Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Florida Keys

on 05/03/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

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

Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Review Team

Members

Marcia Tavares, Lead Reviewer, Consultant - Forefront LLC

Tracy Bryant, Systems Coordinator, Hillsborough County Children Services

Teresa Clove, Executive Director, Thaise Educational Tours Inc.

La Terrance Reed, CINS/FINS Supervisor, Urban League of Palm Beach

Mark Shearon, Chief Compliance Officer, Arnette House

Persons Interviewed

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

1 Case Managers
1 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

1 Clinical Staff
0 Other

Documents Reviewed

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

3 # Health Records
4 # MH/SA Records
16 # Personnel Records
6 # Training Records
1 # Youth Records (Closed)
2 # Youth Records (Open)
0 # Other

Surveys

4 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The Florida Keys Children's Shelter, Inc., (FKCS) is a non-profit community-based corporation sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary Children In Need of Services/Families In Need of Services (CINS/FINS) residential and non-residential services to youth and families in Monroe County. The agency provides a variety of services to both male and female youth under the age of 18 years. The program is located at the Tavernier's Jelsema Center, at the north-end of Monroe County next to the Tavernier Government Center.

In addition to the CINS/FINS Program, the agency operates the Poinciana Emergency Shelter (birth through 10 years) and Poinciana Group Home (11-17 years old) in Key West, for children who have been removed from their families/homes as a result of abuse or neglect. It also provides street outreach through Project Lighthouse where staff conducts outreach in areas where homeless youth congregate with the goal of getting these youth help and providing a safe shelter.

During the entrance conference, the reviewers were updated about the agency's achievements since the last onsite QI and Contract Monitoring visit in November 2016.

· In January 2017, the agency's long term CFO retired and a new CFO, Alvin Bentley, was hired

· In August 2017, a new Chief Development Officer (CDO), Jen McComb, was hired to replace the former CDO

· A new partnership with the school district was started in August 2017 for alternative education classes. The program has the capacity for enrollment of up to 10 youth and allows the shelter to offer classes taught by a certified school district teacher

· In October 2017, the agency decided to improve services to youth and consequently changed 3 Team Leader positions to three Residential Coaches with targeted qualified degrees individuals with expertise in three areas: education, recreation, and life skills

· In April of 2016, the Florida Keys Children's Shelter (FKCS) was successfully re-accredited through July 31, 2020 by the Council on Accreditation (COA) and has been continuously re-accredited by the Council on Accreditation (COA) since its accreditation in May 2004.

· The Agency also completed another successful Mayor's Ball. The 15th Annual Mayor's Ball fundraiser, conducted in January 2017, drew a lot of supporters along with other guests ranging from high ranking local officials to local businessmen.

Standard 1: Management Accountability

Overview

Narrative

FKCS has been in operations for over 30 years. The agency has a twelve-member Board of Directors/Trustees, including a youth member, with representatives from the upper, middle, and lower keys, to oversee the agency's goals, objectives and activities. The FKCS building houses the CINS/FINS shelter on the first floor and the agency's administrative offices on the second floor. The shelter provides separate female and male dormitories to children under 18 years of age that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at risk.

The program has a Senior Management team that is comprised of two Co-Chief Executive Officers, a Chief Financial Officer (CFO), and Chief Development Officer (CDO). In addition, the program has a licensed Mental Health Clinician (LMHC) on staff and a Shelter Program Coordinator. There were no staff vacancies at the time of the review.

At the time of the onsite visit, per the program roster, the shelter program staff included: a Residential Program Coordinator, two Youth Advocates, nine Youth Support Staff, a Food Service Manager, and a Maintenance staff, and three new Coach positions, namely: Education, recreation, and Life Skills coach. In addition to the Counseling Services Coordinator, the clinical component has four community-based Counselor positions, assigned to the upper Keys, Marathon, and Key West, and one Residential Counselor.

The program has an Annual Training Plan for all staff and all employees receive ongoing training from the program's designated trainer, local providers, and the Florida Network. Orientation training is provided to all personnel by the Co-CEO. Each employee has a separate training file that contains a training plan and corroborating documentation for training received. Annual training is tracked according to the employee's date of hire.

FKCS maintains valuable inter-agency agreements with several agencies that ensure a continuum of services for the youth and families. The program has a strong outreach component, with participation of all program staff, with emphasis on areas designated as high crime zip codes. Community based staff provide services throughout the county and maintain offices in schools located in the upper, middle, and lower Keys.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy and procedures that address the background screening of all employees and volunteers. The provider's Policy number 1.12, last approved on 7/27/2017, requires all potential employees, volunteers who work alone with youth, and subcontractors to successfully complete a background check prior to an offer of employment or provision of service within the program and every five years subsequently.

The background screening includes Department of Juvenile Justice Criminal History Acknowledgement, Request for Live Scan, and Affidavit of Compliance with Good Moral Character forms. Additionally, the provider conducts quarterly local background checks for all employees, annual driver's license checks through its Insurance Company, and drug screenings at hire and randomly thereafter. The program maintains personnel records of employee's background screenings in their personnel file.

A total of sixteen (16) background screening files were reviewed for fourteen (14) new hires and two (2) employees who were eligible for a 5-year background screening since the last onsite visit. The fourteen new hire personnel had timely background screenings completed prior to their hire dates. Similarly, the 5-year re-screenings for the two applicable employees were completed prior to their 5–year anniversary dates. The program provided E-verify documentation for the fourteen new staff, verifying authorization to work.

A copy of the provider's Annual Affidavit of Compliance with Level 2 Screening Standards prior to January 31, 2018 was not available upon request. The Co-CEO contacted BSU who indicated one was not on file. Consequently, the provider submitted its Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on May 2, 2018 during the onsite visit.

Exception:

Provider did not submit the Annual Affidavit of Compliance with Level 2 Screening Standards to the DJJ Background Screening Unit by the January 31st deadline. Upon request, it was submitted to BSU on May 2, 2018 during the QI visit.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has comprehensive policies and procedures regarding: Code of Conduct (Policy # E.1), Dress and Appearance (Policy # E.3), Child Abuse Reporting, (Policy #1.07.01-1.07.03), and Grievance Process (Policy #3.22) to ensure the provision of an abuse free environment. The policies were last approved in July 2017 and were signed by the Co-CEOs.

The agency's personnel policy and procedures are provided to new staff at hire. Staff receives a copy of the handbook and is required to review the procedures and sign an acknowledgement of receipt of the manual. The provider's Code of Conduct and Behavioral Expectations are included in the personnel policies manual.

The program's policy and procedures comply with DJJ's requirement as related to incident reporting and requires program employees and volunteers to report all known or suspected cases of abuse and/or neglect to the Florida Abuse Hotline. Both paid staff and volunteers are expected to abide by the agency's rules of conduct that foster an abuse free environment and prohibit intimidation, physical abuse or force. All new staff members receive training regarding the requirement of reporting incidents of alleged child abuse as a part of their initial orientation training.

