Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Orange County

on 05/15/2018

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

Ashley Davies, Lead Reviewer/Consultant, Forefront LLC

Tamara Mahl-Adkins, Regional Monitor, Department of Juvenile Justice

Tanesha Strickland, CINS/FINS Service Manager, Stewart Marchman Act Behavioral Healthcare

Duane Gross, Residential Program Manager, Children Home Society West Palm Beach

Katrina A. Hopkins Boone, Case Manager, Nehemiah Educational and Economic Development

Persons Interviewed

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

2 Case Managers
2 Program Supervisors
1 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

3 Clinical Staff
0 Other

Documents Reviewed

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

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

Surveys

5 Youth
5 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Orange County Youth and Family Services, located in the city of Orlando, provides a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by the Orange County government. The program is also a Staff Secure Shelter and is also a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking.

Youth Shelter Achievements of 2017/2018

Facility Upgrades

New wood floors have been installed throughout the shelter.

The agency has launched a new website that includes a virtual tour of the youth shelter.

The shelter has added a Counseling Corner for Trauma Focused Relaxation.

The sheltered fourteen additional foster care youth during Hurricane Irma.

Staffing

There have been three resignations: a Nurse, a Senior Children's Services Counselor, and a Caseworker.

There have been three new hires: a Nurse and two Senior Children's Services Counselors.

There are currently two vacant positions: a Senior Children's Services Counselor and a Caseworker.

Clinical Services

The Victim Service Center and Health Department continue to provide educational group sessions that discuss prevention/intervention health services.

Decision Dollars were implemented to increase positive behaviors. Youth are able to shop for items that trigger their interest.

Clinical Supervisor provided over 2,000 hours of supervision for four University of Central Florida interns.

Psycho-educational groups are held daily by counselors and volunteers covering topics from Internet Safety to Conflict Resolution.

Training in CINS/FINS statutory regulation (state and federal) was conducted by the Assistant General Counsel for DJJ.

Collaborations with Community Partners

A meeting was held with Truancy Judges and Magistrate to clarify how to process youth's truancy custody order when admitted.

Staff have conducted numerous tours of the shelter for different agencies and organizations including: the Children's Home Society Clinical team, interns from UCF, ten members from the State Advisory Group (SAG), Juvenile Probation Officers, and Orange County Public Schools.

Learning Center

The school year was extended to include summer school sessions. Approximately 98% of youth successfully completed school services. Teachers work to ensure that specific academic plans are tailored to students.

School field trips were taken to several colleges and technical schools.

In recognition of Child Abuse month, a pin wheel garden was created in front of the shelter. Children and staff celebrated with group activities and an ice cream truck was available to serve the children.

Family Counseling Achievements 2017/2018

The first annual “Meet the Counselors Day” was hosted. Key stakeholders of Orange County Public Schools were invited to meet the counselors and take a tour of the Family Counseling and Youth Shelter campus.

Counselors attended the 9th annual Trafficking Awareness Day at Calvary Church.

Piloted a case management program that allowed the case manager to provide focused case management services to current youth and families while allowing counselors to focus on the clinical needs of the youth and families.

Began to pilot case management service through Case Staffing for families that are in need of more concentrated case management.

There were two staff members who were trained to be Peer Reviewers on upcoming Quality Improvement reviews.

Standard 1: Management Accountability

Overview

Narrative

The agency is a local County operated full-service Residential and Non-Residential governmental provider. The agency is a self-insured entity and has extensive General and Professional liability insurance. The agency requires that all staff are background screened prior to hiring. All staff must be trained and complete all initial orientation. In addition, the shelter's direct care staff are trained to provide the following services for the youth: medication distribution; health, mental health and substance abuse screenings; first aid; cardio pulmonary resuscitation (CPR); and referrals. There were a total of four new hire background checks and one 5 year re-screening conducted in accordance with Florida Statute 987 during this review cycle.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy for the program includes Orange County conducting preliminary background screening on all youth shelter employees, interns, and volunteers in accordance with chapter 985.407 of the Florida Statues, and in accordance with Orange County and Division background screening policies.

The agency has a standard operating procedure regarding background screening. The program conducts preliminary background screenings and driver's license checks on all employees, interns, and volunteers prior to their official start date and requires a favorable final screening to obtain/maintain their employment. All staff is to be re-screened every five years from the date of hire. The program manager will ensure all employees who will work during the calendar year are to sign the "Affidavit of Good Moral Character", in January of that year, then complete an Affidavit of Compliance and submit to the Office of the Inspector General, no later than January 31st of each year.

A review of five staff records was conducted. One of the five staff was eligible for a five-year rescreening, which was completed three days prior to the anniversary date. The remaining four staff received the initial background screening prior to the hire date with no exceptions required. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening unit (BSU) on January 3, 2018, prior to the January 31st deadline.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has two policies which incorporate provision of an abuse free environment. One policy for the program states, all allegations of child abuse are immediately reported to the Florida Abuse Registry. All program staff are considered mandated reports for suspected abuse. Staff shall adhere to a code of conduct forbidding use of physical abuse, profanity, threats or intimidation. The Youth Shelter shall provide an environment free of physical, psychological, and emotional abuse, in which youth, staff, and others feel safe, secure and non-threatened by abuse or harassment. The second policy mentions the Youth Shelter having a grievance process, allowing youth to grieve the actions of staff, their peers, or conditions or circumstances, which violate their rights. Staff shall treat all youth respectfully, fairly, and without discrimination. The youth shall acknowledge in writing the grievance was adequately addressed.

The agency has two standard operating procedures regarding abuse reporting, abuse free environment, and the grievance procedure.

The abuse reporting and abuse free environment procedure outlines clients are to be permitted to file a report by telephone without obstruction and the Florida Abuse Hotline phone number is posted throughout the facility. Any staff member being aware of child abuse/neglect known or suspected will immediately report the abuse. If abuse has reportedly occurred at the Youth Shelter it is reported to the Florida Abuse Hotline and the Central Communications Center (CCC) must be notified within two hours of receiving knowledge of the incident. Following the report, the staff is to immediately notify the supervisor. All reports are to be documented in the client file, program log book, if applicable, the Florida Network, and an incident report must be completed and management notified. All employees shall participate in annual training on indicators of abuse, abandonment, and neglect.

The grievance procedure outlines the Youth Shelter caseworker or designee informs youth of the grievance process during the intake process.

Youth have access to grievance forms and staff shall not deny the residents the right to file a grievance. Youth are allowed, in writing, to grieve, situations they feel violates their rights. The form is submitted to the supervisor on duty, who informally addresses the issue; the supervisor response is documented. If the situation cannot be resolved, the form will be forwarded to a counselor, who will address the situation with the staff in question, and then resolve the situation with the staff and the resident, prior to the end of the shift. If there is no resolution, the form is given to the program manager or designee the following working day, who will meet with all parties. The program manager or designee decision is final. Each level of grievance is addressed within two working days.

All newly hired staff are being trained on the program standard operating procedures and policies, as well as rules, which includes the staff adhering to a code of conduct, prohibiting the use of physical abuse, profanity, threats, or intimidation, providing youth with basic needs such as food, clothing, shelter, medical care, and security. Staff sign an employee oath of loyalty, as well as employee acknowledgement receipt of standard operating procedures and access to personnel file. Seven personnel records were reviewed, all staff were trained in “Child abuse: recognition, reporting, and prevention”. The program has the Florida Child Abuse Hotline phone number posted throughout the facility, easily accessible by staff and youth. Youth have unimpeded access to a telephone, to call the Florida Child Abuse Hotline, when needed.

