Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth Crisis Center

on 03/28/2018

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

Amber Minton, Senior Children’s Services Counselor, Orange County Youth and Family Services

Cyntoria Thomas, Program Manager, Thaise Educational and Exposure Tours Jacksonville

Travis Scott, Residential Supervisor, CDS Family & Behavioral Health Services (Central)

Sherl Craft, Counseling Supervisor, Lutheran Services Florida (NW Currie)

Persons Interviewed

- [x] Chief Executive Officer
- [ ] Executive Director
- [ ] Chief Operating Officer
- [ ] Chief Financial Officer
- [x] Program Director
- [ ] Program Manager
- [x] Program Coordinator
- [x] Direct- Care Full time
- [x] 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
2 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
0 # Personnel Records
0 # Training Records
6 # Youth Records (Closed)
2 # Youth Records (Open)
2 # Other

Surveys

5 Youth
5 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [ ] 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
- [ ] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Founded in 1974, the Youth Crisis Center (YCC) located in Jacksonville, Florida provides short term residential shelter, non-residential services, transitional living services, outpatient behavioral health services and more. YCC contracts with the Florida Network of Youth and Family Services (CINS/FINS) program. Through this funding, the agency serves both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to youth who meet the criteria for Staff Secure Shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence and probation respite. YCC is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to runaway and homeless youth.

The Youth Crisis Center has applied many strengths and innovative approaches to the program. They include:

- Began the Duval County Domestic Violence Civil Citation Respite program in January.

- Enhanced the Case Staffing Committee in Clay and Duval Counties and developed a committee in St Johns County.

- Re-started the visual arts classes to residential youth compliments of two grants from the Moran Foundation to the Cathedral Arts Project.

- Continue to provide yoga classes for females through a relationship with Yoga 4 Change.

- Offer psychiatric services to youth receiving CINS/FINS services via two child psychiatrists who work at YCC 24 hours per week.

- Remained open during Hurricane Irma and provided residential services to five youth with our emergency hurricane team in place for over seven days.

- Continue to provide academic instruction via four school teachers through the Duval County Public Schools.

- Continue to offer internship opportunities to undergraduate and graduate students.

- Offer nursing services seven days week through a grant from Baptist Health system and the FL Network.

- Began providing volunteer opportunities for residential clients through the Pawsitivity program. This program offers youth to read to the pets at the Humane Society.

- Served seven trafficking victims last year.

- Promoted a lead residential therapist to Residential Clinical Supervisor and promoted a non-residential therapist to a lead therapist.

- Served youth in non-residential programming through a MOU with Police Athletic League.

Standard 1: Management Accountability

Overview

Narrative

The program Youth Crisis Center (YCC) operates a thirty bed residential shelter and non-residential CINS/FINS program. The program has more than sixty full-time, part-time, and on-call staff members. The agency has a detailed background screening process that is completed by their Human Resources department. The agency has a comprehensive training plan that requires all staff members to complete a broad array of core training topics. The agency has an active self-reporting incident reporting process. The agency completes monthly reporting of its risk management, quality improvement, service delivery, and outreach data reports.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place for Background Screening of Employees and Volunteers. The policy was last reviewed and updated in November 2017.

The policy has procedures in place for background screenings of all new hires prior to employment and prior to becoming an intern or volunteer. The program policy also addresses five-year rescreening of employees and volunteers after the date of the initial background screening. The program maintains a file for each employee with a copy of the employee’s background screening. The files were neatly organized and kept in a locked cabinet.

All staff, interns and applicable volunteers must sign a criminal history acknowledgement form and an affidavit of good moral character form. All staff, volunteers and interns must receive an eligible rating prior to employment. Re-screenings will be completed every five years after the date of the initial screening. All screenings must be maintained in the human resources files. The program must complete the annual affidavit of compliance with good moral character standards form annually in January for all staff.

Since the last Florida Network review, the program has hired seventeen new employees and four interns. All of the staff and intern files had documentation of background screenings completed prior to employment or working as an intern working with the youth population. There were three staff requiring five-year re-screenings. The re-screenings were completed as required.

The Annual Affidavit of Compliance with Level 2 Screening Standards was sent to the Department of Juvenile Justice Background Screening Unit on January 22, 2018.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures for Provision of an Abuse-Free Environment. The policy lists all of the employee conduct and work rules. The program’s code of conduct prohibits the use of physical abuse, profanity, threats or intimidation. Any infractions of the rules of conduct will result in disciplinary action, up to and including discharge of employment. The agency is mandated by law to report all allegations of abuse/neglect to the Florida Abuse Hotline/Child Abuse Registry. Staff must notify parents/guardian of any report of abuse. Failure to report abuse is a second-degree misdemeanor. All staff members must acknowledge in writing they have read and understand the laws of reporting abuse. A copy of the acknowledgement is kept in the staff's personnel file.

The program provides an environment in which youth, staff and others feel safe, secure, and threatened by any form of abuse or harassment. All staff are required to acknowledge mandatory reporting of suspected abuse of a child, F.S. 39.201.

The program has a grievance procedure in place and grievance forms are readily available to the youth. However, there have been no grievances files in the last six months. There were no instances, in the last six months, of management having to take disciplinary actions against any staff member for reasons relating to the abuse free environment. The abuse hotline number was observed posted throughout the facility.

All youth surveyed reported they know the number to the abuse hotline and have never been stopped from calling the abuse hotline. All youth also reported feeling safe in the shelter. None of the youth reported hearing staff use inappropriate language when interacting with youth and

reported that staff treat them professionally.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC incident reporting system requires that staff interns inform their supervisor/designee of all incidents concerning safety and liability such as but not limited to allegations against staff, staff misconduct with youth, youth on youth battery and or assaults, use of force, disruptions, fighting, injuries or suicides, law violation, and property damage that occurs while a client. DJJ Incident Reporting procedures and/or funders reporting requirements must also be followed. Reporting within the required time frames and proper documentation is critical. If in doubt, report it to the central communication center CCC.

All accidents/incidents shall be documented on an internal accident form and funder incident reporting forms. Accidents are to be reported to CCC or OSHA. Staff are to submit completed internal accident/incident report form, if applicable, to supervisor prior to shift. The supervisor/designee shall submit the completed form to VP or Quality Assurance immediately following a review of the form. If the incident is reportable to the CCC, then they are to follow the DJJ Incident Reporting Procedure.

There were twelve incident reports to the CCC in the last six months. All twelve incidents were reported within two hours of knowledge of the incident. All incidents documented follow-up communication with the program and all were successfully closed. The incidents were documented on an incident report form and also in the program logbook.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures for staff training requirements that was last reviewed and updated in November 2107.