The program also has a grievance policy in place that requires families and youth to be informed of their right to grieve; youth acknowledge their understanding of the process by their signature at intake. The program maintains blank grievance forms at the entrance to the male and female dormitories. A grievance box is mounted next to the Residential Coordinator's office for depositing of completed grievances. Per the agency's procedures, completed grievance forms should be placed directly in the grievance box.

Posting of the Abuse Hotline number was observed during the tour on a wall in the youth living room area. The Abuse Hotline number is also included in the resident handbook. A review of eight calls made to the abuse registry during the review period demonstrated that staff is aware of the reporting requirement. Four of the eight calls were accepted by the abuse hotline and the youth made the call to the hotline in one of the four calls. None of the abuse incidents reported was institutional.

The program provided copies of 4 grievances filed in the facility during the review period. All four grievances were resolved and acknowledged as such by the youth at the informal phase as outlined in the program's grievance policy. There were no personnel actions taken against staff as a result of grievances filed, abuse, intimidation, or excessive use of force.

No exceptions noted as of the date of the QI visit.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has Incident Reporting Policy and Procedure, 1.13, that was approved on 7/29/2017 and is signed by both Co-CEO's. Policy is in compliance with Florida Network Indicator for Incident Reporting.

Whenever a reportable incident occurs, the program notifies the Department's Central Communication (CCC) within two (2) hours of the incident, or within two (2) hours of becoming aware of the incident. The program also completes the follow-up communication tasks/special instructions as required by the CCC in order to close the case and assure the incident has been fully attended to as needed.

The program is expected to comply with the requirements and procedures outlined in Department policy and Florida Administrative Code. This indicator shall be rated "non applicable" if the program has not had any reportable incidents during the scope of the review. Incidents discovered and reported by the review team during the review shall be considered "non applicable" unless documentation exists that program was aware of the incident, but failed to report it.

A total of 7 incidents were reviewed by reviewer; 5 of the 7 incidents reported to CCC were in compliance with the required reporting time frame. Out of the 7 incidents that were reported to CCC (5) cases were Medical, (1) was an injury, and (1) was an Absconder. In looking at the CCC book log all incidents were reported in log. In addition, all incidents are documented on incident reporting forms and in the program logs. The program completes follow up communication tasks/special instructions as required by the CCC and all incident reports were reviewed and signed by program Supervisor/Director.

Exception:

Two of the 7 reportable incidents reviewed at the time of the QI visit were out of compliance with the 2-hour reporting time frame. For the first non-compliant incident, the date and time of the knowledge of reportable incident was 4/16/2018 at 7:00 p.m. but the incident was reported on 4/17/2018 at 9:04 p.m. The second incident was also out of compliance with the time in accordance to policy. Knowledge of incident was at 12:00 pm and it was reported at 2:47 pm, 47 minutes out of compliance (not within the 2 hours of staff becoming aware of incident).

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Employee Training Plan Policy and Procedure, 5.01, that was approved on 7/27/2017 and approved by both CO-CEO's. Policy is in Compliance with Florida Network Indicators.

Staff receives training in the necessary and essential skills required to provide CINS/FINS service and perform specific job functions. All direct care CINS/FINS staff (full time, part time and on-call) shall have a minimum of 80 hours of training for the first year of employment and 24 hours of training each year after the first year. Direct care staff in a residential program licensed by DCF is required to have 40 hours of training per year. List of First Year Training Topics are listed in the Policy and Procedures. The program is expected to comply with requirements and procedure outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

A total of five training files were reviewed for two applicable staff in the first year of training, and three reviewed for evidence of in-service training. There was no non-licensed mental health shelter staff hired during the review period. It appears that the two new files reviewed met the criteria for documentation of all of the trainings required during the first 120 days of hire and still has time to complete other required training during the first year. Both staff had received training in excess of the 80 hours required during the first year.

All three in-service training files met the requirements for in-service training. All 3 files had completed training hours in excess of the 40 hours of training required annually for in-service staff.

Each staff's training file was maintained orderly and in keeping with the agency's policy and QI indicator. Program maintains an individual training file for each staff which includes an individual training file for each staff. The files include an annual employee training hours tracking form and related documentation, such as certifications, sign in sheets and agendas for each training attended.

No exceptions noted as of the date of the QI visit.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has multiple policies and procedures (P&P) to ensure adherence to the requirement of Indicator 1.05, Analyzing and Reporting Information. The P&P are listed as follows: Statistical Information -1.20; Case Record Review- 3.50; Service Satisfaction Questionnaires – 3.55; Outcome Goals -1.21; Incident Reporting – 1.13; Grievances – 3.22; and Risk Management and Internal Quality Monitoring – 1.23. All of policies and procedures were reviewed and approved by the Co-CEOs July 7, 2017.

The policies and procedures address the collection of pertinent data required for all of the areas mentioned above. A peer review is completed on both residential and non-residential programs on a quarterly basis. The Co-CEO reviews the incidents, accidents, grievances, staff surveys, outcome data, and monthly review of NetMis data reports. This information is reviewed at the staff meetings, quarterly Board meetings, and monthly leadership meetings.

There is a systematic record system for quarterly reports for case record reviews and risk prevention and management. These reports are compiled and reviewed by management each quarter. Upon completion of each record review, the review team documents the findings on the File Review Form. The form is submitted to the Program Directors and Coordinators to review and address deficiencies. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner.

There is a separate, detailed policy regarding incidents, accidents, grievances, service satisfaction surveys. There is policy regarding outcome data analysis as well as detailed procedures to collect, review, and to report various sources of information to identify patterns and trends. In addition, there is evidence that monthly leadership meetings are conducted where the executive staff and shelter coordinators discuss current concerns, progress, and other various topics. Some of the topics covered in the meeting are vacant positions, surveys, Florida Network data reports, and safety/risk management.

Case File Review is conducted quarterly by the clinical team. The agency submitted Case Record Reports for the 1st, 2nd , and 3rd quarters of FY 2017-2018 showing a total of 28 residential and 52 non-residential files reviewed for the periods. The Co-CEO distributes a copy of the report to the Executive Council and Leadership. Any deficiencies are corrected within two weeks of the records review.

Incidents, accidents, and grievance data is collected monthly and compiled in a quarterly Risk Prevention and Management (RPM) Report. The RPM reports for the 1st and 2nd quarters of FY 2017-2018 were reviewed during the visit. The information is shared with the PQI meeting members and an annual report is compiled and presented to the Board members.

Consumer surveys are administered for staff and stakeholders annually and quarterly for youth in the program. The annual employee satisfaction surveys and stakeholder survey data are aggregated by the Co-CEO and presented to the agency constituents. Staff survey report for FY 2016-2017 and Florida Network CINS/FINS Client Satisfaction Survey as of April 2018 were reviewed on site.