The shelter maintains a folder for Child Abuse Hotline and Central Communications Center (CCC) calls; for each call a form is completed with a narrative of the incident, what outside agency contact was made (law enforcement, CCC, FL Child Abuse Hotline), as well as the outcome, and it is signed by the supervisor. The program provides the youth with the grievance process at the time of admission. Each dorm has grievance forms the youth can complete and then submit to the supervisors on duty. The grievances are addressed and resolved within two days. The program had four grievances in the last six months. All four grievances were resolved within two days, signed by the youth, supervisor and program manager.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy for the program states all youth shelter staff are required to immediately notify supervisory staff, law enforcement, and/or Department of Children and Families, the Florida Network of Children and Families, and the Abuse Hotline and/or Central Communications Center (CCC) of certain types of incidents.

The agency has a standard operating procedure regarding incident reporting and risk management. The procedure specifies the reporting staff member is required to complete a detailed incident report, log each incident in the log book and client file. All attempts to make appropriate notifications and contacts are to be documented on the incident report. Certain types of incidents require immediate notification of the Senior Children Services Counselor, Supervisor on duty or Program Manager. Those individuals will then determine if the next level manager is to be notified and by whom. Management shall take immediate action to address founded incidents of physical and/or psychological abuse and incidents of verbal intimidation, use of profanity, and/or excessive use of force. In addition, if Department of Juvenile Justice youth or shelter staff are involved, the Central Communications Center (CCC) must be contacted within two hours, as well as the chief of probation. The program manager will review incident reports made to the CCC within one working day and appropriate action will be taken.

The program had eighteen Central Communications Center (CCC) reports in the last six months. All eighteen calls were made in the required two-hour time frame and an incident report was completed by the program. The program completed follow-up communications with the CCC on each of the reports where necessary. Five CCC reports were reviewed concerning notes in the logbook; all had entries made in the logbook concerning calls conducted to the CCC, including a brief narrative of the incident.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy for the program states the youth shelter ensures all staff working in direct and continuing contact with youth receive training related to their job responsibilities. The program maintains individual training files for each staff, to be included are the annual training hours being tracked on a form and supported by documentation such as agendas, sign in sheets, and certificates.

The agency has a standard operating procedure regarding training requirements. First year employees are required to complete eighty hours of training related to their job. After the first year of employment, the staff shall receive a minimum of forty hours of training annually, of which twenty-four hours must be job-related training. There are requirements in the first 120 days of hire and requirements within the first year of employment. Further requirements include, forty hours of training after the first year of full-time staff employment, which include twenty-four hours of job related training. All staff must complete training in the Department's Learning Management System (SkillPro). Supervisory staff must obtain twenty-four hours of training in various areas. The employee is responsible to ensure all annual training requirements are completed. The senior youth care supervisor shall monitor employee training files and document the counsel of staff in need of supervision to meet training requirements.

The program provides training throughout the year, through the Florida Network, local providers, and the Department's Learning Management System (SkillPro). The training requirements are to be met starting July 1 and ending June 30. The program maintains a training file for each staff, which includes a training requirement tracking sheet, including the title of the class, target date, date of completion, and number of hours received for the class. The staff and supervisor sign the training plan at the beginning of the training year. The file also contains related training documentation such as the SkillPro print out, training agendas, and certifications.

Two staff training records were reviewed regarding the first 120 days of training requirements. Both staff completed the required training objectives within the first 120 days of employment. The two staff had more than the required eighty hours of training; 136.25 and 126.5 hours respectively. They also completed non-licensed mental health clinical staff training in assessment of suicide risk, in the first year of employment.

Five staff training records were reviewed concerning annual training requirements starting July 1, 2016 through June 30, 2017. All five staff had the required training completed for a minimum of forty hours.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program's policy indicates Youth and Family Services Division conducts program reviews as part of its continuous quality improvement program. In-depth reviews are conducted quarterly to ensure the division continuous to provide high quality services and to identify barriers and opportunities in service delivery. Quality assurance conducts quarterly reviews, evaluating case files, risk management issues, service to clients, program data, review of external contractual audits and licensing reviews, personnel file reviews and employee training file reviews.

The program's standard operating procedure describes in detail the scheduling of program review dates and agenda, which includes quality assurance contacting the program managers to inform them of review dates and steps taken during the review process. The procedure outlines what type of program reviews are conducted, including file reviews and the file selection process. The reviews shall include risk management reviews, review of research being conducted involving program participants, grievances or incidents, compliance with legal requirements, service verification, program data verification, community education and outreach activities, council on accreditation verification, training file reviews, personnel file reviews, compliance with contractual requirements, and external reviews. The results of the program review are discussed with each program during the exit interview and a full written report is provided to the program within two weeks following the evaluation. The program manager has one week after receipt of the report to review it, and forward a written response, including the intent to appeal any findings.

The program conducted required reviews for the last six months.

The program had two quarterly case file reviews conducted in the last six months. The case file reviews included a review of eighteen youth files in the areas of intake/screening, assessments, service plans, case record entries/progress notes/documentation, discharge or after care plan, essential legal and medical information, client rights, behavior and support management. The staff was informed of the findings at the end of the two-day review during the exit interview.

The program conducted two quarterly risk management reviews, which included review of client grievances, incidents, and compliance with mandatory reporting laws. The client grievance review had the date, reason for grievance, reviewed and resolved within timeframe and client

satisfaction noted. The incidents review included the nature of the incident, number of incidents, incidents reviewed and signed by appropriate staff/manager, description of incident, proper internal/external notification completion and comments. The compliance with mandatory reporting laws included the number of abuse/neglect calls made in the quarter, number of incidents reported to the Central Communications Center (CCC) and comments.

In the last six months, the program manager conducted monthly verification of service contacts with five to seven clients during a face to face interview. Some of the questions addressed the satisfaction of contact with the assigned worker, responsiveness of the worker to the youth's needs, referrals made by the worker and effectiveness of those referrals, and opinion of the food in the shelter.

In the last six months the program conducted two outcome measurement reviews, including:

- youth involvements with the Department of Juvenile Justice (DJJ) at the shelter
- youth not readmitted within six months of release
- youth remain crime free six months after discharge
- youth successfully complete the youth shelter program
- youth discharged to home or appropriate setting
- youth reported living at home after sixty days
- youth regularly attending school after thirty days
- youth regularly attending school after sixty days
- youth admitted have a needs assessment initiated and completed
- satisfied families/youth obtained data on satisfaction survey.

The program submits information monthly to be gathered and a monthly review is conducted by the Florida Network. The review includes monthly bed statistics (non-residential admits, filled bed days, physically secure, shelter admission), cumulative completers (screening, data entry within seventy-two hours, service completion, thirty and sixty day follow-up), cumulative admits and exits (screenings, non-residential serviced and exits, residential admissions and exits, filled bad days), benchmarks , cumulative (confirmed, active and total numbers), data (screenings, non-residential admits, confirmed, active, total, percentage, residential admits, exits, confirmed, active, total), FOY (First of the Year, non-residential admits, holdovers), units (non-residential, care days) 30-day (youth ID, intake date, exit date, completed date, early or late, follow-up), and 60-day (numerator, denominator, percentage).

The program completes monthly supervisor, counselor and staff meetings where information is shared with the staff concerning outcomes of reviews. The program identified strength and weaknesses found and when changes were made, the staff was informed during the monthly meetings. The program manager stated staff are instructed to check their e-mail daily while working concerning new information, as well as information is presented during shift change. Also, anything new or updated is documented in the program's Share Drive, which can be accessed by all staff, and they are required to do so on a regular basis. Stakeholders are informed through the Florida Network of any updates and reviews conducted.

There were no exceptions to this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy on transportation of youth. The policy is for the youth shelter to ensure proper procedures are followed when transporting clients and/or residents.