The program has a training plan that is updated annually. All direct care CINS/FINS staff (full-time, part-time, and on-call) shall have a minimum of 80 hours of training for the first full year of employment and 24 hours of training each year after the first year. Direct care staff in residential programs licensed by the Department of Children and Families is required to have 40 hours of training per year after the first year. Following the first year of employment, direct care staff training for residential staff should include refresher training on the use of available fire safety equipment, crisis intervention, training necessary to maintain current CPR and first aid certification and suicide prevention. The program has individual training files for each staff member.

Training addresses the fundamentals of management accountability in CINS/FINS programs. Required training for new staff within first 120 days includes local provider orientation, CINS/FINS Core, managing aggressive behavior, suicide prevention, sign/symptoms of Mental Health and Substance Abuse, CPR/First Aid, behavior management, understanding youth/adolescent development. New staff must complete the remaining training hours within the first year. This training includes title IV-E procedures, in-service component, medication distribution for non-licensed staff, ethics, confidentially, trauma-informed care, PREA, fire safety, information security awareness, LGBTQ youth, and cultural humility. Direct care staff employed for longer than one year must complete 40 hours training from the above list. The training includes refresher classes in fire safety equipment, crisis intervention, training necessary to maintain current CPR and first aid certification and suicide prevention. The program maintains individual training files for each staff member, which includes an annual employee training hour-tracking form and related documentation such as certificates, sign-in sheets, and/or agendas for each training attended.

A total of ten training files were reviewed. Two files were reviewed solely for training completed in the first 120 days, three files were reviewed for training completed during the first year of employment, and five files were reviewed on-going annual training.

The two files reviewed solely for trainings completed during the first 120 days documented one staff received all required trainings and the other staff were missing two of the required trainings.

The three files reviewed for training completed during the first year of employment documented all three-staff received over the required 80 hours with: 105.5, 115, and 68 hours respectively. However, all three-staff reviewed received two required trainings outside the first 120-day requirement. All three staff did receive all required trainings within the first year of employment.

The five files reviewed for annual training all documented staff received over the required 40 hours of training with: 104.5, 125.5, 44, 42, and 59.5 hours respectively. All staff received all required trainings.

The training files were organized. The trainings were listed by staff name, type of training, date of completion and total number of hours.

Exception:

Four training files reviewed documented some required trainings were completed outside the 120 day requirement.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures in place for the Quality Improvement process. The program collects and reviews several sources of information to identify patterns and trends. The quarterly committee meetings include documentation from Quality Assurance, data entry reporting, human resources, facilities, finance, residential, clinical, and development.

It is the policy of YCC for staff to attend regularly scheduled staff meetings. Supervisor/ Designees will meet with their staff on at least a monthly basis. Analyzing and reports are pulled and generated monthly, quarterly, and yearly with upper management and the Quality Assurance staff. They pull multiple quality assurance reports through the year.

The program utilizes the Quality Improvement Council (QIC) notebook to compile aggregated data and meeting minutes. The information collected is used to identify strengths and weaknesses, improvements are implemented or modified. Staff are informed of all changes or modifications through monthly and quarterly meetings and memorandum of changes or modifications. All-Staff meetings are a venue for all staff to give input and receive information of programs and services.

There were no exceptions to this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures in place for client transportation. The program has a list of all approved drivers. The facilities department conducts bi-weekly inspections of all vehicles. The residential program has a total of four vans. All the inspections are documented on bi-weekly van checklist forms.

The ratio guidelines require one staff to six youth when transporting youth. The procedures list the following requirements for staff when transporting youth. The staff must ensure that the ratio of staff to youth are within the program's policy; same gender transporting youth, when possible; if same gender is not possible, the use of multiple staff of another gender, the use of other direct care staff such as a case manager, therapist or a relief staff of the same gender as the youth. Only approved agency drivers may transport clients in the program's vehicles. The program may utilize a third party (staff, volunteer, interns or other client) when transporting.

The agency has a bi-weekly vehicle check form that is completed, as well as, a yearly inspection every year. The staff follows the agency's

policy of one staff to six youth during transports with one staff being the same gender as the youth, when possible. If same gender is not possible, then they will use of multiple staff of the other gender. Only approved agency drivers may transport clients in the program's vehicles.

The vans are inspected annually by Motor Vehicle Safety Inspection Center of Duval County. All five vans contained a vehicle emergency response box which includes: the first aid kit, blood borne pathogen kit, fire extinguisher, and safety triangles. All of the vans have working seat belts, no broken windows, and seat belt cutter/window punch.

The program requires prior notification and approval by management for single client transport. The single client transport log was reviewed and documented all single client transports in the last six months, with supervisor approval.

There were no exceptions to this indicator.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program's staff participates in the local Department of Juvenile Justice board and council meetings representing CINS/FINS. They also facilitate the city's quarterly Nonprofit Advisory Council Meeting. The Youth Crisis Center maintains membership and attends several other community advocacy groups. The Chief Executive Officer/designee meets with other agencies and groups to establish informal linkages and written agreements. The agreements include other prevention/early intervention programs, medical, educational, Mental Health/Substance Abuse and recreational and leisure organizations. All agreements are maintained by the CEO. The program must utilize staff and materials to increase public awareness. Project Safe Place is a program designed to assist youth in crisis providing a safe place for youth.

Staff are to document request for presentations to all segments of the community that may need services and/or refer appropriate clients. Special emphasis is placed on DJJ target area to receive Outreach Presentations. They are to document Special Events forms and to forward the form to the Administrative Assistant if promotional items are needed 5 days to one week before presentation.

The YCC Quality Improvement Plan 2018 lists twenty-one community groups---Florida Network of Youth and Family Services, Changing Homelessness (Jacksonville's Emergency Services Homeless Coalition), United Way, DJJ Advisory Board, Jacksonville Children Commission, Jacksonville System of Care Initiative, Florida Department of Juvenile Justice's Bureau of Quality Improvement, Jacksonville Juvenile Assessment Center Board, Juvenile Detention alternatives Initiative, Nonprofit Center of Northeast Florida, Florida Department of Children and Families, Florida Department of Juvenile Justice Providers Meeting, National Safe Place, Clay County Action Coalition, Duval County Police Athletic League, Florida State University, Unversity of North Florida, Thaise Educational, Kids First of Fl, Yoga4Change, Catherdral Arts, Dignity U Wear, National Safe Place, JASMYN, and Homeless Coalition of St. Johns County.