Outcomes data is generated by the CEOs and included in the Providers Monthly Leadership Report. Data is collected on program effectiveness, client outcomes, and CQI. The outcomes data incorporates all of the contract, NetMIS, and program benchmarks required by the Florida Network and DJJ.

NetMIS outcome data is reviewed monthly and is presented at the Leadership meetings. The Co-CEO reviews this data and activities are conducted to increase performance.

Exceptions:

An annual review of customer satisfaction data was not completed for the FY 2016-2017.

It was evident that management met monthly to review and discuss findings and trends identified; however, it was not evident that this information was disseminated and communicated to staff and/or staff are involved in discussing improvements. Jelsema meetings do not reflect discussion of key data with regards to incidents/accidents, grievances, client satisfaction data, outcomes, netmis data reports. The CBC meetings and emails from Supervisor addressed performance issues but not trends or corrective actions resulting from peer record reviews.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Transportation Policy and Procedure, 10.03, that was approved 7/27/2017 and was signed by both CO-CEO's. Policy is In Compliance with Florida Network Indicator.

The program has a transportation policy that is implemented by agency approved drivers. The basis of the policy is to avoid situations that put youth or staff in danger of a real or perceived harm, or allegations of inappropriate conduct by either staff or youth. The best practice to prevent such situations is to have a 3rd party present in the vehicle while transporting a client. The procedure of the policy addresses the following: 1) Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle; 2) Approved agency drivers are documented as having a valid Florida driver license and are covered under company insurance policy; 3) Third party is an approved volunteer, intern, agency staff, or other youth; and 4) Documentation of use of vehicle hat notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location. In the event that a 3rd party cannot be obtained for transport, the clients history, evaluation, and recent behavior is considered. The agency approved driver's work performance and history indicates no inappropriate behavior is likely to occur. If driver is transporting a single client in a vehicle, there is evidence that the program supervisor is aware (prior to the transportation) and consent is documented accordingly.

The provider's travel logs, for the review period, which contains documentation of the use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location were reviewed. Transportation policy was reviewed. Approved agency drivers were documented as having a valid Florida driver's license and are covered under company insurance policy by looking at a copy of Insurance policy. In addition, according to records reviewed, the 3rd party is an approved volunteer, intern agency staff, or other youth. Policy is well written and explains 3rd party issues if 3rd party cannot be obtained. Also where a single driver is transporting a single client, there is evidence that a program supervisor is aware prior to transport and consent is documented accordingly. Finally, in looking at documentation the agency has a list of drivers approved by administrative personnel.

No exceptions noted as of the date of the QI visit.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Outreach Services Policy and Procedures 9.01, 9.02 and 9.03, that was approved 7/27/2017 with signatures of both CO-CEO's. In addition Community Participation Policy and Procedure was approved 7/27/2017 and was signed by both CO-CEO's. Finally Interagency and Multi-agency Agreements Policy and Procedure 9.03, was approved on 7/27/2017 and signed by both CO-CEO's. The policies are in compliance with Florida Network's indicator 1.07.

The program participates in the local DJJ board and council meetings to ensure CINS/FINS services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention, and treatment services. The program also maintains written agreements with other community partners that include services provided and a comprehensive referral process.

The agency contributes to the implementation of Department objectives through participation in local and circuit level meetings. The assigned representatives to these groups will advocate for the effective use of CINS/FINS services and update agency leadership on meeting activities. There is a lead staff member designated to attend local and circuit level meetings convened by the Department of Juvenile Justice.

The agency provided minutes of the DJJ Board and Council Meetings meetings as verification of attendance. Seven meetings were attended during the review period (4/13/2018, 3/16/2018, 3/1/2018, 2/6/2018, 1/19/2018, 1/5/2018, 11/17/2017). Agency provided support and accommodations for representative to participate in assigned meetings. Along with minutes, an attendance sheet was also included which showed a second verification of agency attendance. The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.

No exceptions noted as of the date of the QI visit

Standard 2: Intervention and Case Management

Overview

Rating Narrative

FKCS is contracted to provide both shelter and non-residential services for youth and their families in Monroe County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, every day of the year. Staff are trained staff to conduct screening and immediately assess the needs of the family and youth. Residential counseling services are provided by Master's/Bachelor level Counselors who conduct individual, family, and group services. Case management and substance abuse prevention education are also offered in both the residential and non-residential service programs.

The Community-based program offers both school and home based services that are divided between four (4) full time counselors under the supervision of a licensed (LMHC) Counseling Services Coordinator. The counselors are responsible for providing case management services and linking youth and families to community services. The community based services span the entire Monroe County. The program's non-residential counselors work out of local schools in the upper (1), middle (1), and lower Keys (2) in Key West, and provide prevention services to youth in the county utilizing several schools as the base of operations in their respective communities. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance.

FKCS 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.

The review of the charts shows that required documentation is in place and all services are being provided to the youth and families in a timely manner by the counselors and case managers. For the purpose of this review, a total of 8 files were reviewed: three Residential (two opened and one closed), and five Non-Residential (four open and one closed).

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys has a written policy that is required for the Screening and Intake indicator. The policy was last updated on April 28, 2017 and last reviewed on July 1, 2017, signed and approved by the two (2) Co-CEO's on July 27, 2017

The procedures are being implemented as it is stated in the policy. The initial screening is received either by phone or face to face by a trained staff. Information is gathered to determine if the youth is eligible for CINS/FINS services within 7 days. Once the youth is deemed eligible for service, the Non-Residential and Residential staff is assigned to the youth and will schedule an intake session with the client and his/her parent/guardian. The Residential staff will initiate the Needs Assessment within 72 hours of completing the Intake Assessment. The Non-Residential Services will complete the Needs Assessment within 2 to 3 sessions or visits.

A total of 8 files were reviewed, three (3) Residential and five (5) Non-Residential, two (2) opened and one (1) closed Residential and four (4) open and one (1) closed Non-Residential.

Florida Keys intake office is located in their building at 73 High Point Road, Tavernier, Florida for Residential and Non-Residential youth and is available 8 to 5 pm for Non-Residential and Residential youth. After hours and weekends, all screenings are received at the shelter 7 days a week. The screenings were received and were screened for eligibility within the seven (7) day standard. In fact, all the screenings were deemed eligible within 1 to 3 days of the referral except for one (1) that was due to the family not responding to the phone calls or messages that were left. The attempts were made within the 7 days period as required but the family did not respond to complete it.

During the Intake session, the parent and the client received in writing the available service options, the right and responsibilities, the grievance procedure, the agency Handbook and the possible actions that could occur during involvement with CINS/FINS services.

No exceptions noted as of the date of the QI visit

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys has a written policy that addresses all the requirements for the Needs Assessment indicators. The policy was last revised on June 20, 2014 and last reviewed on July 1, 2017, signed and approved by the two (2) Co-CEO's on July 27, 2017.

