve (12) client files were reviewed for compliance with this indicator. All twelve (12) files reviewed (7 residential and 5 non-residential) were marked confidential. All open residential files are maintained in the Youth Care office in a locked lateral file cabinet. Open non-residential files are maintained by the case worker or therapist and are kept in a locked brief case that allows the staff to transport the files as needed. When the files are not being transported, they are maintained in individual staff offices behind locked doors. All closed files are maintained in a locked records room that contains numerous verticle filing cabinets that have locking mechanisms. This room is maintained and accessed by limited staff members.

All seven (7) residential files reviewed contained forms and documents that were maintained in a neat and orderly manner. The files were

separated by dividers and marked by sections which made it easy to access information for the residential charts. However the five (5) non-residential charts were not as organized and it was more difficult to locate specific forms. However individual documents were clear copies which were easy to read once located. Although the information was challenging to locate overall, there was sufficient information to determine this indicator as satisfactory.

None Noted.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The Youth Crisis Center program provides residential CINS/FINS services through a contract with the Florida Network of Youth and Family Services. The youth shelter is located in metropolitan area of Jacksonville, Florida. The residential shelter houses a twenty-four beds. The agency maintains an updated video camera system. The agency has a general alert board for immediate notification of the resident's status and general information board that notifies the residents of rights, rules and the Abuse Registry number. The Director of Residential Programs oversees the day-to-day operations of the youth shelter. At the time of this Quality Improvement review, the residential program is staffed with access to licensed staff members. The residential program provides group sessions to clients a minimum of five (5) days a week on various topics that address issues including substance abuse prevention, anger management, effective communication, leadership skill building and many others. The agency utilizes a behavior management system that is used consistently across all of its residential programs.

### 3.01 Youth Room Assignment

Satisfactory                       Limited                       Failed

#### Rating Narrative

Eight (8) open Client files were reviewed and on the 8 all files documentation in the area of room assignments were clear and accurate. Youth's history, initial interaction, presenting problems, suicide risk and sexual aggression levels are present.

No exceptions.

### 3.02 Program Orientation

Satisfactory                       Limited                       Failed

#### Rating Narrative

A total of eight (8) open residential charts were reviewed and of them all documentation was present and available to be reviewed. Seven (7) of the 8 charts were signed by the youth and guardian at intake and all contractual required documents were present. Agencies forms are very clear and precise.

One (1) of the 8 charts (intake on 4/14/13) neither the youth, staff or parent signed the Consent for Services, Consent for Residential Care, Residential Contract, and the Client Orientation. After asking the Shift Supervisor she stated it is documented in the progress report that attempts were made to contact Guardian. Reviewing the progress notes it appears an attempt was made at intake and not again until this morning at 9:45A.M.

### 3.03 Shelter Environment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency is very clean and neat. The maintenance department clearly makes great efforts to keep the facilities maintained. Also, the Residential Director and Youth Care Worker take pride in the way their Shelter looks and it appears with no graffiti present and all rooms are neat and organized. There does not appear to be any insect infestation and the facility is sprayed on a monthly bases.

No exceptions.

### 3.04 Log Books

Satisfactory                       Limited                       Failed

#### Rating Narrative

The Agency has a very well organized code system for making logbook entries and it makes it very easy for an outside source to find things in the logbooks. Handwriting for the most part is legible and it appears that staff are all signing at the beginning of each shift. Corrections are struck with a single line and initialed.

Logbooks were reviewed back to 10-24-12 and after interviewing the Residential Director it appears that the Shift Supervisors are reviewing the logbook at the beginning of each shift which is above the standard requirements however they are not documenting accordingly that they are doing it according to standard requirements. Also, best practice would be that eventhough the Shift Supervisors are doing their review that the Residential Director still do his own review periodically.

Rating Narrative

The Agency has a very clear schedule for both school days and weekends posted in the handbooks that they hand out to each youth and also post on the bulletin board as you come into the separate wings of the facility. Youth are given appropriate times to complete all contractually required events.

No exceptions.

**3.06 Behavior Management Strategies**

Satisfactory                       Limited                       Failed

Rating Narrative

The Agency has a clear and precise policy on there behavior management strategies that has a wide variety of rewards used in the program, appropriate consequences and sanctions used by the program. The Agency uses a wide variety of points and levels in its Behavior management system. Every youth is given a handbook at intake and it clearly spells out the Behavior Management program and the rewards and consequences of the Program. Agencies training plan does show that all employees will recieve behavior management training within the first year as part of there 80 hour required training. Residential Training files were reviewed for new employees hired since July 1, 2012 and of those employees 7 have had the Behavior Management Training and 8 have not recieved that training yet. 4 of the employees that have not had the training was hired in the last month. Staff discuss the Behavior Management System during their residential meeting to ensure all the employees remain familiar with the program and tweak any possible problems.