YCC is also involved in professional groups such as the National Association of Social Workers and Society of Human Resources Management. Management staff attends community meetings and provide the community with information on the services provided by CINS/FINS. The program representative collects information regarding community needs and the ability of the program to meet these identified needs that influences both long and short-term planning priorities.

There are staff members designated to attend certain community meetings. The program maintains minutes and support documentation of staff representative participation in community meetings.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Youth Crisis Center (YCC) operates residential and non-residential services to provide CINS/FINS services. The youth shelter has residential therapists under the supervision of the Clinical Director. The Family Link program has eight Therapists and one intern. The agency routinely works with local colleges and universities to hire interns.

The program provides these services to non-residential services to Duval and metropolitan areas. The agency also provides these services in outer-lying counties that include Clay and Nassau. The agency also maintains on-going partnerships with local service organizations. YCC also maintains referral agreements to provide CINS/FINS services in the aforementioned Counties in the North Florida area.

YCC also performs Case Staffing meetings on an as needed basis to address identified problems and facilitate positive outcomes for both the youth and their family. The Case Staffing Committee can also recommend CINS Petitions to be filed in court to order chronic status offenders to participate in additional treatment services to assist and resolve serious non-delinquent issues.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC Operations Manual was last reviewed and approved on November 29, 2017. This indicator is addressed in section two of the manual "Centralized Screening and Intake".

The Operation Manual states that services are accessible by phone 24 hours a day, 7 days a week; the phone number is distributed through outreach and the local phone directory. YCC's residential program admits youth to the shelter who are runaway, throwaway/lockout, homeless, ungovernable, truant, and/or short term respite due to household circumstances that make the home unsafe for the youth to be there. YCC's Policy requires an initial eligibility screening within seven days of the client being referred. There is a process in place for intake services that include screening for eligibility, crisis counseling and information, and referral. Once the referred youth is deemed eligible for services, designated direct care staff complete intake paperwork and open the case for services. The six indicators are found on three different forms; Screening Form, Consent to Services, and CINS/FINS Shelter Placement.

A total of eight files were reviewed to assess the program's implementation of this indicator; four files were residential and four files were non-residential. Of the files reviewed, two were open cases and two were closed cases from each.

All eight files completed the eligibility screening either the same day as the referral for residential or within seven days of the referral for non-residential. All eight files covered service options, parent and youth rights and responsibilities, parent brochure (non-residential), and grievance procedures covered in the Consent for Services form, which were signed by the parent/guardian and child or included documentation of sufficient attempts/verbal consent by phone. The parent brochure (residential) and possible actions occurring through CINS/FINS involvement were covered in the CINS/FINS Shelter Placement form. All reviewed files reflected signatures by the parent/guardian and child or included documentation of sufficient attempts/verbal consent by phone. Out of the four non-residential files reviewed, one was referred to the case staffing committee for truancy. The case staffing committee recommended a CINS petition, but the case was closed due to lack of cooperation by DCPS, per documentation.

There are no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC Operations Manual was last reviewed and approved on November 29, 2017. This standard is addressed in section 2 of the manual "Centralized Screening and Intake".

The Operations Manual states that the assigned therapist is to meet with the youth and/or family to initiate the needs assessment, which is to be completed within 24 hours for residential and signed off by the Director or designee within 72 hours. For non-residential, the assigned therapist is to meet with the youth and parent/guardian to gather information to complete the needs assessment, which is to be completed no later than three face to face contacts following the initial intake and signed off by the Director or designee within seven days after completion. If the suicide risk component of the assessment indicates a positive response for suicide or homicide, it must be reviewed, signed and dated by a

licensed clinical supervisor or written by licensed clinical staff within 24 hours.

A total of eight files were reviewed to assess the program's implementation of this standard; four files were residential and four files were non-residential. Of the files reviewed, two were open cases and two were closed cases from each.

All four residential files reviewed had initiated and completed the needs assessment within twenty four hours from admission. All four non-residential files reviewed had initiated and completed the needs assessment within three face to face contacts. All eight of the needs assessments were completed by a Bachelor's or Master's level staff and signed off by a Licensed Supervisor. Two of the four residential files were reviewed by a Licensed Supervisor within 72 hours of completion of the assessment, and the remaining two files were signed off six days from the completion of the needs assessment. The four non-residential files indicated all assessments were reviewed by the supervisor within the designated seven day requirement of YCC. Two of the four residential files identified an elevated suicide risk; an assessment of suicide risk was completed on both youth and reviewed by a licensed therapist. None of the non-residential files identified suicide risk during assessment.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC Operations Manual was last reviewed and approved on November 29, 2017. This standard is addressed in section 2 of the manual “Centralized Screening and Intake”.

YCC's Operations Manual states that service plans (goal plans) are to be developed with the youth and family within twenty four hours of meeting with the therapist (residential) and no later than the third (3rd) face to face session (non-residential) following the completion of the assessment. The program procedure indicates that goal plans are individualized to each client based on the needs of the client/family as identified during assessment. Goal plans are developed and revised over time as indicated by presenting issues and potential completion of initial goals. Goal plans are to be developed no later than the third (3rd) face to face session for non-residential cases and twenty four hours from admission for residential cases. Residential goal plans are to be reviewed and signed by a supervisor within seventy two hours; non-residential goal plans are to be signed by the youth and parent or documentation of verbal agreement/attempts to reach them and signed by a supervisor within seven days. Goal plans are to be reviewed with the youth and family at each face to face session (residential) or every thirty days for the first three months (non-residential). If staff are unable to meet face to face with the youth and/or parent/guardian for review before their targeted date expires, phone attempts are to be made and documented. All referrals, case staffing recommendations and court orders are to be included on the goal plan.

A total of eight files were reviewed to assess the program's implementation of this standard; four files were residential and four files were non-residential. Of the files reviewed, two were open cases and two were closed cases from each.

All eight goal plans were completed within seventy two hours for residential cases and seven days for non-residential cases from the date of the assessment. All eight files had the following requirements completed: individualized needs and goals; service type, frequency, location; person(s) responsible; target date(s) for completion; signature of counselor; signature of supervisor; and date the plan was initiated. Four of the four residential files did not have actual completion dates, but this was due to the case still being active, goals not being met, and the youth being Baker Acted shortly after arriving. One of the four non-residential files did not have an actual completion date due to the goal plan's recent creation.