The procedures are being implemented as it is stated in the policy. For the shelter, a master's level staff completes a written Needs Assessment within 72 hours of admission and for the Non-Residential Services a master's level staff initiates and completes the Needs Assessment within two (2) to three (3) face to face contacts following the initial Intake. A supervisor is required to review and sign the Needs Assessment upon completion for both Non-Residential and Residential Services. The same master's level licensed Supervisor signs off on both the Residential and Non-Residential Needs Assessments. If a youth is identified as having a suicide risk behavior during the Needs Assessment the youth is referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a Licensed Mental Health Professional.

A total of 8 files were reviewed, three (3) Residential and five (5) Non-Residential, two (2) opened and one (1) closed Residential and four (4) open and one (1) closed Non-Residential.

The Needs Assessment for all five (5) Non-Residential case files were implemented and completed the same day of Intake by a master's level staff and was signed and reviewed by the licensed Supervisor. Two (2) Residential files did not complete the Needs Assessment within 72 hours of the Admission. One was justifiable due to the client being on pass (away or on leave from the shelter) for 7 days as requested by his father. Upon returning the Needs Assessment was completed that day.

One Residential youth was identified as having suicide risk behaviors and was given an Evaluation of Suicide Risk Among Adolescents. The Evaluation of Suicide Risk Among Adolescents was reviewed and signed by a licensed clinician.

Exception:

One residential youth's Needs Assessment was initiated 4 days after the Admission. The client was admitted on 4/6/10 but did not have the Needs Assessment initiated and completed until 4/10/18. It was a day late. There was no justification in the case notes stating why it was not completed within 72 hours of the admission. After the Needs Assessment was completed the supervisor did not sign or state in the progress note that she had reviewed it.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys has a written policy that addresses all the requirements for the Case/Service Plans indicator. The policy was last revised on November 20, 2008 and last reviewed on July 1, 2017, signed and approved by the two (2) Co-CEO's on July 27, 2017.

The procedures are being implemented as it is stated in the policy. After a case is opened a Case/Service plan is developed within seven (7) working days following the assessment and identifies the services that will be rendered to the client/family assisting them in reaching their goal.

A total of 8 files were reviewed, three (3) Residential and five (5) Non-Residential, two (2) opened and one (1) closed Residential and four (4) open and one (1) closed Non-Residential.

The Case/Service Plans were developed on the same date or within seven (7) days of the Needs Assessments in the Non-Residential and Residential case files. All of the case/service plans reviewed addressed the following areas:

- Identified Needs and goals,
- Type, frequency, and location,
- Target dates,
- Actual completion dates,
- Date plan was initiated and

· Signatures of the youth, parent, counselor and supervisor.

Exceptions:

Service Plan Reviews were deficient in three (3) of the three (3) Residential files reviewed. One case file did not have a 30-Day Review completed but stated on 11/21/2017 that the client and counselor were unable to meet to review the Service Plan. The next case note, on 12/1-5/2017 stated that the counselor was out of the office and will return 12/6/2017. There was time between 11/21/17 and 12/1/2017 to complete the Service Plan but no attempt was indicated on the progress note. In this same case file, the counselor did not date the initial Service Plan.

In the second case file, the Service Plan was missing the Supervisor signature and date.

The third case file, all parties (4) signed the Initial Service plan but did not date the plan. In this file the counselor completed a 30-Day Review on 3/23/18 and made a progress note in the file but did not sign and date the Service Plan Review. In the same case file, the counselor completed a 60-Day Review on 4/23/18 and documented it in the progress note but did not sign or date the Service Plan Review. The parent and Supervisor did not sign or date any of the Reviews.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys has a written policy that addresses all the requirements for the Case Management and Service Delivery indicator. The policy was last revised on July 12, 2010, last reviewed on July 1, 2017, signed and approved by the two (2) Co-CEO's on 7/27/2017.

The procedures are being implemented as it is stated in the policy. Each youth is assigned a counselor and is provided an array of services that utilizes appropriate resources for children and their families.

A total of 8 files were reviewed, three (3) Residential and five (5) Non-Residential, two (2) opened and one (1) closed Residential and four (4) open and one (1) closed Non-Residential.

All Residential and Non-Residential case file were assigned a counselor, were offered services, monitors/ed youth's/family's progress in services and provides/ed support for the families. There was only one client referred to the case staffing addressing the problems and needs of the youth.

In each of the 8-case files the youth and family were provided the required services as stated in their Service Plan and Needs Assessment.

No exceptions noted as of the date of the QI visit.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys has a written policy that addresses all the requirements for the Counseling services indicator. The policy was last revised on April 28, 2017, last reviewed on July 3, 2017, signed and approved by the two (2) Co-CEO's on 7/27/2017.

The procedures are being implemented as it is stated in the policy. The procedures address how the youth access services, whether the youth needs respite services as a cooling off period, who are being identified for services and who provides the services.

A total of 8 files were reviewed, three (3) Residential and five (5) Non-Residential, two (2) opened and one (1) closed Residential and four (4) open and one (1) closed Non-Residential.

All Non-Residential and two (2) Residential services provided individual counseling and/or case management services to the youth and for the families. One (1) Residential youth did not receive counseling services due to being discharged soon after admission. The presenting problems were addressed in their service plans and their progress were documented in their individual case files.

This Reviewer looked at the Agency's Group Log book and went all the way back to March 26, 2018. During these five week periods there was only group given 4 times a week for three weeks and only three times a week the other two weeks. This was brought to the attention of the Residential Director and Residential Counselor and both state they are not aware of any other groups given but will go back and look in the logbook to see if they can find any groups. Upon further review from the Residential Counselor and the Residential Director prove was given to

the Reviewer showing that the Groups were being conducted in accordance with Policy and Procedure meeting the criteria of this Standard.

Two (2) out of the three (3) Residential Youth were offered group counseling or group activities 5 days a week. The Residential program provided regular group sessions, out-door group activities, church groups activities, Art Walks, Life Skill groups, Fishing groups, card games, etc. The discharge plan was completed, and recommendations were made for the one youth that was discharged.

Exception:

Evidence of group services was not found for one (1) youth for the duration of time the youth was receiving services. Lack of participation was due to the youth going home on pass daily during the times group sessions were being held.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys has a written policy that addresses all the requirements for the Adjudication/Petition Process indicator. The policy was last revised July 12, 2010, last reviewed July 1, 2017, signed and approved by the two (2) Co-CEO's on 7/29/2017.

The procedures are being implemented as it is stated in the policy. Florida Keys has developed a case staffing committee that is committed to ungovernable, runaway and truant youth. The case staffing team meets every month in the Keys and consist of a host of representative from DJJ, school, state attorney, CINS/FINS representative, etc.