Upon reviewing the youth surveys it appears that this program is working and the youth feel safe here.

**3.07 Behavior Interventions**

Satisfactory                       Limited                       Failed

Rating Narrative

Agency has a clear policy on it's behavior Intervention techniques and its disciplinary measures to be used and not used. The policy tells what Physical Intervention techniques are acceptable according to the Agency, Florida Network and DJJ. Policy states how Staff are the only one to enforce the disciplinary and youth never discipline other youth. Youth surveys were reviewed and only one of the 9 youth stated that they were sent to there room for punishment but the door was left open. 31 Residential staff training files were reviewed and 23 of the 31 have recieved some sort of crisis intervention training, be it de-escalating or self defense training.

The Agency states that they are a Hands-Off facility and physical intervention is used only as a last resort when youth safety is required.

**3.08 Staffing and Youth Supervision**

Satisfactory                       Limited                       Failed

Rating Narrative

Agency does a very good job at ensuring that the required staff ratio is met at all times. They also ensure that all shifts are covered with at least one male and one female on every shift. The Residential Staff schedule is kept in a binder in the Youth Care Workers office and it clearly has available on-call workers that can be contacted if needed. Overnight rooms checks are documented starting at 1015pm and completed every 15 mins through out the night. Agencies video was reviewed and room checks appear to be completed within the 2 to 3 minute windows.

Per QI Standards the rooms checks are to start when the youth enter their rooms for the night which according to the Agency they enter their rooms at 915pm on week nights and the room checks are starting to be documented at 1030pm. According to Standards the agency needs to change its practices and start those checks when the youth enter their rooms and not have a gap in the documentations.

**3.09 Staff Secure Shelter**

Satisfactory                       Limited                       Failed

Rating Narrative

Agency has a clear policy and procedure in place for admitting a staff secure youth and how the counselors would handle the youth. However the agency has not had a staff secure youth for over three years so no charts or youth were available to review at this time.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The Youth Crisis Center is located on a residential area of the City of Jacksonville. The Youth shelter and Administrative offices are co-located on the same site. The youth shelter was recently licensed by the Department of Children and Families (DCF) for twenty-four (24) beds and it primarily serves youth from Duval County, as well as youth from surrounding counties. There are a total of eight (8) bedrooms with four (4) rooms on the male resident wing and 4 rooms on the female resident wing of the facility.

There are a total of twelve (12) beds within the 4 male resident rooms, and a total of twelve (12) beds within the 4 female resident rooms. Each bed has an individual bed, bed coverings and pillow. The shelter also admits youth from the FNYFS Domestic Violence Respite Program. The shelter is designated by the Florida Network to provide staff secure services. The agency has two (2) staff members onsite that are Licensed Clinicians. During the tour of the facility, the review team toured all major areas include sleeping rooms, kitchen, female and male bathrooms, dining area, medication storage area, recreation area, wash room, as well as other areas.

The day to day operation of the residential program is 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-five (25) Youth Care Specialists. Youth Care Specialists are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The residential program's counseling services are managed by Stacy Sechrist, Program Manager – Family Link Program and seven (7) Therapist, two (2) Case Managers and one (1) Wrap Around Coordinator.

### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has written policy and procedures called Healthcare Admission Screening to address the admission process to include an in-depth health screening which is completed during the intake process. The written procedure addresses the referral process and follow-up medical care. The screening is completed on the Admission Form (which is printed on yellow paper and makes it much easier to locate quickly). The form is located in section 1 which is labeled "Intake/Orientation". The form addresses physical appearance/distinguishing features (scars, tattoos, bruises, other skin markings, etc.). It also includes a "Body Chart" to mark specific location of distinguishing features. The Admission form also has a heading of "Physical and Mental Health Screening" which addresses all seven required areas which are: current medications, existing medical conditions, allergies, recent injuries or illnesses, observation for evidence of illness, injury, physical distress, difficulty moving, and observation for presence of scars, tattoos, or other skin markings. The screening also includes a check list for the following conditions: Asthma, Bleeding Disorder (within past 2 weeks) Heart Condition, Diabetes, Head Injury (within past 2 weeks), Seizures/Blackouts, Tuberculosis, Pregnancy, and Hepatitis. The form includes specific instructions for staff to follow should a youth have a medical condition that requires follow-up. The form specifically advises staff to complete an intake note and to document as a special need (SN) in the Program Log, in the client's file and on the census board. Medical follow up is also required and the initiation of the medical alert system. The procedure manual also addresses what actions must be taken in the event of a health or medical health condition which renders admission unsafe from a medical standpoint. The screening tool addresses all elements of the indicator with no exception on the form used by the agency.