All non-residential files documented all thirty day reviews were completed as required. Three of the four residential files included client signature; the other youth was Baker Acted shortly after arriving. Four of the four residential cases did not have a parent/guardian signature; three of the four had sufficient documentation of attempts and the remaining youth was Baker Acted shortly after arriving. One of the four residential files documented goal review; one youth was released after two weeks; one was a newly opened case and a review was not yet indicated; and the final youth was Baker Acted shortly after arrival. Four of the four non-residential files documented a goal review.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC Operations Manual was last reviewed and approved on November 29, 2017. This standard is addressed in section 2 of the manual “Centralized Screening and Intake”.

YCC's Operations Manual states that case management is a process of service coordination where a therapist is assigned to follow the youth's case and ensure delivery of services through direction provision or referral. Procedures indicate the coordination and monitoring of goals, progress, out of home placement, referrals to the case staffing committee, recommendations of court intervention, accompanying youth/family to court hearings/related appointments, continued case monitoring/review of CINS court orders, and case termination with follow up with youth/family post discharge.

A total of eight files were reviewed to assess the program's implementation of this standard; four files were residential and four files were non-residential. Of the files reviewed two were open cases and two were closed cases from each.

All eight files showed evidence of established referral needs/coordination, coordination of service plan implementation, support provided to families, and case monitoring provided. The remaining indicators either did not apply due to residential and/or open status or the family ceased communication/participation after intake. However, one non-residential file indicator was found to be out of compliance for 60 day follow up; one phone attempt was made and ceased after documenting that the phone was disconnected.

Exception:

One non-residential file was out of compliance with 60 day follow up. One attempt was made and due to phone disconnection, attempts ceased. Upon confirmation from a representative of the Florida Network, it is a requirement to complete three attempts of the 30/60 day follow up. The lead therapist completed a training with nine therapists while on site to address.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC Operations Manual was last reviewed and approved on November 29, 2017. This standard is addressed in section 2 "Centralized Screening and Intake" and section 7 “Intervention Services” of the manual.

YCC's Operations Manual states that youth and families receive counseling services (residential and non-residential) to address the needs identified during the assessment process and to meet the objectives outlined on the goal plan in chronological progress notes. Non-residential counseling is to provide interventions necessary to stabilize and maintain an intact family unit, minimize out of home placements, and establish aftercare services to prevent delinquency and/or dependency. Group counseling is to be facilitated in the residential shelter at a minimum of five days per week by anyone approved by staff. An internal process is to be maintained to ensure clinical review of the client files, youth management, and service delivery of CINS/FINS services.

A total of eight files were reviewed to assess the program's implementation of this standard; four files were residential and four files were non-residential. Of the files reviewed two were open cases and two were closed cases from each.

All eight files received counseling services as indicated in their goal plan with the exception of the youth who was Baker Acted shortly after arrival and the family that ceased contact/participation immediately after intake. Goal plan reviews were completed for all eight files with the exception of the youth who was Baker Acted shortly after arrival and newly opened cases. Group counseling progress notes indicated sessions lasting beyond the minimum thirty minute requirement, a designated facilitator, psychoeducation, and youth engagement in question and answer. In an interview with a therapist, he indicated that he participates in weekly supervision of cases with the supervisor. In an interview with the clinical supervisor, she provided documents of weekly intern supervision, monthly Family Link clinical supervision, and monthly peer review of files.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC Operations Manual was last reviewed and approved on November 29, 2017. This standard is addressed in section 2 of the manual “Centralized Screening and Intake”.

YCC's Operations Manual states that therapists are to conduct ongoing review of goal plans to monitor for ungovernability, lack of progress in goal achievement, unavailable/or ineffective treatment, or refusal of family to participate in treatment. The therapist is to submit a request for the case to be staffed by the case staffing committee if any of the previously stated issues are present. The family is to be advised within five working days either by certified mail or a hand delivered letter that includes the date and place of the case staffing meeting with a request for

the youth and family's participation; a copy of the letter is to be placed in the file. The committee consists of a DJJ representative, youth, parent/guardian, a CINS/FINS representative, DCPS representative, and mental health.

A total of two files were reviewed to assess the program's implementation of this standard. Both files show evidence of an established case staffing committee process that meets all indicators. Letters were mailed within the required time frames before and after the case staffing committee meeting. One file was missing one notification; the supervisor was able to provide a copy to place in the file. The committee is reported to convene on Tuesdays once a month per interview with the clinical supervisor. Additionally, the clinical supervisor reported that they did not receive any requests from parent to initiate staffing.

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

YCC Operations Manual was last reviewed and approved on November 29, 2017. This standard is addressed in section 2 of the manual “Centralized Screening and Intake”.

YCC's Operations Manual states all youth receiving services will have a confidential file that will begin immediately following acceptance in the program and will be clearly stamped "confidential". All files are to be stored in a secured room or locked cabinet that is only accessible by authorized personnel. Any transported files are to be locked in an opaque carrying case and labeled as confidential.

Residential and non-residential client files were observed to be secured in filing cabinets secured behind a locked door; client files are organized by case status of open or closed and by therapist for non-residential. A confidential sticker was added to the filing cabinets while on site to match YCC Operations Manual. Interviewed staff reported that files transported off site for use are locked inside an opaque carrying case during transport. An opaque carrying case with a combination lock was observed during audit. A total of eight files were reviewed to assess the program's implementation of this standard; four files were residential and four files were non-residential. Of the files reviewed two were open cases and two were closed cases from each. All eight files were clearly marked "confidential" and were maintained in an organized manner.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

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

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy 3.01- Shelter Environment. The policy was last revised on 11/29/2017.

The staff will assist the Facilities Department in identifying disrepair and/or unsanitary conditions including but not limited to: furnishings are in good repair, the program is free of insect infestations, grounds are landscaped and well maintained, bathrooms and shower areas are clean and functional, no graffiti on walls, doors or windows. All sleeping quarters have: adequate lighting, bed covering and pillows, individual bed for each youth, and no extraneous cover, wire mesh, paper, cardboard, etc. installed over glass, windows, vents or sprinklers heads in sleeping area. In addition, staff may correct conditions and/or notify Facilities Department by completing a Maintenance and Safety Hazard Report/Request form. The original form is sent to Facilities Department.

During the tour of the facility, an inspection of the shelter environment was conducted. All findings meet the requirements of indicator. The Disaster Plan was reviewed and approved on 03/19/2018. The Fire Safety Inspection was completed on 01/18/2018 by Life Safety Designs Inc. The Fire Sprinkler System was last inspected on 01/10/2018 by Life Safety Designs Inc. The alarm system was last inspected on 01/18/2018. The Group Care-Child Caring Agency license was issued on 02/27/2018 and expires on 02/27/2019. The agency has a current DCF Child Care License valid through April 21, 2019.