The program's standard operating procedure (SOP) states, the program manager or designee will ensure program and employee compliance with the following:

- Employees transporting clients or residents must have a valid driver license per county policy and Division SOP
- transportation shall only occur in County issued vehicles

- ratio of staff to client 1:6
- maintaining vehicle passenger limits
- only transporting County employees, volunteers, residents or clients
- safety check is conducted prior to transport of clients.

One employee is prohibited from transporting one client. Exceptions to the procedure must be approved by the program manager, designee or senior program manager, who will use specified criteria. If an approval is granted, the following must occur:

- A trip plan completed
- Transporter shall check in by cell phone at agreed upon intervals
- Documentation of check in.

The program has a vehicle mileage log. In review of the log, the program documents the following items:

- month and year
- division
- location
- vehicle number
- year, make, model, beginning of month odometer reading
- end of month odometer reading
- date of trip
- destination
- beginning mileage
- ending mileage
- number of miles per trip
- driver’s name
- supervisor name and signature.

A review of the last six months of the monthly van and cell phone check out logs and trip plans was conducted. The program completed a monthly van and cell phone check out log, including the following information:

- Date
- Destination
- number of clients
- number of staff
- supervisor approval
- safety check completed
- vehicle used
- cell phone used
- GPS used

- staff signature.

The program's trip plan document included:

- name of the youth
- staff name
- supervisor name approving the trip
- date and time of departure
- destination
- approximate mileage to destination
- anticipated time of arrival
- arrival check in time
- arrival call received by what staff
- departure check in time
- departure call received by what staff
- arrival time at the shelter
- reviewer signature
- reviewer title
- date.

In the last six months, there was a total of thirty-three incidents where transportation was conducted by one staff with one youth present in the vehicle. In all instances a trip plan was completed and documented a supervisor approval.

There were no exceptions to this indicator.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that is called Interagency Agreements and Outreach. The policy was last reviewed on July 28, 2017.

The agency's procedures related to Outreach Services includes using the Youth and Family Services Division interagency agreement to establish a working partnership with other entities. The interagency agreement includes a focus on Medical; Educational; Mental Health and/Substance Abuse; Prevention/Early Intervention programs; Recreation and Leisure. Specific staff members are designated to participate and coordinate and attend outreach functions. The purpose of the outreach function is to educate and promote the services and link with other needed services. The education and promotion is required to be done through the dissemination of printed materials, presentations to various audiences and groups. The areas of focus for outreach centers around substance use/abuse, adolescent behavior, education, information at CINS/FINS programs and parenting classes/family functioning. Other outreach outlets for promoting and creating partnerships includes: radio and television coverage, newspaper reports, billboards, meetings, brochures, presentations, special events, and community involvement to include schools, community groups and youth centers.

The agency is a member of the local area Circuit 9 Juvenile Justice Circuit Advisory Board. The mission of the circuit board is to develop a comprehensive plan for the circuit and provide recommendations to the Florida Department of Juvenile Justice regarding the delivery of juvenile justice services and grants. The local Circuit 9 Advisory Board meets on a regular basis. The Orange County Youth and Family Services Division have evidence of attending meetings. There were agendas and minutes from the meetings available for review.

The agency attends the Children and Family Services Board meetings. There were ninety-two outreach activities documented in NetMIS in the last six months which include local schools and community centers. There are also designated staff members from administration participating in other local organizations such as: statewide Florida Network of Youth and Family Services, United Way of Orange County, United Way of Central Florida, Bay Area Youth Services, and Circuit 9 Domestic Minor Sex Trafficking Board. The Program Manager for the agency also acts as the Liaison for the Orange County Government Domestic Violence Child Abuse organization.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Orange County Youth and Family Services' staff provides thorough and detailed documentation regarding services provided to the youth and client needs in the case files. All case files are organized and well maintained. Information is easily located due to tab inserts and a table of contents in the front of each file. Time-frames are adhered to as required per standard. Appropriate level staff are conducting assessments and assessments are reviewed by a supervisor. Eight client files were used to verify adherence to the Florida Network's Standard 2 requirements.

The Family Counseling Non-Residential Program employs a Program Manager, an Administrative Specialist, a Counseling Service Supervisor, six Senior Children's Services Counselors, and one Children's Services Counselor. The Program Manager and Counseling Service Supervisor are both Licensed Clinical Social Workers (LCSW). The Senior Children's Services Counselor is a Licensed Mental Health Counselor (LMHC), as well as a Licensed Marriage and Family Therapist (LMFT). Two of the Senior Children's Services Counselors are LMHC's and one is a Registered Clinical Social Worker Intern. All but one counselor have a Master's degree. The Children's Services Counselor has a Bachelors degree. Both the Program Manager and Counseling Service Supervisor have Master's degrees as well.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a policy in place for Screening and Intake. The policy was last reviewed on July 28, 2017.

The policy and procedures state that the initial screening is completed within 7 calendar days of referral to the program and documented on the CINS/FINS NetMIS screening form.

This policy further states that the CINS/FINS Consumer Handbook is provided to the youth and parents during intake. The Consumer handbook includes: 1) available service options, 2) rights and responsibilities, and 3) grievance procedures. The family is also presented with a brochure on drugs and alcohol use/abuse.

There were four residential (two open and two closed) and four non-residential (two open and two closed) files reviewed.

All eight files documented that contact was made with the family within seven calendar days from the date of the referral. The parents and clients were given the CINS/FINS services brochure which describes the case staffing committee, CINS petition process, and CINS adjudication, at the time of intake. Consent to treatment, client rights and responsibilities, grievance procedures, and notice to privacy practices were also given to the client and parents. The youth and parents received a copy of the service availability options in writing. All eight files that were reviewed had signed documentation from the client and parent that they received the information at intake.

There were no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy and procedure titled Assessment Process and Service Plan, which provides the procedures addressing the Needs Assessment and Service planning. The agency completes a needs assessment for each incoming youth receiving services. The policy was last updated on July 28, 2017.

The procedure details the process staff follows for the completion of the needs assessments. The needs assessment is initiated within 72 hours of admission for all assessments. Service plans are initiated at the face-to-face intake. The assessments are to be initiated within the required time frames. All needs assessments include a suicide risk screening section.

There were four residential (two open and two closed) and four non-residential (two open and two closed) files reviewed.

The needs assessments were completed in all eight files within the required time and completed by a Bachelors or Masters level staff, with a supervisor's review signature upon completion.

There was one residential file and one non-residential documented the youth required a suicide risk assessment to be completed. In both files the youth were assessed using a suicide risk assessment completed by a licensed clinical counselor.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There are two written policies to address this indicator, Assessment Process and Service Plan and Service/Case Plans and Case Plan Review. Both policies were updated on July 28, 2017.

The agency's policy requires service/case plans for non-residential youth to be completed within seven days of the completion of the Needs Assessment and the service/case plan for youth in shelter will be developed within five working days of admission to the Youth Shelter.

All service/case plans should include: identified needs/goals, frequency, target date, completion date, initial service/case plan date, and signatures of the parent and the youth.

There were four residential (two open and two closed) and four non-residential (two open and two closed) files reviewed.

All eight files had a case/service plan completed within the required time frame. All case/service plans that included: individual goals; service type, frequency, and location; persons responsible; target and completion dates; plan initiation date; and signatures of the youth, parent/guardian, counselor, and supervisor.

All applicable 30, 60, and 90 day reviews were completed in all eight files as required.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy and procedure titled Case Staffing Committee, a Client/Family Involvement Policy and Procedure, and Client Eligibility Policy and Procedure. These policies were last reviewed on July 28, 2017.

Youth are assigned a counselor/case manager who will follow the youth's case and ensure delivery of services through referrals and other case

management tasks.