Only one (1) Non-Residential youth was staffed to the case staffing team since the last QI visit. The case followed the protocol for scheduling a case staffing. The counselor initiated the staffing and sent a letter notifying the parent of the case staffing. The letter was sent out in the appropriate time frame (more than 7 days before the staffing). The client, parent, counselor and case staffing team were available on the day of staffing. As a result of the case staffing team meeting, a new Case/Service Plan was implemented and signed by the counselor, client, parent and supervisor.

No exceptions noted as of the date of the QI visit.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys has a written policy that addresses all the requirements for the Youth Records indicator. The policy was last revised November 11, 2008, last reviewed July 1, 2017, signed and approved by the two (2) Co-CEO's on 7/27/2017.

The procedures are being implemented as it is stated in the policy. The agency has developed a procedure that assures a case record is maintained for each youth enrolled in the program and that the case files are marked confidential and kept in a secure locked location.

A total of 8 files were reviewed, three (3) Residential and five (5) Non-Residential, two (2) opened and one (1) closed Residential and four (4) open and one (1) closed Non-Residential. All eight (8) files were marked confidential and are kept in a secure locked file cabinet and in a locked room. The file cabinets are also marked confidential.

The records are transported in either a small or large black digital lock rolling or hand-held case file box. All are marked confidential. Each Residential and Non-Residential counselor has their own portable black digital lock case file.

All youth records/files were neat and orderly.

No exceptions noted as of the date of the QI visit.

Standard 3: Shelter Care

Overview

Rating Narrative

FKCS is located in Tavernier, Monroe County, Florida and serves the entire county. It provides services to youth in the Department of Juvenile Justice CINS/FINS program and is licensed by the Department of Children and Families as a nineteen (19) bed child caring facility. The license is effective through January 31, 2019. Through a contract with the Florida Network, the shelter is authorized to provide staff secure, domestic violence respite, probation respite, and domestic minor sex trafficking services to youth.

The agency has policies and procedures in place to address all of the indicators in Standard 3. A tour of the facility revealed that it has a clean and well maintained facility with adequate accommodations for the clients which include bed linens and separate beds in each room, adequate furnishings, clean functional bathrooms and adequate lighting. The day room has several chairs for youth to sit and relax. Next to the day room is the dining area with an adjacent television room/library. In the middle of the facility, between the boys and girls wing is the observation area where the mentors and shift leads go about their duties. Also in the observation room are the monitors for the video surveillance system.

There are schedules generated for weekly activities and weekly school schedules. All fire extinguishers were updated and had valid inspection tags. Client rules, grievance procedures, rights and responsibilities, behavioral expectations, and important phone numbers for reporting abuse or incidents were posted in visible locations in the shelter for easy viewing for the clients. Both hallways were clean and painted with beautiful murals. The bedrooms and bathrooms were organized and well-kept. Clients' items were tidy and put away in an orderly fashion. Each client bedroom has exquisite murals painted by local artists.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has clear Policy and Procedures to meet all the requirements for this Standard. The Policies presented to this reviewer are as follows: Number 1.16 (Maintenance of the Building), 3.14 (Sleeping Arrangements/Room Assignments), 3.15 (Daily Activity Schedule), 3.16 (Group Sessions/House Meetings for Youth), 3.17 (Participation in Religious Services/ Faith& Community Based Opportunities) 3.18 (Residential Sleeping Quarters/Bathroom and Shower Facilities), 3.19 (Personal Hygiene) 3.20 (Linen and Towel Distribution).

All Policies were last reviewed by the Co-CEO's on 7/27/2017.

FKCS policy 1.16, as it relates to the maintenance of the building, outlines the internal policies as to how repairs are to be made, when weekly inspections are completed, and the schedule of maintenance of large appliances. FKCS policy 3.15, daily activity schedules, encompasses the requirements that youth have structured activities, are given the opportunities for religious activities and specialized treatment services. Policy 3.16- group sessions/house meetings- directly correlate to offering life skills lessons 5 days per week. Policy 3.17, Participation in Religious services and faith/community based opportunities, outlines the rights of clients to participate in services and prohibits consequences to be given should the client chose not to participate. FKCS 3.18, residential sleeping quarters/bathrooms and shower facilities, encompasses a majority of the standard as it relates to lighting, cameras, shower and bathrooms being fully functional and operational, it also dictates repairs are completed and done in a timely manner.

The provider's practice supports this indicator in that inspections are up-to-date and the facility appears to be maintained in a clean and hazard free manner. The most recent satisfactory Food Service Inspection was done last on 1/22/18. A Public School and Public Charter School inspection was last done on 9/5/17. The Monroe County Fire Equipment inspection was completed on 1/5/18. The annual Islamorada Fire Safety Inspection was done on 1/8/18. The Security System was inspected by Mid-Keys Security Company on 12/5/17. The sprinkler system was lasted checked by Cutler Bay Fire Sprinkler Inc on 9/29/17.

The agency has a very well kept facility that has paintings in all the youth's rooms that make for a very inviting atmosphere. All the furnishing throughout the Agency are in great condition and free of graffiti. The agency has evidence of insect inspections from a Pest Control company and during the tour no insects were present. The grounds are in great condition.

Each youth is given a Facility Handbook upon entering the program that lays out the daily schedule, youth's rights and responsibilities. Each youth is given their own bedding and linen. There is a securely locked place for youth to store items within a safe located in the file room closet. Shelter schedules are posted throughout the facility and the youth are scheduled meaningful structured activities which includes time for counseling, recreation, and groups which include social skill training. The youth are given opportunities to participate in religious activities.

No exceptions were found for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has very clear and precise policy and procedure for this indicator that meets all requirements. The agency's policy Orientation to the Program pertains to indicator 2.06 and was last reviewed by the Co-CEO's on 7/27/17.

FKCS policy 2.06 states that all youth entered into the program receive an in-depth orientation which includes a review of staff members, building evacuations procedures, policies on contraband, a review of the daily schedule, room assignments, abuse hotline and or DJJ CCC hotline numbers, grievance procedures, a review of CINS/FINS service, procedures to access medical care, visitation schedule, telephone policy, behavior management and youth development. FKCS policy 3.14 provides for information that must be considered in child placement. Policy 3.40 provides for an outline of the Residential Handbook in addition to visual inspections of the youth and their belongings, documentation of the inventory of the youth's belongings, restricted items, and items in the youth's possession, and the removal of items that may be harmful or otherwise offensive. Upon entering the Program the youth are given the Jelsema Center Residential Handbook that is a 41 page document that goes over 35 different things that a youth might have a question about, everything from Rights and Responsibilities, menus, behaviors, mail, schedules, grievances and so on. The youth and parent sign a document attesting that the handbook and its contents were explained and that they understand the information contained within.

The agency has plenty of signs and posters placed throughout the facility that explains daily schedules, the menu, and grievance process. This reviewer looked at two open charts and one closed chart and all the charts are clearly organized and easy to find the required documentation. In all the charts there was clear evidence that the agency informs every youth that comes through the program of all required information.