During the facility and site inspection, furnishings were in good repair; program was free of insect infestations; grounds were landscaped and well maintained; bathrooms were clean and functional; no graffiti on walls, doors, windows; lighting is adequate; exterior areas are free of debris and hazards; dumpster and garbage can(s) covered. In reference to Fire safety and health Hazards, a staff was interviewed and was able to articulate the Fire safety and drill procedure. All annual fire safety equipment inspections are valid and up to date, Current Group Care inspection report is up to date, and a current Satisfactory Food Service inspection was signed by a Licensed Dietitian.

All cold food was properly stored and labeled. All dry storage/pantry area was clean and food was properly stored. All refrigerators/freezers were clean and maintained at required temperatures. All chemicals were listed, approved for usage, inventoried, and stored securely. Washer/dryer were operational and general area/lint collectors were clean. Each youth had their own individual bed with clean covered mattress, pillow, and adequate linens and blankets.

Youths are engaged in meaningful and structured activities seven days per week and allowed at least one hour of physical activity daily. They are also given an opportunity to participate in faith-based activities, and opportunities to complete any homework and/or quiet time allowed.

The reviewer also inspected all of the facility vehicles and all were equipped with major safety equipment including first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter, and air bag deflator etc.

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure 3.02- Program Orientation. The policy was last revised on 11/29/2017.

The procedure is to ensure youth are oriented to the program in a timely manner and youth is made aware of program rules, expectations, services provided, and youth is made to feel at home. Upon admission to the Residential program, staff will offer the client a Client Orientation

Handbook which includes: Disaster Preparedness Instructions, Search Policy, Identification of Key Staff and their Roles, Abuse Reporting, Youth Rights, Center Rules and Consequences, Medical/Dental/Mental Health Access, Dress Code/Personal Hygiene, Activity Schedule, Room Assignment, Facility Tour, Confidentiality Guidelines, School Attendance, Explanations of Individual/Family/Group Therapy, Review of Program Services, Temporary Release Procedure, Client Grievance Procedure, Client Suggestion Box, Visitation Policy, Telephone Guidelines, Letter/Postage Policy, and Suicide Prevention and Awareness.

The staff and youth will sign and date the Client Orientation form, which is located in client's file.

There were five open residential case files reviewed for this indicator. All reviewed files met the minimum requirements for this indicator. All of the five files reviewed, the youth received the orientation handbook within 24 hours, disciplinary action explained, grievance explained, emergency/disaster procedures explain, contraband rules explained, youth provided physical/facility layout map, room assigned, and suicide prevention process explained. The signature of youth and parent/guardian obtained, daily activity reviewed, and abuse Hotline provided.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure 3.01-Classification/Room Assignment. The policy was last revised on 11/29/2017.

The procedures ensure that all youth are interviewed upon admission to determine the most appropriate sleeping arrangement and to increase staff awareness of classification issues. The following is considered for room assignment: physical characteristics, initial collateral contacts, separation of younger and older youth, separation of violent youth from non-violent youth, Identification of youth susceptible to victimization, presence of medical, mental and physical disabilities, suicide risk, sexual aggression, gang affiliation, current alleged offense, delinquent history, attitude upon admission, and past involvement in assaultive behaviors.

Five residential open files were reviewed for this indicator. All reviewed files met the minimum requirements for this indicator. All off the five files reviewed, the room assignment was indicated on the admission form or indicated in the entry note or both.

The reviewer also interviewed staff who was able to articulate the policy and procedure regarding Room Assignment.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure 3.04-Log Books. The policy was last revised on 11/29/2017.

The procedure ensures that all documentation in the first column should consist of date and time. The contact code should be documented in the second column and a narrative explanation should be documented in the third column. The log book should illustrate extensive outlining of all the books codes and their meanings and staff should be diligent in using the codes on a consistent basis.

Two program log books (one current and one old) were reviewed for this indicator. Both log books met the minimum requirements for this indicator. Safety and security issues were documented, all entries were brief and legible, all incidents documented, any errors were struck through with "VOID" written over any mistakes, and supervisor/designated reviewer exceeds the minimum required one time per week review of the log book. Supervision and client count were all documented, including all visitation and home visits. All entries were documented in ink without any signs of erasures and/or white-out areas.

There were no exceptions for this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Youth Crisis Center has a policy in place that is designed to foster accountability and compliance with program rules, expectations and consequences. This policy was revised and reviewed on 11/29/2017 by the CEO.

Policy states that youth are given written handbook at admission that details the behavior management system and are provided with ongoing feedback concerning their behavior.

Youth Crisis Center's policy states that the agency uses a Behavior management system that is based on points that operates on a level system. Points are tracked and range from 0-104. Within the point system are 3 levels. They are as follows: Level 1 (0-61), Level 2 (62-74), Level 3 (75-104). The policy states that the behavior management system is explained to clients at orientation which details. It details how points are earned and based on the client's choices points will be earned accordingly. Policy states that points are tracked daily and posted daily in boys and girls day room each morning. Clients earn daily rewards which are activities based on their level. Policy also states that consequences are given on an individual basis and are determined based on the severity of the infraction.

Youth Crisis Center utilizes a behavior management system that operates on a 3 level point system. The levels are as follows: Level 1 (0-61), Level 2 (62-74), Level 3 (75-104). Client are provided with written and verbal details on program expectations related to the point system at orientation. Staff are trained on how to document and track client points. Reviewer observed client level system standing being displayed in the dayroom of the boys and girls dorm. Monthly calendar detailing daily groups and activities were also displayed in the same area. Clients engage in numerous activities based on their level standing including: TV, onsite activities (Level 1), Nintendo Videos games, DVD, radio (Level 2), extra phone call to authorize persons, X-Box, offsite activities (Level 3). Reviewer witnessed clients engaged in outside time where some were doing physical exercise and others were seating and talking. Other client activities include art classes, yoga, and a clubhouse with a pool table and TV. Clients are also taught social skills that relate to the behavior being addressed with extra points possible when they exceed expectations related to social skills.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Youth Crisis Center has a policy in place that to address staff schedule. Policy is designed to maintain a staff schedule to ensure coverage across shifts. This policy was revised and reviewed on 11/29/2017 by the CEO.

Policy states that the program maintains a 24 hour awake supervision of 1 to 6 staff to client ratio and community activities during wake hours and a 1 to 12 ratio during sleeping hours. Policy also strives to have one male and one female on shift when both male and female clients on housed in the program. Policy also states that youth are observed every fifteen minutes while in room when during such times as illness, reading writing or sleeping. Policy also states that staff will conduct ten minute observations for clients that are on risk supervision.