The Counselors/Case Managers are to coordinate and complete referrals to address the youth's needs. The Counselor/Case Manager will monitor the youth's progression with services and provide the families with support. If necessary, referrals to the case staff committee will be completed to address youth/family needs. If applicable, recommendations of judicial intervention or accompanying families to court hearings. Counselors/Case Managers are expected to provide case monitoring and case termination follow-up.

There were four residential (two open and two closed) and four non-residential (two open and two closed) files reviewed.

All eight files showed documentation of referrals to local agencies within the community. All files showed written documentation of the counselor monitoring the youth's/family's progress in services, as well as the monitoring of progress in services and family support.

The four closed files (two residential and two non-residential) included documentation of case termination and follow-up.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy and procedure titled Counseling Sessions, and Counseling services, Services/Case Plans & Case Plan Reviews, which provides the guidelines addressing the Counseling Services. These policies were last reviewed on July 28, 2017.

The Counseling Sessions policy addresses the development of a service plan, review of the service plan, follow-up monitoring of progress made, and revised service plans as a result of the case staffing and/or adjudication. Up to twelve sessions are made available to clients and/or their families. Counselors engage and motivate the client or family, as well as motivates and informs the family of service options, case staffing, and of resources and supportive services related to case staffing opportunities. Counseling Services Supervisor or Designee reviews the case plan and case plan reviews.

Group Counseling is provided in shelter at a minimum of five days per week for at least thirty minutes. Groups are to be conducted by staff, youth, or outside community-based agencies. Documentation of group participation, date, and time should be included in the youth's file.

Non-residential staff should maintain chronological case notes on the youth's progress with counseling services. An ongoing internal clinical review of case records, youth management, and staff performance should be documented in the youth's file.

There were four residential (two open and two closed) and four non-residential (two open and two closed) files reviewed.

All files reflected the youth and families received counseling services in accordance with the service plan.

The four residential files included documentation of group counseling five days per week while the youth was in the shelter. In addition, the four residential files included documentation of individual and/or family counseling.

The four non-residential files included documentation of ongoing individual and family counseling with the youth. Also, there is documentation of an internal clinical review of case records, youth management, and staff performance.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place called Case Staffing Committee. The policy was last reviewed on July 28, 2017.

Orange County Family Counseling utilizes a Case Staffing Committee in an attempt to obtain solution when the Counselor is unable to assist in resolving a client's problem. The Case Staffing Committee is used when all other reasonable efforts to resolve the problem fails. Upon receipt of request for a Case Staffing from parent/guardian, the case staffing committee must meet with the parent/guardian within seven working days. Notification to the parent/family and case staffing committee are provided within five working days of the scheduled meeting. A copy of the case staffing committee recommendation report is given to the parent within three days of the case staffing meeting. Within seven days of the case staffing committee, a written report/letter is sent to the parent/guardian outlining the reasons of the case staffing recommendation. If the case staffing recommends modification within five days the youth and family are provided with a new or revised service plan.

The agency has an established case staffing committee that they have regular communication with. There committee has a schedule they follow for committee meetings. There were three files reviewed for the case staffing process. All three files showed evidence of service initiation within the designated time. Notification to the family and case staffing meeting was no less than five working days, in all three files. A revised service plan was in place and provided to the family after the meeting, in all cases. A written report was provided to the parent/guardian within seven days of the case staffing meeting, outlining recommendations and reasons behind the recommendations. One youth was recommended judicial intervention with the circuit court and the counselor completed a review summary prior to the court hearing.

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for Youth Records. The policy was last reviewed on July 28, 2017.

All youth files must contain specific content related to the youth that has been admitted to a residential or non-residential program. The client files must be organized according to an established format by the residential counseling service supervisor or their designee.

All files both open and close are required to be stamped confidential. All files are required to be kept in a locked file cabinet marked confidential that is located in the intake office. There is no copy equipment permitted in the file room. Files must be organized and arranged in alphabetical order and kept locked in the file cabinet at all times.

All records that require transport must be secured in an opaque container that is marked confidential. The open container must remain locked during transport.

The agency must maintain a separate file for health information and it also must be maintained and marked confidential.

All records are maintained in the counselor's offices, locked in file cabinets marked confidential. All records are maintained in a uniform manner and are in order according to the agency's client file protocol. All records reviewed were marked confidential.

The agency uses containers that are marked confidential when records are required to be transported.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

OCYFS Youth Shelter is a twenty-four hour per day, seven days per week facility. The youth shelter is licensed by the Department of Children and Families for twenty beds. Once a youth is admitted, the shelter provides an orientation of the shelter and program. The orientation includes a review of the youth handbook with the staff, and questions and answers. Also, the shelter provides new youth entering the shelter with at Trauma Inform Care Bang that includes a journal, t-shirt, and rights and responsibility manual. The shelter staff includes a program manager, an administrative specialist, a nurse, a senior youth care supervisor, a residential services supervisor, a counseling services supervisor, one senior children services counselor, two children services counselors, seven case workers, five family teacher assistants, and two youth resident coordinators. The family youth resident coordinators and teacher assistants are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The supervisory and counseling staff members receive referrals and monitor the provision of services.

Residential services, including individual, family, and group services are provided. Case management and substance abuse prevention education are also provided. The shelter has a color-coded medical and mental health alert system in place. The program also has an effective grievance process, in which the grievances are responded to within twenty-four hours of being submitted to management.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a shelter environment policy. This policy requires the agency to operate an Emergency Youth Shelter 24 hours a day, 365 days a year. The policy was last reviewed on July 28, 2017.

Policy requires that the Orange County Children's Services Department facilitate the operation of a youth shelter. The facility is officially called an emergency shelter youth shelter. The shelter serves residents age 10-17 that meet the eligibility profile that includes status offenders, runaway, ungovernable, truant, homeless, lock out. A review of the policy indicates that it meets all the general requirements to ensure adherence to this performance indicator.

Youth Shelter vehicles are locked at all times when not in use and vehicle keys are stored in a locked cabinet in the intake office that is not accessible to shelter youth. Youth Shelter vehicles have first aid kits, a fire extinguisher, flash light, glass breaker, seat belt cutter, air bag deflator and unbroken safety glass on all windows, and inside rearview mirror seat belts.

The Senior Youth Care Supervisor or designee maintains a list of all flammable, hazardous, and toxic chemicals used in the shelter. A MSDS is maintained on each item. Items are locked in a storage cabinet. A weekly perpetual inventory of chemicals is being completed.

The program maintains a current license from the Department of Children and Families.

The Youth Shelter is equipped with fire alarms. The Shelter is fitted with security systems. The Shelter has approved detection devices that are sensitive to smoke and heat. The facility is equipped with the required fire extinguishers, which are located in strategic, obvious and accessible locations throughout the building. The staff is trained on the appropriate use and operations of the extinguishers. Evacuation, escape plans, and escape routes are posted in the facility in an obvious location that is visible to all that enter/reside in the building. During fire drills and actual building evacuations, staff members assist and supervise the residents' exit from the building. When two or more staff is present in the shelter, one staff goes to the designated outside area to account for all residents and to ensure residents' safety. The other staff member checks the population board to get an accurate account of residents present at the shelter, each dorm, bathroom, and other areas to ensure complete evacuation of the building. When only one staff member is present in the building, she/he directs the Youth to the designated area as she/he checks the population board for an accurate count, dorms, bathrooms and other areas of the building for complete evacuation. The staff member then goes to the designated area to account for all residents. The Shelter is inspected on an annual basis by a designated fire inspector employed by the Orange County Fire & Rescue Department.