There are no exceptions noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has clear policies and procedures that were reviewed by the Co-CEOs on 7/27/17. The policy and procedure meets all requirements of indicator 3.14 and correlates to the Indicator 3.03.

Policy 3.14 states staff must take the following into account prior to making a room assignment: clients physical characteristics, observed level of maturity, gang affiliation, current alleged offenses, previous delinquency history, levels or degrees of previous violent behavior, suicide risk, sexual aggression history, runaway history, substance abuse, and requires the separation of violent from non-violent youth.

The agency demonstrates practice by capturing the requirements on the CINS/FINS Intake Form and with this information the staff can make the decision where to place the youth.There were three charts that were reviewed by this reviewer. There were two open charts and one closed chart. All charts were clean and nicely organized. All required information regarding the youth's physical characteristics, level of maturity, gang affiliation, current alleged offenses, previous delinquency history, levels or degrees of previous violent behavior, suicide risk, sexual aggression history, runaway history, and substance abuse was captured by the program prior to room assignment.

There are no exceptions found for this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a very clear policy regarding the Logbooks and that policy is 3.47 (Logbooks). The Policies and Procedures were reviewed by the CO-CEO's on 7/27/17.

FKCS requires documentation of the daily activities, events, and incidents, where the safety and security of a client is compromised, in the logbook. All entries are to be brief and recorded by time of day. All errors are to be corrected per the requirement. The program director reviews the log book and makes notes for needed follow up or correction. The log book also documents any changes in youth's health status, appointments, discharge, head counts, or newly admitted youth and pertinent pass down information. FKCS uses the electronic logbook as well as manual logbooks.

The log books were reviewed for the past 6 months. The notes were concise and legible. The supervisor reviews the logbook but not on a regular basis. The paper log book does have some scratch out in it but very limited.

Exceptions:

There were instances where staff scratched out entries instead of correcting the error as required by the policy and procedure in that they are to be corrected by one single line and initials.

The supervisor does not review the logbook on a weekly basis consistently.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Behavior Management Strategies are outlined in FKCS policy and procedure 3.26, Behavior Management and Youth Development System, in accordance with the QI Indicator. The agency's policies that deal with Behavior Management are 3.26 (Behavior Management System/Youth Development System), 3.26.01 (Youth Development System Staff Monitoring), 3.28 (Consequences of Violation of Program Rules), 3.29 (Disciplinary Sanctions other Youth), and 3.30 (Room Restriction). These policies were last reviewed by the Co-CEO's on 7/4/17.

The FKCS policy is designed to change the behaviors of the youth served and FKCS finds this is essential in program operations. The shelter utilizes a points and level system. The point system requires the shift to provide points for the youth on a daily basis. Clients can obtain anywhere between 0-6 points depending upon their performance with 0 points being awarded for poor behavior and 6 points being awarded for exemplary behavior and school work. Youth can earn up to an additional 3 points for completing extra chores, assisting with new client orientation, or taking the initiative to assist with a special project.

In this system the points are usually given by shelter staff and the additional points can be obtained with the shift leader. There are 3 levels in their level system and there is an orientation level which takes 2 days and attainment of 54 points to move to level 1. From level 1 to level 2 the child must attain 64 points for 3 days to be able to make that level. Each level clearly states the youth responsibilities for that level and what is needed to achieve the next level. It also explains what behaviors will cause the youth to drop back down to a lower level. There is also a very clear incentive program for the youth in each level. The system also explains House Meetings in which they discuss "Safety and Structure", "Self-Worth", "Mastery and Future", "Belonging and Membership", "Responsibility and Autonomy", and "Self-Awareness and Spiritually" issues that the youth my be experiencing. The plan also discusses "Recreation" opportunities that are available for the youth that are on Level with the program.

The daily and weekend schedules are posted throughout the facility. Youth are given the Behavior System Plan upon orientation into the program. There were six staff training files reviewed and all six received training in "Program Rules and Behavior Plan". All three youth files reviewed included a signed form stating receipt of program rules, rights and responsibilities, and behavior management system.

The level system includes incentives which include the option to actually earn money for completing shelter jobs. The Mentors and Shift leaders are responsible for monitoring and assessing the youth’s behavior and assigning the appropriate number of points. The Residential Program Coordinator reviews the point sheets weekly and ensures the youth receive the appropriate monetary payments should they have been earned.

There are no exceptions found for this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has very clear policies and procedures that address the requirements and have been reviewed by the Co-CEO's on 7/27/17. The policies are 3.46 (Staffing Ratios) and 4.12 (Physically Counting Youth).

The residential program coordinator is responsible for creating and maintaining a staff schedule and ensuring that Florida Administrative code regarding 1 staff to 6 youth ratio on days and 1 staff to 12 youth during night sleep time. The policy ensures that when possible there is a staff

member on shift which represents the make-up of the youth within the shelter. The shelter roster is provided to staff and hung in the monitoring station. In addition, it dictates youth are to be seen once every 15 minutes in cases where youth have been identified as high risk or on suicide risk.

As per the agency's P&P, the agency will ensure that there is an appropriate amount of staff on each scheduled shift and make sure there is at least one of each gender on the shifts. The schedule is created by the residential coordinator and posted in the observation room. There is an on-call roster, which provides for at least 2 staff for each shift. Most second shift schedules provide for 3 staff members. There have been times during the review period where the shelter has been staffed during the overnight shift with two females instead of a male and female, especially on Saturdays. It was observed that sixty-five days out of the last 180 days, on the 10 p.m. to 6 a.m. shift, there was only two female staff working.

Exception:

Exceptions were noted on some of the overnight shifts where the program did not provide coverage of staff who were the same gender as youth in the program.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a separate policy and procedures in place for each special population youth as follows: Domestic Violence Respite (3.13), Staff Secure (3.13.1), Probation Respite (3.13.2), and Domestic Minor Sex Trafficking (3.13.3). All of the aforementioned policies and procedures were last approved 7/27/2017 by the Co-CEOs.

Florida Keys Children's Shelter accepts youth who are court ordered in to staff secure services and approved by the Florida Network. Upon approval, the staff notates and highlights the entry of the staff secure youth and staff assigned on each shift in the program logbook. Written reports for any court proceedings are maintained in the legal section of the case file.

The program has applicable Domestic Violence Respite procedures in place for the provision of DV respite services. Per the P&P, youth placement are screened by the JAC/Detention will not exceed 14 days; however, the QI indicator provides placement for up to 21 days.

Probation respite policies and procedures are also in place that meets the requirement of the indicator with the exception of obtaining approval from the Florida Network prior to admission of Probation Respite placements.

Domestic Minor Sex Trafficking procedures in place at the time of the visit met the requirements of the indicator specifying approval by the FN prior to placement and for stays beyond 7 days as well as outlining appropriate services and level of secure supervision for youth.