Agency procedures states that staff schedules are designed to ensure coverage is maintained at the proper staff to client ratios. The Shift supervisor or designee develops the weekly schedule which will be posted in the Youth Care Station and maintained for one year. Agency procedure also states that 15 minute checks are conducted during sleep time and every ten minutes for risk supervision and are documented in the sleep log or pro log. If possible checks will be conducted by the same gender staff member.

A random selection of days were conducted to measure adherence to this indicator. The pro log was reviewed, as well as, staff schedule for the last two months, and YCC staff sign in/out sheets for the last thirty days. Staff was found to have exceeded the ratio of staff to client ratio for most shifts. The program also has relief people indicated for 1st, 2nd, and 3rd shift on the schedule that can be called when scheduling issues occur. If issues still occur, supervisors can be called to assist with coverage. Agency does an exceptional job with having male staff on all shifts. During the last six months, the majority of shifts had a minimum of two males on staff with occasionally having three males.

Reviewer conducted a random selection of days in order to verify that fifteen minute bed checks were conducted within standard. Camera data was reviewed for Feb 28th. Bed checks were conducted at fifteen minute internals starting at 12:30am which matched the sleep log. Camera data was also reviewed for March 9th. Bed checks were observed starting at 2:30am and were conducted at fifteen minute intervals which also matched the sleep log. No issues noted within this area.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Youth Crisis Center has a policy for special populations. This policy was revised and reviewed on 11/29/2017 by the CEO.

This reviewer conducted a review of the following files for special population: two Sex Trafficking, two Probation Respite, four Domestic Violence Respite. Of the files reviewed, two were open to services. The agency did not have any staff secure cases during this reporting review period.

For Domestic Violence four files were reviewed, two open and two closed. Each file indicated having been screened at JAC Center and having a charge pending for DV. Each client had less then a twenty-one day stay. One file indicted a change from DV to CINS/FINS status after fourteen days which is the agency standard. The other three files did not require a change due to the length of stay. The case plan reflected goals related to reducing occurrences of violence in the home. These goals included anger management, coping skills to manage conflict in the home, and identifying ways to avoid conflict in the home.

The agency has served two Probation Respite youth in the last six months. Both of these files were reviewed. Agency provided documentation displaying that referral originated from DJJ with adjudication withheld. Each file documented a recommended length of stay. One of the files recommended a thirty day placement. The other was recommended for a fourteen day placement but client was baker acted after two days.

The agency has served two Domestic Minor Sex Trafficking youth in the last six months. Both of these files were reviewed. Agency provided written documentation in the progress notes that showed obtaining approval from Florida Network. Therapist was able to identify risk factors and behaviors that indicated possible victimization. The DJJ screening tool was used to help facilitate further identification of sex trafficking. Each client was assigned a one-to-one staff member to help maintain client in shelter while maintaining the safety of other clients in shelter. The assigned staff member was noted in the pro log at the beginning of each shift. Treatment plans contained goals including: helping client change risky behavior (running away and drug use), and coping skills. One of the Domestic Minor Sex Trafficking clients was placed on risk observation for suicide precautions and was baker acted twice during her stay.

Staff Secure-This reviewer requested files for staff secure during the last 6 month. Agency reported not having any staff secure clients within this reporting period. Agency does provide this service but it was not utilized during this review period.

There were no exceptions to this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Youth Crisis Center has a policy to address the agency's camera system. Policy states that the security system is in operation at all times. This policy was revised and reviewed on 11/29/2017 by the CEO.

Video surveillance system is used to monitor the safety of the facility as well as all staff interaction with youth, activities and events. Cameras are placed throughout the facility with written signs on the premise for security purposes. All cameras are placed in visible areas with the exception of bedrooms and bathroom.

Youth Crisis Center has sixteen cameras that are placed in highly visible areas where youth and staff congregate. There were no cameras in bedrooms or bathrooms. Signs are posted at the entrance of the facility to inform the public that cameras are in use. Signs were also placed in various common areas and hallways thoughout the interior of the facility. Upon review of video footage, it was noted that all images were clear and facial images were recognizable. The agency has three designated people that are able to review footage for third party reasons, as well as, for supervisory purposes. Supervisory reviews of video footage were conducted regularly, every three to four days, which exceeds the the fourteen day requirement. This was noted in the pro log. The System allowed for viewing of at least thirty days of data, with date and time stamp.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The agency conducts health and mental health screenings to determine eligibility and presence of current and past mental health status risks. In addition, the agency has an active suicide risk screening process. The agency also has numerous master level counselors that complete the assessment of suicide risk to determine the youth's level of risk.

The residential program uses a general alert board to inform all staff members on each shift of the health and mental health status of all residents. The agency provides assistance to all youth admitted to the program that require medication. The agency provides medication distribution training to select direct care staff members. The agency does provide all staff with first aid response, CPR, first aid, fire safety, emergency drills and exercises, and training on suicide prevention, observation and intervention techniques.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that is named Health Care Admission Screening. The policy was last reviewed and updated in November 2017.

The agency's procedure indicate the agency staff members must complete a physical health screening for all clients upon admission to the residential program. The screening information is located on the Admission form. The admission form requires staff members to ask screening questions and for evidence of acute health conditions and also conduct observation of evidence of any illness and/or symptoms. The form screens for a vast array of health issues and lists those accordingly.

Further, the procedures require that if the screening indicates the client has a health or mental health condition of a nature which render admission unsafe from a medical standpoint, the agency must take certain action steps to address the possible health issue. The procedure also requires that the agency include any positive answers directly into the client's progress notes. When screening is completed, the agency must refer to the sections on the medical follow-up and mental health alert processes for additional requirements.

Any client with visible pains or problems with sustaining program activity may be denied admission until medical clearance is granted and documentation is provided. The procedure also allows them the right to refuse a child for health-related issues due to the potential liability of the youth and others while in the program. Follow-Up policy requires that staff notify a shift supervisor of any youth that are admitted with specific conditions.

A review of five active client files was conducted onsite to determine agency's adherence to the requirements of this indicator. Each file contained evidence of a health screening form called a YCC Admission Form. This form is in subsection 6 under the Intake tab in the 3-ring client case file. All five client files had evidence that the Physical and Health Screening section was completed as required. All nine general health questions, as well as an additional nine health symptoms were documented as being completed.