The Youth Shelter maintains a daily schedule established by the Sr. Children's Service Counselor or designee that outlines when and where daily activities will occur. This schedule is posted publicly and easily accessible. There must be daily, one hour of physical activity, which is best referred to as physical education. All youth are to participate in physical education class unless there is a medical reason stating otherwise. Faith-based activities are provided for the youth who wish to participate in faith-based activities. However, non-punitive structured activities are offered to the youth who do not wish to participate in the faith-based activities. The youth are encouraged to read more. Therefore, books are made accessible to the youth for their reading pleasure; in addition youth are allowed to read in their rooms.

A review and tour of the entire shelter (interior/exterior) was conducted upon completion of the "entrance interview." Throughout the facility tour, the shelter's environment appeared to be safe, clean, neat, and well-maintained. The common areas and youth sleeping quarters depict novel furnishings and equipment, as well as new wood flooring and freshly painted walls. The program is free from any visible insect infestation.

The grounds and landscape are additionally well-maintained; recent removal of shrubbery that lined the walkways and driveways was completed to provide a more welcoming appeal to the facility's backdrop. There is no sign of garbage or debris. The shelter is located on a larger campus that houses a school, cafeteria, training area, and a pavilion for outdoor activities, as well as a basketball and volleyball court.

The agency provided an up-to-date record of health and fire safety inspections, as well as an up-to-date DCF Child Care License, which is displayed on several locations throughout the facility.

The resident bedrooms are split into boys and girls dorms, with the staff control center, and youth common areas (dayroom, mini-kitchen, gaming area, and computer access area) dividing each dormitory. The facility is also equipped with several offices, conference room, and a reception area. There are no visible signs of graffiti on walls, doors, or windows in any of the rooms.

Each youth has her/his own individual bed with clean covered mattress, pillow, linens, and blanket. Both the male and female dormitory have large communal bathroom facilities that are clean and functional. The lighting in the dorms, common areas, and staff areas is adequate for task performed; reading and general indoor activities. Residents also have a lockable place to keep personal belongings, which is housed in the staff control center.

The shelter's staff control center houses the Pyxis MedStation med cart, first aid kit, fire & safety equipment, Key Lock Box, a digital security surveillance system, a multi-function copy machine, as well as other office related items.

The agency has a daily/weekly structured in-house and outside activity programming schedule that provides engaging and meaningful activities (i.e. education, recreation, counseling services, life and social skill trainings). The schedule depicts at least one hour daily (more on the weekends) of physical activity. Residents are provided the opportunity to participate in faith-based activities on Sundays. Non-punitive in-house structured activities are offered to youth who do not choose to participate in this religious opportunity.

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Program Orientation. The policy was last reviewed on July 28, 2017.

Program Orientation is to be completed with the youth within twenty-four hours of admission. Youth are given a welcome shelter bag that includes the Youth Shelter Handbook. The handbook includes kids rights, program rules, the behavior management strategies system, and the schedule. The youth then get a facility tour and get an overview of the shelter policies such as grievances, telephone use, abuse reporting, emergency drills, medical services, and more. The orientation checklist is signed by the youth and caseworker or designee.

There were five youth files reviewed for orientation. All five files documented the youth received an orientation to the program within the first twenty-four hours. All files contained an Orientation Checklist that documented a review of the BMS system, grievance procedures, emergency practices, their rules on what contraband is and what is not allowed, tour of the facility, daily schedules, and abuse hotline. Each item on the checklist was initialed by the youth and staff and dated as it was completed. All checklists had the youth's signature, the staff who completed the orientation, and a supervisor's signature. All files contained documentation the youth and parent received a handbook.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Room Assignment. The policy was last reviewed on July 28, 2017.

After the youth's intake is complete, a caseworker, Senior Counselor, or Children's Services Counselor will determine the appropriate room assignment. Efforts are always made to keep siblings together if possible. There are many factors that these staff take into consideration when making the determination for an appropriate room assignment such as age, gender, physical size, suicide risk, levels of aggression, risk history, gang affiliation and many more. If a youth has been identified as having an area of risk, that risk is immediately entered into the program's alert system.

There were five open files reviewed for room assignment. The shelter uses the Client Room Assignment section on the CINS/FINS Intake Assessment form to document room assignments. All five files reviewed had this section completed and a room and bed assigned. Each youth's room assignment was made based upon the following criteria: age, gender, history of violence, disabilities, gang affiliation, suicide risk, sexual behavior history, and physical size. All five of the files reviewed had alerts documented on the outside of the file and also documented on the on the alert board in the staff office. All five files also documented staff's initial interactions and observations of the youth.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on logbooks and was last reviewed on July 28, 2017.

The Program Manager or designee reviews the logbook every week and makes a note in the logbook followed by any corrections, recommendations, or follow up required. The entry is signed and dated. The Supervisors review the logbook back to the previous working shift to become aware of any unusual situations. The Residential Counseling Services Supervisor (or designee) reviews the logbook for the previous two shifts to be aware of any occurrences or problems. The direct care staff reviews the logbook for the previous two shifts in order to be aware of any occurrences or problems. All staff must sign and date the entry they make in the logbook. When mistakes are made in the logbook, staff members are required to strike through the errors once and initial and date the correction. The staff person must sign and date the correction. All entries are brief and legibly written in ink. No erasures or whiteout entries are allowed in the logbook. All entries include: Date and time of the incident, event or activity, name(s) of youth and staff involved, a brief statement providing pertinent information, the name of the person making the entry with the date, time and signature. Logbook entries, which could impact the security and safety of the program, are highlighted.

Logbooks were reviewed from November 2017 to May 2018. There is a Color Key found on the interior cover of the logbook to indicate important or emergency situations. The color key is: pink for medical related information, blue for intake/admission, yellow for releases/discharges, green for AWOL/runaway, and orange for other pertinent information that staff should need to know. These highlights are being consistently utilized to depict the nature for its use.

Supervisors were consistently reviewing the logbook for the previous two shifts. In addition, the Residential Counseling Services Supervisor and all direct care staff on duty were consistently reviewing the logbook for the previous two shifts.

The logbook entries are well documented; they include the date and time of daily incidents, activities, events, and other major occurrences, includes the resident(s) names, and are signed and dated by staff. The entries are brief and written in ink. However, there are numerous entries made by staff that are difficult to read. Fire Drills (for all three shifts) are also documented on a monthly bases with consistency.

Safety and security issues were documented in the logbook to include: residents being placed on sight and sound, suicide risk assessments, abuse hot line calls, and calls made to CCC. There entries are appropriately highlighted in orange.

There was consistent documentation the Program Manager reviews the logbook weekly. However, the procedure also dictates that upon review, the Program Manager will include in her/his note any corrections, recommendations, or follow up required. This was not being consistently documented.

Per operating procedures, when mistakes are made in the logbook, staff are required to strike through the errors once, initial, and date the correction. On nine separate occasions, throughout the last six months, only the "strike through" was completed with no staff initials. On four separate occasions, throughout the last six months, only the "strike through" was completed with no initials nor date.

Per operating procedures, additional guidelines used when making entries in the logbook are as follows: staff members sign and place a time on every entry made in the logbook, a line is not skipped between each entry, and draw a straight line to denote the end of the page. On nineteen separate occasions, throughout the last six months, a skipped line or multiple lines were found between entries. There were multiple occasions where lines were not crossed out to denote the end of the page.

Exceptions:

There are numerous entries made by staff in the logbook that are difficult to read.

Corrections, recommendations, or follow up required was not being consistently documented by the Program Manager during the weekly review.

There were multiple entries where errors were not being documented correctly (i.e. struck through with a single line, staff initials, and date of the correction).

There were multiple occasions where skipped line(s) were found between entries and lines were not drawn to denote the end of a page.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on their Behavior Management Strategies (BMS). It was reviewed on July 28, 2017.

