



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Orange County Youth and Family Services
Residential Program

May 15 - 16, 2019

Compliance Monitoring Services Provided by

 **FOREFRONT**



Quality Improvement Review

Orange County Youth and Family Services – May 15 – 16, 2019

Lead Reviewer: Ashley Davies

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	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 & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 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	Satisfactory

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%



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Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewer

Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Kamille Payne, Regional Monitor, Department of Juvenile Justice

Alex Culbreth, Residential Counselor, CDS

Erik Kline, Residential Supervisor, Family Resources

Tiffany Martin, Project Manager of Research and Operation, The Florida Network



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Strengths and Innovative Approaches

Non-Residential

Family Counseling celebrated the inception of the Florida Network S.O.G.I.E policies by decorating the office during Pride Month. The program added posters to the client lobby area welcoming all youth and families without regards to gender, sex, sexuality, race, or religion.

The program attended the 10th Annual Human Trafficking Awareness day at Calvary Church.

Family counseling, along with other non-residential programs within Orange County, are in charge of Persons with Special Need (PSN) shelters for disasters. They have created an instructional video on how to respond to a PSN shelter during a hurricane.

The program participated in QIC meeting in March 21st – 23rd where two staff members were trained as peer reviewers.

After the attack on Marjory Stoneman, Douglass High School Family Counseling created a non-residential harm to others questionnaire to identify clients who may have ideations of harming others. The Florida Network acknowledged that Orange County has spearheaded the questionnaire as the Network looks to create a statewide policy.

Family Counseling is on pace to service 115% of contract requirement youths.

Residential

FACILITY UPGRADES

New bedroom furniture

Replaced several light fixtures throughout the building

Existing you-tube website with virtual tour of the Youth Shelter.

Revitalized the Counseling Corner for trauma focused relaxation

Campus wide alert system

STAFFING

Two staff resignations: Caseworker and Administrative Specialist



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Four new hires: Residential Services Counseling Supervisor, Children's Services Counselor, Caseworker, Sr. Children's Services Counselor.

No staff vacancies

CLINICAL SERVICES

Devereux and the Health Department continue to provide educational group sessions that discuss prevention/intervention health services.

The program has made improvements to the behavior management store and revamped the positive reinforcement system. The use of 'decision dollars' continues to increase positive behaviors as youth are able to shop for items that trigger their interest.

The program has new behavior management groups including smaller individual groups with staff to encourage more staff/youth interaction that will reduce youths' negative behavior.

Clinical Supervisors have provided over 1000 hours of supervision for interns.

There is more focus on Family Counseling participation.

They have one licensed Counseling Supervisor and three registered mental health interns.

The program utilizes morning and evening motivation (Hakuna Matata), Wellness card personalized with to-do list encouraging success in different domains, and a create your own toolbox with vision board and canvas to take home.

The program provides daily psycho-educational groups by counselors and volunteers covering topics from internet safety to conflict resolution.

COLLABORATIONS WITH COMMUNITY PARTNERS

One of the pilot sites for the Adolescent Domestic Battery Typology (ADBTT) with three staff as certified trainers.

The human trafficking committee have implemented human trafficking backpacks to hand out.

LEARNING CENTER

Extended school year that included summer school sessions, 100% of eligible youth successfully completed school services. Teachers work to ensure that specific academic plans are tailored to students.



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School field trips and other off campus activities include several college and technical school tours.

In recognition of child abuse month, a beautiful pinwheel garden was created in front of the shelter. The children and staff celebrated with group activities and an ice cream truck was available to serve the children.

Standard 1: Management Accountability

Overview

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; cardiopulmonary resuscitation (CPR); and referrals.

1.01 Background Screening of Employees/Volunteers

Satisfactory Limited Failed

The agency has a policy titled Background Screening that addresses the requirements of this indicator. The policy was last reviewed on July 30, 2018 by the Program Manager.

Orange County conducts preliminary background screenings and driver's license checks on all employees, interns, ad volunteers prior to their official start date and requires a favorable final screening to obtain/maintain their employment. All screenings and re-screenings will be through the Clearinghouse. Guest speakers, guest performers, ministers or other personnel who visit occasionally or who interact with youth on an intermittent basis for less than 10 hours per month and no more than once per quarter and are under constant and direct supervision of background screened personnel will not need to have a background screening. All staff will be re-screened every 5 years after date of hire. This date will remain consistent throughout the employees' career. It is the responsibility of the Program Manager to ensure all background re-screenings including law enforcement checks are conducted within the program time frame.



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The Program Manager will ensure that all employees who will work during the calendar year are to sign the “Affidavit of Good Moral Character” in January of that year. The Program Manager or designee will then complete an Affidavit of Compliance and submit it to the Office of the Inspector General no later than January 31st of each year.

There were nine staff hired since the last on-site quality improvement review requiring a background to be completed. All nine staff documented a background screening was completed prior to the employees hire date. The agency also completes a local criminal history record check and an FDLE sexual offender and predator check on each employee prior to hire. There were four staff who required a five-year re-screening during this review period. All four staff documented a re-screening was completed prior to the employee’s anniversary date. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening unit (BSU) on January 7, 2019, prior to the January 31st deadline.

The agency completes a pre-employment suitability assessment on all new hires. The assessment used is called Criteria. There were five new staff hired since August 2018 and all five staff had a copy of the completed in their personnel file. All five employees were rated by the assessment as either a medium or high candidate for the position they were applying for.