During the review, four (4) open files and two (2) closed files were reviewed and found to contain the appropriate documentation on the Admission form. All six (6) of the files reviewed were completed the day of the youth's admission. All six (6) files had a corresponding case note that accurately reflected the findings from the Health Screening form. None of the six (6) files reviewed had any check mark for an existing (acute or chronic) medical condition but several of the forms also did not have an indication that None existed therefore it was difficult to ascertain if the issue was appropriately addressed. In other words, that area of the form appeared blank. It is recommended that staff should write the word "None" if none of the medical conditions exist.

### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a revised the current Suicide Risk policy as of April 2013 on Suicide Assessment on April 2013. The Florida Network approved the previous policy in June 2011. The policy had not seen a major adjustment since that time. Each child admitted to the shelter is screened for suicide risk. The resident is initially screened by the suicide risk instrument with questions listed in the Risk Screening section the Admission form. The agency asks at total of eight (8) suicide risk related questions to screen for suicide risk as administered by a Direct Care Staff person. In addition, the agency repeats the same 1-8 Suicide risk questions as administered by a MS Level Therapist on the Psycho-social

assessment. If the youth indicates a positive on the admission form the child is placed one (1) of two (2) levels of supervision. If the child placed the initial level if the answers to any of the questions 1-5. The youth will be placed On the one to one level. The second category suicide risk screening involves 3 questions and the child can be placed on Sight and Sound if they answer a positive to any of these questions. See Policy for definition of One to One and Sight and Sound. If the youth is placed on 1 to 1 status, a staff member of the same gender is assigned to the resident and is to remain no more than 5 ft from the resident at all times. An Observation log entry is documented every 30 minutes during awake hours and 10 minutes during sleep hours. Sight and Sound requires that the resident be in the line of sight of a general staff member. Observation is documented every 30 minutes during awake hours and 10 minutes during sleep hours. All youth on either are assigned to sleep on a cot that is placed in front of the youth care station.

The agency has a total of 4 licensed (1 LMHC and 3 LCSW) clinicians and 4 Registered Interns. All of these staff members report to the VP of Clinical services.

A total of two (2) active and four (4) closed cases were selected as the sample for this indicator. All cases contain general information required by the indicator. The forms found fully completed suicide assessment and include admission screen, psycho-social, assessment of suicide risk, observation log, discontinuation, and progress notes.

One (1) out of six (6) resident files did not have evidence of a completed Assessment of Suicide Risk. This document is required when all youth are screened positive to any suicide risk screening questions. This form is also important because it require the agency to place the resident on one of 2 levels of supervision. A review of the youth's progress notes indicate that they had not been placed on any level of supervision. A review of the agency logbook did not indicate that the youth was placed on any level of supervision.

One (1) youth placed on one to one supervision did not have evidence documenting the staff assigned 1 to 1 supervision in 1 of the 5 days that the youth was placed on this status between 02/09/2013 – 02/13/2013. The agency should revise the current Observation log to include a line to capture evidence that the shift supervisor is conducting reviews as required.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has detailed policies on medication that upon review meet the general requirements of this indicator. The agency recently revised its Medication Policy in April 2013. The agency has a part-time Registered Nurse on staff to assist in overseeing the medication distribution and documentation to residents admitted to the shelter. The Nurse also assists with training. The nurse is on duty two (2) on the AM work shift and 2 hours on the PM work shift five (5) days per week. The program had a list delineated in writing of staff members that are authorized to have access to secured medications, and limited access to controlled substances. The program also posts a list of Controlled Medication to advise staff of specific Medications and times that medication are to be given. The agency also provides other the counter medication (OTC). All medications in the shelter are stored in a separate room in the youth shelter that is inaccessible to youth. All medications are stored behind two (2) locks in a large metal five (5) drawer cabinet inside locking plastic utility boxes. There are six (6) separate locking medication boxes that include Controlled, Non-Controlled, Liquids, Topicals, Sprays, and OTC/Overflow. Oral medications are stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a medications only refrigerator in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review.