The Youth Shelter's Behavior Management System is designed to be easily understood by both youth and staff. It is designed to promote positive behaviors in the youth through the application of logical consequences applied in a caring and humane manner. The Behavior Management System prohibits the use of group sanctions/consequences and also prohibits youth imposing disciplinary consequences/sanctions over other youth. The Youth Shelter does not utilize room restrictions for any reason. If a resident receives a sanction under the behavior management system, the sanction imposed will not deny the resident any of the following rights, included but not limited to the following: Denial of regular meals, hydration, or clothing; Denial of sleep; Denial of exercise; Denial of educational services; Denial of physical health services or mental health services; Denial of correspondence privileges; Denial of contact with parents or probation officers; Denial of school; Denial of legal assistance; or Denial of faith-based/religious services or activities.

The youth Shelter has a detailed written description of the Behavioral Management strategies that is consistent with the principles of learning theory including but not limited to: a wide verity of rewards is used by the Youth Shelter such as the following: The Way-To-Go Store, the treasure chest, extra snacks, community outings, extended weekend bedtimes, pizza parties and ice cream socials; Appropriate consequences are used by the Youth Shelter Staff; Consequences are applied immediately, with the assurance that the consequence does match the severity of the behavior. All Shelter Staff are trained in the theory and practice of administering rewards and consequences; both are administered fairly and consistently. The Youth Shelter also provides a protocol for providing feedback to staff regarding the use of rewards and consequences. The supervisors monitor the rewards and consequences issued.

Upon Intake all residents receive a handbook which includes the Youth Shelter's Behavior Management Strategies. The Intake process includes a checklist accounting for staff discussion and documentation that the BMS with the resident is being completed. All Shelter Staff are trained on the theory and practice of the BMS. Upon the staff's performance evaluation the BMS is revisited/retrained.

Five files were reviewed and in each the BMS had been gone over with the youth at Intake via staff, as documented on the Orientation Checklist. The 4-Tier Level System is characterized in Nautical Theme, depicted by Rank according to Level (i.e. Ensign, Commander, Lieutenant and Captain) and was found to be utilized by staff appropriately through a daily Point System, and in a way where it provides for positive reinforcement and recognition, as well as thoroughly explaining consequences for certain behaviors, which are logical and designed to promote skill-building for the youth.

The agency's BMS includes an array of positive incentives, which includes The Way-To-Go Store, community outings, extended weekend bedtimes, pizza parties and ice cream socials. The BMS also includes the possibility of a fine/infraction as a consequence when a youth's behavior is not apropos. The fines received are in increments of 10, 20 and 30 depending on the severity of the infraction.

Youth have the ability to earn up to 550 points per day (includes the possibility of earning up to 50 Bonus Points), and are able to purchase her/his levels (i.e. Level 1 = 350 pts, Level 2 = 400 pts, and Level 3 = 450 pts), with the remaining of their daily point balance going towards the Way-to-Go Store.

Three staff training files were reviewed that depicted BMS training (i.e. Youth Shelter House Rules, Review of BMS, Cardinal Restrictions, and Client Grievance Procedure) was completed upon hire.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Staffing and Supervision. It was reviewed on July 28, 2017.

Youth shelter staff are required to constantly monitor the children at all times. The ratio of staff to children during wake times should not exceed six children to every one staff. The ratio of staff to children during sleep time should not exceed twelve children to every one staff.

Staff schedules are created by Youth Care Supervisor(s) two weeks in advance. Schedules are then typed and posted in the Control Room by the Supervisor at least three days prior to the beginning of the workweek.

The Supervisor must ensure that there is always at least one staff on duty of the same gender as the youth and that there is at least one staff member to six residents during waking hours and one staff member to twelve residents during sleeping hours.

Staff observes youth at least every fifteen minutes while they are in their sleeping room, either during the sleep period or at other times. This does not supersede the requirement for constant supervision of youth at risk of suicide or short room check times when authorized by treatment staff or management. Times are documented in real time.

Staff weekly work schedules are created by Youth Care Supervisor(s) two weeks in advance. Staff initial the tentative schedule to acknowledge their understanding of their assigned shifts. These schedules are then typed and posted in the Control Room by the Supervisor at least three days prior to the beginning of the workweek. There is always a Direct Care Staff of the same gender as the youth on each of the three shifts.

The shelter's staff weekly work schedule and logbooks were reviewed and paralleled to reflect the appropriate client to staff ratio during wake hours and sleep hours. The weekly work schedules document the Direct Care Staff, as well as job/duty assignments via the following abbreviations: CO – Close Observation, M – Medication, SS – Sight & Sound, O – Office, and SSC – Staff Secure. Overnight (3rd Shift) staffing depicts a minimum of two staff on duty, which was also confirmed by the staff's "on duty" signing in via the logbook. There is a holdover overtime rotation roster included on the staff's weekly work schedule. However, due to where the schedule is posted, and the visibility access from residents, staff contact numbers are withheld.

The Resident Accountability Checklist shows that overnight staff observes youth at least every fifteen minutes during sleep hours and are documented in real time. These Resident Accountability Checklists are kept in monthly binders and housed in the Staff Control Center. Three random overnights were selected and reviewed via the video surveillance system, where it shows that fifteen minute checks during sleep hours are being done in both the boys and girls dorm consistently.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on special populations that was last reviewed on July 28, 2017.

The program's standard operating procedure outlines staff secure respite, probation respite, domestic violence and domestic minor sex trafficking.

Staff secure youth must meet the legal requirements outlined in Chapter 984 F. S. for being formally court ordered into staff secure services. Youth may be placed in staff secure services for up to ninety days with a possible thirty-day extension. A staff will be specifically assigned, during waking hours, to monitor and mentor the youth, and an in-depth orientation is provided to the youth. The staff assigned is documented on the staff work schedule, shift change report or in the log book. The youth's file has documentation of coordination between presenting problems, needs assessment, service plan, service plan reviews, case management and follow-up. The youth shelter staff will work with parents/guardians to acquire the appropriate releases of information to ensure coordination of services can occur; weekly family visitation is encouraged. All staff are informed and made aware of the need for extra supervision of the youth, and an appropriate level of intervention with staff and the counselor is emphasized.

Probation respite youth referred to the youth shelter must meet specific criteria. Criteria includes, youth referral must come from the Department of Juvenile Justice, youth is on probation with adjudication withheld. The Florida Network must be contacted for approval, length of stay is

determined at time of admission from fourteen to thirty days, and if extension is needed, the approval of the juvenile probation officer, chief of probation and Florida Network is required.

Domestic violence youth referred to the youth shelter must meet criteria for admission. Youth must have a pending domestic violence charge, been screened by the juvenile assessment center (JAC)/detention or screening unit, but do not meet secure detention criteria. Youth's length of stay cannot exceed twenty-one days.

Domestic minor sex trafficking youth are approved by the Florida Network, exhibit behavior which require additional supervision for the safety of the youth or the program. All requests may be approved for maximum of seven days; approval beyond can be obtained on a case-by-case basis.

A review of one staff secure, two domestic violence respite and two probation respite youth files was conducted. The program did not have any domestic minor sex trafficking youth during this review period.

The staff secure youth met the legal requirements outlined in Chapter 984 F. S. and was court ordered to receive staff secure services; a court order was in the youth file. The program assigns a staff per shift to complete staff secure observation, when needed; this is documented on the weekly work schedule. In the one file reviewed there was one staff assigned per shift to supervise the youth. The youth was a Crosswinds youth and placed at the shelter due to issues with her continuous running away in her home county, therefore documentation of reports to the court were not maintained at the shelter, but with the other agency.