Two files were reviewed that were identified as a Staff Secure cases. The program has practice, staffing and programming in place regarding Staff Secure youth assigned to the program. Agency has applicable Staff Secure policies and procedures in place. Program only accepts youth that meet legal requirements of F.S. 984 for being formally court ordered into Staff Secure services. Program practice provides one staff secure bed and assigned staff supervision to one staff secure youth at any given time. In addition program assign specific staff during each shift to monitor location and movement of Staff Secure youth. In the log book it is clearly documented the specific staff person assigned to staff secure youth. Finally, the agency provides a written report for any court proceedings regarding the youth's progress.

The provider stated there were no Domestic Violence, Probation Respite, or Domestic Minor Sex Trafficking youth served since the last QI visit.

There are no exceptions found for this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a clear and precise policy and procedure that answers all requirements for this standard. The policy is: 4.23 (Video Surveillance and recording). The Policies and Procedures for this Standard was reviewed by the CO-CEO's on 7/27/17.

FKCS policy and procedure 4.13 ensures that the agency has adequate lighting and security monitoring cameras to prevent absconds and to document incidents and or injuries. Additionally the policies and procedures require playback capabilities of 30 days. FKCS policy 4.23 requires that the Co-CEOs or individuals approved by the Co-CEOs have the ability to view the cameras. In addition, supervisory reviews are conducted bi-weekly. Written notices of video surveillance are posted and no audio from the video cameras is enabled, if available, to ensure some level of privacy. Video surveillance according to policy may be released to third parties in cooperation with requirements of Federal, State, or local law enforcement agencies.

The agency has a camera system in place that is monitored in the staff office and can only be accessed by approved personnel that the CO-CEOs appoint. The system has at least 30 days of retention, is designed for facial recognition, and has its own battery back-up supply for electrical outages.

The Residential Director has a separate log showing that he reviews the cameras on periodic days at least once ever fourteen days. This reviewer looked at the logbooks to ensure that bed checks were being completed at least every 15 minutes. The camera system was reviewed with the Residential Director and all checks coincided with the times in the logbook.

There are no exceptions found for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The FKCS has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted into the program. Upon admission, Youth Support staff will interview youth and complete the intake. If available, the contracted Nurse will complete the Health Screening during the intake. An initial intake assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations.

Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history (including gang or criminal involvement), potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on page 2 of the CINS/FINS Intake Assessment form.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The licensed clinical professional is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board that discreetly mounted in the staff control room and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored the PyxisMed-Station 4000 Medication Cabinet located in the medication room. Topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication. Medication records for each youth are maintained in a binder.

The program provides a full range of mental health and healthcare services to all youth in the program. The program has comprehensive policies and procedures (and a comprehensive master plan) that contains mental health, substance abuse, suicide prevention, crisis intervention and emergency procedures to ensure that the program staff follows the more appropriate practices to fulfill the youth's treatment needs. The program maintains an excellent partnership with the middle keys community and universities, and maintains interagency agreements with several local individuals and organizations that enhance the program's services. The residential area of the program provides every youth with a highly artistic, positive and therapeutic environment. There were no healthcare professionals in the program at the time of the review.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure number 7.01 to address health services that was last reviewed on July 1, 2017 by the CO-CEOs.

The policy states that all initial screenings are completed either at initial contact or within twenty-four (24) hours of admission, depending upon the program, using the NetMIS Youth Screening and CINS/FINS Intake Form. If present on premises the agency's Nurse will conduct the health screening. If no nurse is present, Non-health care staff may perform this screening. Information is obtained from the youth/parent/guardian, placing agency case manager or law enforcement. Information obtained through the interview process is used to determine eligibility, identify current problems, establish the existence of any physical or mental health concerns, develop potential service plan goals and assign room assignments in cases where the youth is admitted to a residential program.

Information regarding the youth's situation, presenting problems(s), immediate needs, CINS/FINS eligibility and any current status with other service providers (i.e., Wesley House Family Services, Department of Children's and Families, etc.) is assessed during the screening process and is documented on the CINS/FINS Intake Form and NetMIS Youth Screening form. This information is used for service and discharge planning. Screenings are completed within 7 calendar days of receiving the referral. All initial screenings, whether conducted by phone or face-to-face, are done prior to or upon admission to the Jelsema Program or becoming an open case in the Community-Based Counselor Program.

The comprehensive assessment (Needs Assessment) for youth who have open cases with the agency is initiated within 72 hours of admission for youth in shelter care.

Three youth files were reviewed and each contained a completed preliminary healthcare screening identifying each youth's healthcare concerns. Documentation evidenced youth on current medications, with allergies, and observed with tattoos. No youth in the program during the review period had any chronic conditions; therefore, no instances of follow-up medical care were reviewed, although the program nurse was able to state the program's procedure for referring youth for follow-up medical care for chronic conditions.

Exceptions:

Upon interviewing the nurse, she stated that she reviews the youth file but does not document in the file that she reviewed the health screening form. As there is no place for her to sign that she reviewed. She also stated that when she comes in and if there is a new youth, she introduces herself and ask them questions i.e. if they are allergic to anything.

There was no evidence to determine if the nurse is reviewing the health screening form within five days of the youth entering the shelter.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Florida Keys Children's Shelter, Inc. has a Suicide Assessment and Precautions Policy number 4.14, last reviewed and approved on July 7, 2017 by the Co-CEOs.

The program has a written comprehensive master plan that includes mental health and substance abuse services, suicide prevention procedures, mental health/crisis intervention and emergency response procedures for youth in need of such services. The plan is reviewed annually by the CO-CEO and updated as needed. The plan includes the following elements for suicide assessment, precautions and prevention: suicide risk screening as part of the intake process with an additional assessment completed as warranted; procedures related to the identification, monitoring and supervision of youth deemed to be at high, moderate or low risk of suicide, procedures to obtain mental health consultation and clinical assessment of suicide risk; referral procedures to access mental health care providers or emergency facilities, including Baker Act or Marchman Act of youth, if needed; requirements for staff training in the verbal and/or behavioral cues that may indicate suicide risk until a clinical assessment is conducted or the youth is removed from the program; requirements for on-going staff communication regarding a youth's status by use of an alert system; procedure for notification of the CO-CEO, Counseling Services Coordinator, Residential Coordinator, Jelsema Supervisor, Residential Counselor, House Parent(s), Project Lighthouse Director and/or designee, outside authorities including law enforcement and/or parents, guardians or placing agency case managers of potential suicide risk or an suicide attempt, and procedures to document identification and monitoring of potential risk of suicide or an attempted suicide.

A CINS/FINS Intake form is completed for youth served, with the exception of the Project Lighthouse Program, at the time of the initial intake. Completion of the CINS/FINS intake form requires responses from the youth, parent, guardian, placing agency case manager and/or other referral regarding specific questions asked by the applicable Florida Keys Children's Shelter staff member. The assessment of suicide risk is completed within twenty-four (24) hours after the screening. If the screening occurs after hours beginning on Friday to Monday morning and there is no access to staff to conduct an assessment within 24 hours, the assessment must be completed by the morning of the first business day.