Shift-to-shift counts and a perpetual inventory is maintained, and documented for controlled and prescribed medications. The program utilizes the DJJ Medication Distribution Log (MDL). The MDL contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff person and youth initials on MDL when medication is disbursed and received. The agency's over the counter (OTC) medications are stored in a separate cabinet. Over the counter medications that are accessed regularly are generally inventoried weekly on a perpetual inventory.

Sharps are maintained in a locked cabinet. Scissors are maintained in a locking box. There were a total of eight (8) scissors at the time of this onsite review.

Medication disposal is completed by a management level staff person or on site nurse will dispose of the medication and another staff is required to witness the disposal.

Two (2) CCC incidents that involved medication errors were documented in the DJJ CCC database. An incident on 03/13/2013 indicated that one youth did not receive their psychotropic medication the current number of time per day. An incident dated 04/08/2013 indicated a staff member failed to give youth their medication due to irregular distribution times. Following these incidents, both staff were given documented verbal counseling and was required to take remedial training from the registered nurse on provide medication to shelter residents.

The OTC distribution log indicated that t staff person received medication, but the staff failed to document this from the perpetual inventory.

At the time of this onsite review, the agency's medication verification process of confirm the medication with the pharmacy that filled the prescription is not in practice. The agency policy does not reference the process of verifying the medication with a pharmacy. The agency began to revise the policy to include these steps during the onsite QI review.

A review of the agency's medication disposal process indicated that a medication was left behind without any documentation of attempts to notify the parent/guardian contact or follow up by the agency.

#### 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. If there is no special need, it 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, six (6) client files were reviewed and three (3) of the six (6) were found to have either a medical or mental health condition or food allergy. Observation of the census board revealed that all clients were appropriately placed on the program's alert system with a written note to "see file". The alerts were noted in the client's files and the program logbook. One youth had a food allergy and that youth's name and food allergy was also appropriately placed on a board in the kitchen area where staff can quickly check current clients who have food allergies/special diet.

The client board, client files and program logbook entries were reviewed to ensure that staff members were provided sufficient information regarding the youth's medical or mental health condition to allow them to recognize and respond to the need for emergency care.

All six (6) client files were observed to be in compliance with the Medical/Mental Health Alert process. However, it was noted that the agencies Alert system is very fundamental. It is recommended that a more detailed color-coded system or number-coded system be initiated to identify specific medical/mental health conditions rather than having only two colors identified for risks (red for medication and green for ALL other risks). Also it is recommended that the program log book be consistent with the color-coding to more rapidly locate the alerts. At the time of the review, the log book had all risks highlighted, but the color of the highlights varied and had no significance to the difference in color. It would be beneficial to have a specific, different color for medications, and suicide risk at a minimum. It is also recommended that the agency provide "Informational" sheets in the client's record when a condition is present. The informational sheets should provide staff with vital information regarding the major medical condition such as the signs and symptoms and first aid to be rendered for the following conditions : Asthma, Bleeding Disorders, Heart Conditions, Diabetes, Head Injury, Seizure/Blackouts, Pregnancy, Tuberculosis, and Hepatitis.

None Noted.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

Youth Crisis Center has a detailed policy with extensive procedures regarding Episodic/ Emergency Care. Upon review of these procedures, it was noted that the program's procedures include the following mandatory components: obtaining off-site emergency services, parental notification and implementation of a daily log. Upon review of this process and the daily log at YCC, it is evident that the agency is following written procedures to ensure that clients are receiving episodic and emergency care when needed.

The Episodic/Emergency Care Log was reviewed from October 2012 through present and there were three incidents that required EMS to be called for emergency treatment. Two of the three incidents required that the youth be transported to the hospital (2/15/13, 2/16/13). The parent was notified in all three cases and procedures were followed according to policy.

The program was able to provide proof of the following safety items: first aid kit is located in Youth Care Station and vehicle. The knife for life, wire cutters were in a locked (code must be entered) box. The shelter also had universal precautions bio hazard disposal bags in the Youth Care Station.

Upon review of six (6) staff training records the following was determined:

CPR was successfully completed in eight (8) of the eight (8) training records reviewed.

First-Aid was successfully completed in six (8) of the eight (8) training records reviewed.

Universal Precautions training was successfully completed in eight (8) of eight (8) training records reviewed.

None Noted.