The two domestic violence respite youth reviewed had been screened by the juvenile assessment center (JAC) and did not meet criteria for secure detention. Each youth had a pending domestic violence charge and the respite placement did not exceed the twenty-one days. Data entry into NetMIS and the juvenile justice information system (JJIS) was completed within twenty-four hours of admission and seventy-two hours of release. Both files had documentation transferring placement to children in need of services (CINS)/ families in need of services (FINS) or probation respite. The case plan for each youth contained goals reflecting aggression management, and family coping skills, which were addressed while the youth was in the shelter, as well as other services provided consistent with CINS/FINS program requirements.

The two probation respite youth files reviewed were referred by the Department of Juvenile Justice probation officers, through the probation respite referrolator. The two youths had a history of probation placements with adjudication withheld, and they were approved through the Florida Network prior to admission. At the time of admission, the length of stay was determined and neither youth stayed past the thirty-day time frame. Data entry into NetMIS and JJIS was completed within twenty-four hours of admission and seventy-two hours of release. The program conducted a needs assessment at the time of admission and addressed the needs identified while the youth was in the shelter, as well as made recommendations for services, at the time of release.

There were no exceptions to this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the requirement for operational video camera surveillance systems in their youth shelter. The policy was last reviewed on July 28, 2017.

Orange County requires the youth shelter staff to constantly monitor the residence at all times during their shelter stay. Orange County has a shelter video surveillance system that is required to be in operation 24 hours a day, seven days a week to monitor and capture recording of happenings continuously to ensure the safety of all youth, staff, and visitors while guaranteeing personnel accountability.

The agency utilizes the video system to assist as a deterrent means for any misconduct and to ensure that any allegations of incidents are identified through recorded visual means. Orange County requires a video surveillance camera system to capture and retain video photographic images for storage purposes for a minimum of thirty days. Orange County's procedures indicate the system must be able to record date, time, and location, as well as maintain resolution that enables clear facial recognition.

The agency has limited access to video camera footage and supervisors are required to review video once every fourteen days and/or sooner and document reviews in the program logbook. Reviews by supervisors are required to include a random review and sample of overnight work shift activity. The agency must also post visual notice to visitors, staff and residents that video camera surveillance systems are in use in the shelter facility. Video camera surveillance systems are to be placed in general areas, and not in areas including bathrooms and or sleeping areas.

The reviewer did a walk-through of the program grounds and noticed that all cameras were visible in the interior (front reception area, living

room, staff office) and exterior (all parking lot areas, entrance/exit and recreation area) areas. There were no cameras in the sleeping quarters and bathrooms. The cameras were reviewed with Program Manager of Orange County Youth Shelter. There were three different time frames of reviewing the camera from the night before, two weeks ago, and a month ago. The camera system does record date, time, and location and has the capability to store video up to thirty days. All staff, visitors, and youth were easily visible on camera. Program Manager did inform reviewer that the cameras do have a back-up system in case of a power outage. There is multiple documentation in the logbook of the Program Manager reviewing video surveillance once every fourteen days. Written notice of video surveillance is place conspicuously throughout the premises for the purpose of security.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

Orange County Government Youth and Family Services Youth Shelter has policies and procedures in place to manage and address a healthcare admission screening upon admission, suicide prevention screening, medication management, medical and mental health alert screening and identification process and episodic/emergency care.

The shelter nurse will conduct the health screening if present. Non-health care staff may conduct the health screening and the nurse or supervisor will review all intakes within five business days. This screening is used to determine if the youth has a medical condition that requires immediate attention or might render admission to the shelter unsafe to the youth or other. During the initial screening and intake interview, all youth will be screened for suicide risk through the use of the Florida Network approved CINS/FINS Intake Assessment. The agency employs a Licensed Clinical Social Worker (LCSW) who completes all documentation regarding suicide precautions. The shelter utilizes a CareFusion Pyxis MedStation 4000 to store medications. The shelter has a Registered Nurse (RN) who has been employed by the agency since October 2017. The RN is on-site twenty hours each week. The RN distributes all medications when on-site. The shelter has a medical, substance abuse, and mental health alert system in place. A color-coded sticker is placed on the youth's file and on the population board to provide continuous information on the medical, mental health, or substance abuse status of the youth. The shelter maintains first aid kits and emergency equipment and supplies to use in the event that staff has to provide care. All shelter staff are trained to detect and intervene in emergency situations and are certified in CPR and First Aid.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Healthcare Admission Screening. The policy was last reviewed on July 1, 2017.

The shelter nurse will conduct the health screening if present. Non-health care staff may conduct the health screening and the nurse or supervisor will review all intakes within five business days. This screening is used to determine if the youth has a medical condition that requires immediate attention or might render admission to the shelter unsafe to the youth or other. If there are medical conditions or concerns, the guardian will be contacted, the Supervisor on Duty will be notified, and incident report procedures will be followed. The guardian may be active in planning any follow-up appointments.

There were eight youth files reviewed for Healthcare Admission Screening. In all eight files the CINS/FINS Intake Assessment Form was completed at admission. In three of the files reviewed the youth were taking medications and those were documented on the Intake Assessment Form. Two of the youth had allergies documented. One youth had an allergy to pollen and one youth had an allergy to bananas, raisins, and peanuts. One youth was documented as having asthma. There was documentation the youth reported having an inhaler but had never had an asthma attack. The youth did not have the inhaler at the shelter at the time of the review and there was no further documentation of communication with the youth's parent to determine if the youth did have an inhaler and if the inhaler was needed while at the shelter. None of the youth required any type of follow-up medical care.

In seven of the eight files, there was documentation the RN reviewed the intake and completed an additional health assessment within five business days. The last file still had two days left to be reviewed by the RN.

Exception:

One youth was documented as having asthma. There was documentation the youth reported having an inhaler but had never had an asthma attack. The youth did not have the inhaler at the shelter at the time of the review and there was no further documentation of communication with the youth's parent to determine if the youth did have an inhaler and if the inhaler was needed while at the shelter.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for suicide precautions titled Mental Health and Substance Abuse Services (Emergency and Non-emergency).

The policy was last reviewed on July 28, 2016.

During the initial screening and intake interview, all youth will be screened for suicide risk through the use of the Florida Network approved CINS/FINS Intake Assessment. The results of every screening will be reviewed and signed by the supervisor and documented in the youth's case file. If the youth answers "yes" to any questions one thru six on the CINS/FINS Intake Assessment, the youth must be placed on continuous sight and sound supervision until a further screening is completed. A licensed mental health professional or a non-licensed mental health professional working under the supervision of a licensed mental health professional, must complete the screening within twenty-four hours. If at any time the youth engages in suicidal/homicidal gestures, repeatedly states he/she wishes to harm him/her self or others, states a specific plan for suicide, the youth will be placed on one-to-one supervision and Baker Act procedures will be followed.

The agency has three different levels of supervision. The first level one-to-one supervision is the most intense level of supervision and is used in high risk cases. One staff member, who must be the same gender as the youth, will remain within arm's length of the youth at all times. The next level of supervision is Constant Sight and Sound Supervision. This supervision level is for youth who are identified as being high risk but are not actively expressing intent to engage in high risk behaviors. A staff member must have continuous, unobstructed and uninterrupted sight of the youth and be able to hear the youth at all times. The last level of supervision is Close Observation. This is an elevated level of supervision and is for youth who are identified as being at a low risk for risky behaviors.

There were five files reviewed of youth who had been placed on suicide precautions. The CINS/FINS Intake Assessment form was completed at admission and documented positive "hits" requiring the youth to be placed on suicide precautions. The CINS/FINS Intake Assessment was reviewed and signed by the supervisor in all five files. Two of the three youth were seen immediately by the LCSW who completed an Assessment of Suicide Risk and placed both youth on standard supervision. The remaining three youth were placed on constant sight and sound supervision until seen by the LCSW. All three youth were seen and assessed within twenty-four hours by the LCSW. The LCSW completed the Assessment of Suicide Risk and placed all three youth on close observation. There were ten-minute observations maintained on all three youth until placed on close observation. Once placed on close observation fifteen-minute checks were maintained. All three youth remained on close observation status until discharged from the shelter.