All files were organized in a uniform manner. The RN reviewed all health screenings within two to three days of completion. The RN noted any concerns in the nurse's notes in the file. There were three youth on medications and the reasons for the medication were documented. One youth had allergies to seafood, that was documented as well, and entered into the alert system. One youth had asthma. There were numerous chronological notes documented by the RN, contacting the youth's parent to obtain a current inhaler or a doctors note stating the youth does not need the inhaler any longer.

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that is named Mental Health, Substance Abuse, Suicide Risk Screening. The policy was last reviewed and updated in November 2017.

The policy is a written description that includes a plan for mental health/suicide risk and substance abuse screening, a Risk alert process, mental health and substance abuse services, suicide prevention procedures and mental health, crisis intervention and emergency response

procedures for clients in need of these types of services. The governing principle of the policy is to ensure that prevention and intervention methods are applied to the children in care by agency staff members through in-depth procedures on how to prevent crisis. This review of the policy found that the agency's policy in this area meets the general requirements of this indicator. The agency's suicide assessment has been approved by the Florida of Youth and Family Services.

The second section is titled one-to-one supervision. The agency has a total of three levels of supervision. The first level of supervision is called standard supervision. The second level of supervision is called sight and sound supervision. The third level of supervision is called one-to-one supervision. Sight and sound supervision requires the resident to be within the sight and within sound of staff at all times. One-to-one supervision requires that the resident be no less than 5 feet of an assigned staff member at all times.

The agency is required to screen 100% of all residents admitted to both the residential and non-residential CINS/FINS program. The agency is required to train all direct care and counseling staff to screen all admitted clients for any past or current suicide risks. The agency screens for suicide risk primarily through the use of two agency forms. These forms are called the Screening Admission Form for Residential Clients and the Needs Assessment for Non-Residential Clients. Other associated forms for suicide risks include the Observation Log, Follow-Up Assessment, Client Safety Contract, and Request for Discontinuation of Suicide Precautions and Observation Form. All youth are required to be screened no later than 24 hours after being admitted to the shelter. All assessments are to be completed only by counselors under the supervision of a licensed clinician. All assessments must be completed no later than 72 hours from the screening.

A review of six randomly selected client files was conducted by the reviewer. Of the files that were viewed, a total of five were open cases and one was closed. Each file reviewed contained a yellow intake form that contains the Risk Screening section to assess the past or presence of suicide risk.

There is evidence of completed intake forms. The forms are completed by direct care staff and reviewed by a supervisor. All six cases had evidence of a completed risk screening that indicated a positive result for either sight and sound status or one-to-one status. All six files contained screening results that were reviewed and signed. A total of five cases had evidence that the resident was placed on sight and sound. One youth was placed on one-to-one supervision status.

All six cases had evidence that clients had been placed on observation checks in a timely manner. Observation checks contained evidence of timely checks being conducted by direct care staff that included observations of the time, behavior, and initials of staff member conducting the check within the required time period of thirty minutes or less intervals. The agency completes observation checks every fifteen minutes during the awake hours and every ten minutes during sleeping hours. Observations in the agency Pro Log of each client being placed on sight and sound or one to one supervision status are documented. In addition, times when youth were removed or discontinued from the original placement status were also found.

All six client files reviewed contained documented evidence of each assessment being completed by a Masters level staff member under the supervision of a licensed clinician. Each person had twenty hours of assessment training under the supervision of a licensed clinician.

Each client file review had evidence that the established supervision level had not changed or been reduced until a licensed professional or non-licensed under the supervision of a licensed professional completing the assessment reviewed it. The agency has Discontinuation of Risk Level form that is used to either step down or remove the client from their current supervision level.

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Medications. The policy was developed to provide a safe, secure and effective medication distribution process and system that includes storage, access, inventory, and disposal of medication. Policy was last reviewed and updated in November 2017.

The agency has a procedure that outlines how the agency will execute the process of safe storage, access, inventory, and disposal of medication. The agency requires all medications to be stored in the Pyxis MedStation 4000 medication cabinet. The agency must store medications and ensure that they are not accessible to residents of the residential group care facility. The agency must maintain a minimum of ten trained key staff to use and operate the Pyxis medication cabinet. The procedure also requires medications to be stored separately from topical medications. The agency must also have a refrigerator where they can store medications that require refrigeration in a secure manner. Medication must be stored behind two locks. Any sharps must also be secured in the designated area. Access to medication must be limited. Medication inventory must be conducted every shift for controlled medications. All other medications including prescribed medications must be counted on the medication form by the third shift on the dates designated in gray area on the medication form. Perpetual inventory must be documented and maintained when given.

Documentation of medication distribution must be made on the medication log. Periodic medication inventory counts must be initialed by Tuesday. The agency must conduct weekly inventories of sharps and all non-controlled prescribed medications. Sharps must be counted once a

week. Over-the-counter medications may also be counted once a week.

Non-controlled prescribed medications must be documented daily in the medication form by the third shift on the dates designated by the light gray areas on the form. Documentation must be marked for each time a medication is given as well as once a week on the third shift.

Medication disposal must also be conducted once a child is discharged and the child's parent or guardian fails to take custody of the child's medication. The agency staff must document that following the discharge, any and all attempts to contact the parent/ legal guardian to pick up the medication. Medication that has not been picked up for seven days from the client's departure must be disposed of. There must be a witness to the disposal. All disposals must be conducted by a manager and a witness to conduct and document inventory of the medication being disposed of. Disposal of the medication is to be done by flushing the medication down a staff toilet.

Policy also includes steps to distributing medication by appropriate staff. All medication must be documented on the medication distribution mark form. Staff must document missed client's medications. Staff must report all refusals and/or missed medications and/or medication errors to the Florida Department of Juvenile Justice’s (DJJ) Central Communication Center (CCC).

Medications are stored securely in a locked room inside a locked Carefusion Pyxis Med-Station 4000 medication cabinet. All medications in the shelter were found to be stored in the MedStation cabinet. The cabinet is not accessible to the residence unless they are accompanied by an authorized staff person. The room is only accessible with a key. All medications including controlled, prescribed, and over-the-counter medications are stored separately. All medications are stored in their own cube in a medication cabinet drawer that is inside the medication cabinet. Over-the-counter medications are stored in drawer one and regular prescription and controlled medications are stored in drawer two. Medications are verified at admission. Staff will call the pharmacy to verify the medication and the RN will review the medication the next time on-site.

The facility does have a medication specific refrigerator. All medications that require refrigeration are stored in the secure refrigerator. There is a thermometer located inside the medication specific refrigerator that reads the temperature is between 36 and 46°F for storage purposes.