Two applicable youth files were reviewed for this indicator. Both youth were placed on the appropriate level of supervision based on the initial risk assessment until they were assessed by the licensed clinical staff. The clinical staff met with both youth and completed the assessment. Based on the scores the youth received from the SPS tool, they were placed on the appropriate level. Documentation was noted by the counselor in the progress note and also in the logbook.

Staff documented both youth's behavior at least every 10 minutes on the precautionary observation log sheets.

There are no exceptions found for this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy that reviewed and approved by the Co-CEO on July 7, 2017. Youth are provided only the prescription and/or over-the-counter medication as ordered by a duly licensed professional (medical, dental, mental health).

Prescribed medication must be in the original labeled pharmacy container. Over the counter (OTC) medication must be in the original container. Client medications must be verified by a pharmacist as part of the intake process and prior to (MDR) completion. Agencies will maintain a minimum of 2 site-specific super users for the Med-station. A medication distribution record (MDR) is used to monitor and record medication distribution. Current medication sheets are retained in the MDR. Other medication sheets are retained in youth case records. Controlled substances are inventoried on a shift-to-shift basis with a running balance maintained. Non-controlled or over-the-counter medications and medical supplies/sharps have a perpetual inventory with a staff inventory completed once per week.

The program's written procedure requires the program to: verify and document the verification of prescription medication with the pharmacy; store all medications in the Pyxis med-station which should be inaccessible to youth; the program must have two supervisors for the med-station; store oral medications separately from injectable and topical medications; utilize a secured refrigerator only for the storage of medication with storage temperature requirements; store controlled medication in the med-station; allow only staff designated with user permissions to have access to secured medication and allow only limited access to controlled substances; perpetually inventory controlled substances via witnessed shift-to-shift counts; and maintain a perpetual inventory for OTC medication which must be inventoried at least weekly.

The agency has a nurse on duty in the evenings for twenty hours a week. The nurse trains the staff on first aid and medication distribution. There is an approved medication distribution list maintained in the nurse station.

The program uses an Individual Client Medication Distribution Log form to document distribution of medication by nurse or staff to each youth. The nurse also highlight on the youth MDR when a youth has off hours of receiving medication to alert staff of the different med times.

Medications are stored separately from both injectable and topical medications.

The nurse trains staff on using the Med-station and there is a list of approved staff to distribute medications in the med station. When on duty, the nurse conducts medication distribution. Only staff designated with user permissions have access to the Pyxis med-station and limited access to controlled substances is maintained via a required electronic staff witness log in to the station.

Controlled substances are perpetually inventoried as well as documented via witnessed shift-to-shift inventory counts. A perpetual inventory is maintained for OTC medication in both the Pyxis med-station and via a hand written log. OTC medications are inventoried weekly. Syringes and sharps are secured and documented in the logbook.

The agency has three super users that have been trained for the med station.

There are no exceptions found for this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintained policy and procedure number 7.03 to address the programs medical and mental health alert process. The policy was last approved July 7, 2017 by the Co-CEOs.

At the time of admission and anytime thereafter, the staff member completing the admissions process or receiving healthcare instructions from a licensed healthcare provider will complete or update the CINS/FINS Intake Form, which indicates any medical conditions, mental health diagnosis, suicidal ideation or behaviors either past or current, special diets, allergies, behavioral issues, substance abuse issues either past or current, medications that are prescribed or contraindicated, history of delinquency or criminal offenses, history of assaultive or aggressive behavior, past or current gang affiliation, history of sexual assault as a victim or perpetrator, chronic runaway behavior or other pertinent treatment information the youth may have that need to be communicated to staff.

Information is written, recorded or communicated in various sources in each program even if this is redundant. Communication includes, but not limited to, the preliminary health screening form, staff log book, medication administration record (MAR), case progress notes, client file (both outside cover and individual sections, as applicable). A listing of all youth alerts is maintained in an unobtrusive area in the monitor station at the Jelsema Shelter and updated as needed. Youth's food allergies and/or special diets are also posted on the freezer door in the kitchen area. The organization documents all critical care information in the client's file.

Medical and mental health alerts status may change throughout a youth's placement.

Staff receive training on the importance of the alerts system as part of orientation.

If during an admissions process or anytime during a youth's residence, a youth or his/her parent/guardian, Wesley House Family Services case manager or other placing agent, indicates that the youth has medical or mental health problems requiring follow-up care or medications to be taken while at the facility. If the youth is admitted in the program, staff will place a label on the outside front cover of the client's file with any of the following labels with the following codes as appropriate on the outside of a youth's record: AL (allergies including food or medications); AR (arson); ASO (alleged juvenile sexual offender); ATD (Alcohol, Tobacco, Drugs); HC (health or medical concerns); MH (mental health alert); PA (physically aggressive); R (runaway behaviors); SA (sexually aggressive); SD (special diet); SH (current or historic suicidal ideation or plan); SS (sight and sound); and VSA (victim of sexual assault). The youth advocate, residential supervisor or residential coordinator will enter the information into the communications book and complete other required forms if the youth has medication. If immediate medical care is indicated, staff will follow through and document this information in the youth's progress notes and the communications book.

Four youth files were reviewed. All youth files reviewed for the Medical/Mental Health Alert process were screened and placed on the program's alert system. The youth alerts are documented in the staff logbook as well as the E-logbook.

Staff training files documented the staff received training in the medical/mental health alert process.

The agency maintains a Daily Alert Report Binder which contains the daily alert of youth in the shelter. A printed copy is also posted in the staff monitor station.

There are no exceptions found for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure, Emergency Medical and Dental Care, Number 4.19 approved by the CO-CEO on July 6, 2017.

Staff are aware of the available emergency medical and dental care facilities in the immediate area and are knowledgeable in how to access such care, as needed. All direct care staff receive first aid training.

In the event that a youth is in need of emergency medical or dental care, the following procedures are followed: staff should assess the situation and determine if 911 is required. If so, staff will call the 911 system and ask for transport of the victim. In the event of a medical or dental emergency, staff addresses the emergency first. As soon as the situation in under control, the parents/guardian/placing agency case manager is contacted by phone. Incident reports are completed in compliance with Incident Report policy.

The nurse maintains a logbook of all off-site care for youth in the nurse station. Interviewed the on-site nurse indicated the agency’s practice of emergency care and aftercare. During this review period, there was one youth that required off-site care at Mariner’s Hospital emergency room. Documentation and follow-up instructions were documented in the logbook. Parent was notified of the medical transportation.

The nurse conducts training and refresher yearly training. All staff are trained on medical procedures. The agency has three knife-for-life located in the monitor station and in a storage closet in both hallways were youth are housed.

First aid kit/supplies are located in the nurse station next to the monitor station.

There are no exceptions found for this indicator.