All observation sheets were filled out in their entirety and reviewed by the LCSW. Observation sheets were found for every day and shift the youth were on precautions. The LCSW completes a form every time the youth's supervision level is changed which documents the new supervision level and the date and time of the change. This form was found for every instance a supervision level was changed in all three cases.

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has two policies in place for Medications called Medication: Ordering and Distribution, Storage, Access, Inventory, and Disposal and Medication: Distribution and Monitoring (Documentation, Delivery, and Security). Both policies were last reviewed on July 28, 2017.

There are procedures in place for the storage of all medications in the Pyxis Med-Station and access to the medication by trained staff delineated in writing. Procedures specify oral medications are to be stored separately from topical medications. There are procedures in place that require a refrigerator to be on-site that is solely used for medication storage, if needed. Procedures are in place for the inventory of all medications, as well as, all sharps. Procedures are in place for the use of a Medication Distribution Log (MDL) and documentation requirements on the MDL. Procedures state when a nurse is on duty they must conduct all medication processes and procedures. The nurse must also review medication management practice via the Knowledge Portal or Pyxis Med-Station Reports monthly. The procedures list the four approved methods to verify medication. There are procedures in place to ensure discrepancies are cleared out each shift.

The shelter provided a list of eighteen staff who are trained to supervise the self-administration of medications. There were six staff on that list who were listed as "Super Users" for the Pyxis Med-Station.

The shelter has a Registered Nurse (RN) who has been employed by the agency since October 2017. The RN is on-site twenty hours each week. The days the RN is on-site and the number of hours on-site that day vary week to week. The RN provides the Program Manager a schedule a week in advance of the days and hours she will be on-site for the next week. The RN distributes all medications when on-site.

The RN recently conducted a refresher training with all staff on medication distribution. Each staff was required to show the RN how to use the Pyxis Med-Station including: how to load the medication and how to distribute the medication. There have been no new hires that have required medication distribution training; however, the RN reported she would train any new hire on the medication process.

All youth medication is stored in the Pyxis Med-Station. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. Drawer one is where all the over-the-counter (OTC) medications are stored. Drawers two and three are where all prescription medications belonging to the youth in the shelter are stored. Drawer four is empty. Drawer five is used for any over-sized medications that do not fit in the compartments in drawers two and three. The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review.

All medications in the shelter are inventoried once per week by the RN, including the OTC's. All prescription medications are inventoried twice each day, once on first shift and once on third shift. The RN and Program Manager reported they have not had any controlled medications in the last six months that would require shift-to-shift inventories. Each day a Daily Medication Schedule and Count form is printed out. This form documents each youth in shelter taking medication, the time the medication is to be given, the medication name, and the dosage. Each time the staff give a medication they are to initial in the spot next to that youth indicating the medication was given. The staff also document in the shelter logbook the youth's name, medication given, and time. Attached to Daily Medication Schedule and Count form each day are the print outs from the Pyxis Med-Station, from first and third shift, documenting all medication in the Pyxis Med-Station and the count. The staff initial next to each medication as they are doing the inventories indicating the count is accurate. There was documentation for the last six months confirming these inventories were completed.

The RN reported there are very few discrepancies made by staff. On average there are about two per month. There were no open discrepancies at the time of the review. Staff were aware of the requirement to close the discrepancies by the end of their shift. The RN runs a weekly Discrepancy Report from the Knowledge Portal to see where discrepancies are commonly occurring and by whom. In addition, the RN also runs monthly reports from the Knowledge Portal, including: Summary by Station, Summary of Loads and Unloads, Average Number of Cancellations by User, Pyxis Summary by Month, User Summary by Transaction Type, All Profile Overrides, and Transaction Types.

There were four youth in the shelter reviewed for verification of medication administration. Each youth has a separate Client Medication Folder where all documents relating to medication administration are kept until the youth is discharged. Each folder contains a picture of the youth on the outside cover, the medication policy and procedures, a printout from www.safemedication.com for each medication the youth is taking, and all the MDL's for each medication. All medications are verified at admission by the staff doing the intake by calling the pharmacy. This is documented on the back of the MDL. All MDLs reviewed documented the youth's name, allergies, medication the youth was taking with dosage/frequency, reason for the medication, common side effects, the pharmacy and prescribing physician, staff signatures, and youth signature. All MDLs reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MDLs reviewed for the youth also documented that all medications were given at prescribed times.

There have been six medications disposed of in the last six months. The Medication Waste Log documented the client's name, the medication, the amount wasted, the RN's signature, and the signature of a witness. The RN reported the medications were dissolved in vinegar, then mixed with coffee grounds, then placed in a bag and disposed of.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Alert Procedures. The policy was last reviewed on July 28, 2017.

The shelter has a medical, substance abuse, and mental health alert system in place to inform staff of a youth's medical, mental health, or substance abuse condition, allergies, common side effects of prescribed medications, foods, and medications that are contraindicated or other pertinent treatment information. A color-coded sticker will be placed on the youth's file and on the population board to provide continuous information on the medical, mental health, or substance abuse status of the youth. The colors of the stickers are: red for medical condition, yellow for mental health, blue for substance abuse, green for allergies, and orange for trauma. Common side effects of prescribed medication, food and medication contraindication, and other treatment information are documented in the youth's file and/or medical file.

There were eight open youth files reviewed. All alerts identified during the screening process were documented with the appropriate color-coded stickers on the front of the youth's file. There is an alert board located in the staff office. All youth in the shelter are documented on this dry erase board. If the youth have any alerts the appropriate color-coded sticker is placed in the alert column. Staff review this alert board when coming on to shift and can then find additional information regarding the youth's alert in the youth's file or medical file if applicable. All youth in the shelter who had alerts were appropriately documented on this board.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Medical and Dental Procedures (Episodic/Emergency Care). The policy was last reviewed July 28, 2017.

If a medical or dental emergency arises that is considered life threatening, staff is to immediately call 911 and then immediately contact the parent/guardian to advise them of the situation and ask that they meet them at the hospital. The shelter maintains first aid kits and emergency equipment and supplies to use in the event that staff has to provide care. All shelter staff are trained to detect and intervene in emergency situations and are certified in CPR and First Aid. All staff involved in medical/dental incidents shall follow proper notification and incident reporting procedures in accordance with Program, Agency, and Contractual requirements. The Program Manager and/or Senior Youth Care Supervisor shall ensure the program conducts mock emergency drills at least quarterly on each shift.

There have been nine instances in the last six months of youth being transported off-site for emergency medical care. All nine incidents were reported to the CCC and documented on the Youth Shelter Emergency Response System Log. In all nine cases there was documentation the youth's parent was notified and transported the youth to the emergency room. An internal incident report was completed in all nine cases. An addendum was completed on each incident report when the youth returned to shelter documenting the diagnosis, any medications, discharge instructions, and any follow up care needed. All discharge paperwork was also maintained in the youth's file. All incidents documented the CCC was notified when the youth returned and provided with the diagnosis and follow-up care instructions.

The shelter has completed an emergency care drill on each shift the last two quarters. One drill was a youth with a nose bleed and another drill was a youth with a knee injury. The drills were typed up for each shift with each staff members response to the incident. The drills were signed and reviewed by the Program Manager.

There is a main first aid kit located in the staff office. This kit was reviewed with RN on-site and was fully stocked. There are also first aid kits for all the vehicles. The knife-for-life and wire cutters are located in a cabinet in the staff office.

There were no exceptions to this indicator.