The agency has two Registered Nurse’s (RN). One RN is on-site Monday thru Friday from approximately 7am until 9am. The other RN is on-site every other Saturday and every Sunday and can come in the evenings if needed. An RN will distribute all medications when on-site.

The agency provided a list of twenty-five staff who are trained to supervise the self-administration of medications. There are eight Super Users listed, including both RNs. There is a Super User always on-site. The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. This is a very thorough training, which includes the staff being given fake medication containers and having to input all the information correctly in the Pyxis Med-Station. The RN also completes on-going trainings with staff on various health related topics. A monthly training calendar is completed which documents at least one training by the RN each month for staff. The RN also does health education training with the youth.

The shelter has different alert processes in place to ensure youth are given medications at prescribed times. There is an alert board in the medication room that documents all the times medications are to be given. There is also an alert board in the supervisors’ office that documents all the youth in the shelter, if they are on medication, times to be given, and any other alerts the youth may have. In addition, the shift supervisor has an alarm on the supervisors’ phone that goes off every time a medication needs to be given.

All medication is stored in the Pyxis Med-Station. Regular prescription/non-controlled medications are stored in drawer two. Controlled medications are stored in the third drawer of the Med-Station. Drawer four is used for over-sized medications. Medications are verified at admission usually by the RN; however, if the RN is not present for the admission the staff will call the pharmacy to verify the medication.

There are weekly and monthly reviews of the medication management practice. The agency is familiar with the Carefusion Knowledge Portal and process in which to produce instant reports. The RN’s and supervisors review the Knowledge Portal on an as needed basis to review the trends for medication distributed in the last month, quarter, and other designated periods of time. The RN will also use the knowledge portal to access different reports and information anytime there is a discrepancy noted. The shelter has very few discrepancies and staff are aware that all discrepancies must be closed out by the end of the shift.

All controlled medications are counted three times a day. All shift-to-shift counts must be conducted with a witness and include one person coming off a shift and one person coming on a shift. Each person was found to have documented shift-to-shift counts as required. All medication is stored in its own cubicle in the drawer and the drawer was accessed as required to verify this requirement. Perpetual inventory with running balances were documented for all controlled substances.

A review of a total six open client cases found that all client files included confirmation of verification of medication. All six client files had evidence of medication logs that had all sections completed. All six files contained client pictures, parent consent forms, medication information, and side effects information. The client sharps log captured evidence of weekly reviews of sharps. The sharps are also counted each day on the third shift. The onsite medication documentation process in the medication logs used by the agency meets the requirements of the Florida Network of Youth and Family Services medication management policy.

There have been no CCC reports in the last six months relating to medication errors.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on the Medical and Mental Health Alert System. The policy was last updated in November 2017.

The policy includes information related to the youth's medical condition that include allergies, common side effects of prescribed medications, food and medication and conditions or other permanent treatment information. The goal of the policy is to ensure that staff are provided sufficient information and instructions that provides the opportunity for them to recognize and respond to the need for emergency care and treatment.

The procedure requires all staff to be trained to conduct a physical and mental health screening using the admission form at the time the client enters the program. The staff policy indicates that staff member must alert all other staff on any client with a physical medical or mental health concern. Staff can document in the file and in the professional log.

Staff are required to use codes. Staff can highlight special needs as well. Staff can use initials for special needs. Staff can alert others by using the code on the census board to indicate a client has a special needs condition. If the client does not have a special-needs condition, there is no marking to be used on the general alert board. The client general alert board is also called the census board.

In general, the staff are to indicate conditions that include medication, any general allergies, any food allergies, or medical conditions. Clients are also required to document any high risk for suicide. It is a part of the alert process. All staff are required to be trained in CPR, standard first aid, signs and symptoms of mental health conditions, substance-abuse, proactive intervention, and crisis intervention and risk assessment. These trainings require staff to know how to recognize and respond the need for various types of emergency care.

There were five open residential files reviewed. Of the five files, all files contained the required screenings related to medical, health, mental health, allergies, food allergies, and/or any type of behavior or mental health risk. All client files were found to be organized in a clear manner and all risks associated with each client were clearly identified and marked. Three clients were on medication and those alerts were documented on the agency’s alert board. One youth had an allergy to seafood and one youth had asthma. Both those alerts were also appropriately documented on the alert board.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy related to episodic emergency care that was last was reviewed and updated in November 2017.

The policy was developed and used in their processes and procedures that are in place for episodic emergency care so staff can adequately respond to routine and non-routine care. The policy provides a process for providing emergency care that includes training to staff, awareness, and proper response for various types of emergency situations. The policy was last reviewed by the agency and signed in March 2017. The agency has made no major changes to the policy since the last review occurred in May 2016.

The agency's procedure requires that they have specific equipment that includes first aid kits and emergency equipment. The agency must also conduct emergency drills. The agency must also post emergency numbers. The agency must also be prepared for any type of episodic emergency that can occur on a daily basis that includes severe physical pain, acute dental pain, and conditions in which the severity of the illness or injury is known. The agency is required to provide basic first aid and to intervene and provide an appropriate emergency transfer when indicated.

The agency is required to maintain an episodic or first aid/emergency care log. The agency is to provide emergency care by calling 911. The agency is to be prepared to provide CPR. The agency is required to notify the parent or guardian of the situation and where client was transported to receive medical treatment outside of the agency. The agency is required to report the incident and record on the internal accident/incident report form. The agency is also required to inform all staff of environmental stressors that include inclement or severe weather.

All staff have current training in CPR/First Aid. There are first aid kits located in the supervisor office area and in all four vans. A review of the kits revealed they were all fully stocked with no expired contents. The contents of all the kits are checked on a weekly basis. The knife-for-life and wire cutters are located in a box in the supervisor work area.

The shelter maintains an Episodic and First Aid Emergency Care Log. There have been five instances of episodic care which required the youth being transported off-site for emergency care. Those five incidents were reported to the CCC. All five incidents were documented in the Episodic and First Aid Emergency Care Log. All incidents documented all applicable parties were notified. An internal incident report was completed for all incidents. Incident reports included a very detailed description of the event also including the page number the incident is documented on in

the pro log. It also included a supervisory review of the report and the event. The follow-up instructions/care from the hospital were attached to all five reports. All five incidents were also found documented in the logbook.

The shelter has completed twenty-five emergency drills in the last six months, on various shifts at various times of days. Some were mock drills and some were actual events. All drills included an Observation of the Event and a Critique/Follow-up/Corrective Action.

There were no exceptions to this indicator.