Exceptions:

No exceptions are noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

The agency has two policies titled Abuse Reporting and Abuse Free Environment and Grievance Procedure that address the requirements of this indicator. Both policies were reviewed on July 30, 2018 by the Program Manager.

All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Registry. If a client wishes to file a report, they will be permitted to do so by telephone without obstruction. The number is posted throughout the facility. If abuse is reported to have occurred at the facility it is reported immediately to the Florida Abuse Hotline and the CCC must be notified within 2 hours of receiving knowledge of the incident. Staff is expected to report all incidents of suspected or known abuse, abandonment, or neglect, or if a child is in need of supervision and care because they have no legal guardian or responsible adult relative to the registry. Following the report,



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the staff is to immediately notify his/her supervisor of the call and the circumstances of the allegations. All reports are to be documented in the client file, the program logbook, if applicable to the Florida Network, and an incident report must be completed, and management must be notified.

The Orange County Youth Shelter mandates that all employees participate in training annually on indicators of abuse, abandonment, and neglect. The Program Manager or designee, immediately responds to and takes the appropriate action to address incidents of physical and/or psychological abuse and incidents of verbal intimidation, use of profanity, and/or excessive use of force by youth shelter staff.

Youth and staff believe the environment is free of physical, psychological, and emotional abuse. The youth are not deprived of basic needs such as food, clothing, shelter, medical care, and security.

The Youth Shelter Caseworker or designee informs youth of the grievance process during the intake process. Youth have full access to grievance forms and staff cannot deny the residents the right to file a grievance. Youth are allowed, in writing, to grieve any situation they feel violates their client rights. When completed, the youth may place the form in the grievance box located outside the control room. The Program Manager or designee will check the box once a day. The Program Manager or designee will then meet with all parties. The Program Manager or designee's decision is final.

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. There were nine staff training files reviewed, all staff were trained in child abuse reporting procedures. 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 binder for all Behavioral/Information Reports which includes all Child Abuse Hotline 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. There are grievance forms available to the youth at any time, along with a locked grievance box, located outside the staff control room for youth to submit the grievances.



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There have been no grievances submitted by any youth since the last on-site quality improvement review.

There were four youth surveyed. All four youth reported they knew the Abuse Hotline was available for them to call if they wanted, however, all four stated they have never needed to make a call. All four youth stated staff treat them professionally and they have never heard staff use threats or intimidation on them or any other youth. All four youth felt safe in the shelter.

There were four staff surveyed. All four staff reported they have been trained on abuse reporting and all reported they were aware they needed to report any suspected abuse to the Abuse Hotline. All four staff reported they have never heard a staff deny a youth access to the abuse hotline. All staff reported they have never heard another staff use inappropriate language in front of the youth.

Exceptions:

No exceptions are noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

The agency has a policy in place titled Incident Reporting and Risk Management that addresses the requirements of this indicator. The policy was last reviewed July 28, 2018 by the Program Manager.

All Youth Shelter Staff are required to immediately notify supervisory staff, law enforcement, and/or the Department of Children and Families, and the Abuse Hotline, and/or Central Communication Center (CCC) of certain types of incidents. The reporting staff member is required to complete a detailed incident report. All attempts to make appropriate notifications and contacts are to be documented on the Incident Report. All CCC reportable incidents are to be reported within 2 hours of the incident.

The program had seven Central Communications Center (CCC) reports in the last six months. Out of the seven reports: three reports were court ordered youth who absconded, two reports were youth requiring off-site medical care, and two reports involved a behavioral incident. All seven 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. All seven reports were closed out successfully by the CCC. All CCC reports were reviewed



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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.

Exceptions:

No exceptions are noted for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

The agency has a policy in place titled Training Requirements that addresses the requirements of this indicator. The policy was last reviewed on July 28, 2018 by the Program Manager.

All first-year employees in a CINS/FINS program are required to complete 80 hours of training relating to their job. After the first year of employment, the Youth Shelter ensures that all staff receives a minimum of 40 hours of training annually of which 24 hours must be job related training. Required trainings are listed that are to be completed during the first 120 days of employment, during the first year of employment, and after the first year of employment. There is also a list of trainings that must be completed on DJJ-Skill Pro. It is the responsibility of the employee to make sure their annual training requirements are met. It is the responsibility of the Senior Youth Care Supervisor to monitor employee training files and to document the number of staff in need of supervision to meet their training requirements.

There were nine staff training files reviewed. One of the nine files was reviewed for first year training requirements. There were no other files to review for first year training as the staff were all newly hired and had just begun the training process. The one file reviewed was a staff hired September 24, 2018 so this staff still had approximately four months left in their training cycle. This staff documented 103.5 hours of training so far. However, there were four trainings the staff did not receive in the first 120 of employment, CPI, Suicide Prevention, CINS/FINS Core, and Understanding Youth/Adolescent Development. Three of those trainings the staff did receive outside the 120-day requirement and one training, Understanding Youth/Adolescent Development, the staff still has not yet received. This staff has three additional trainings left to receive that are required during the first year of employment and has approximately four months to receive these trainings.

The remaining eight files were reviewed for annual training requirements. The training cycle reviewed was from 7/1/2018 through 6/30/2019, so all staff still have



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approximately one and a half months left in the cycle to receive all required trainings. Five of the staff have already documented more than the required 40 hours of annual training. The remaining three staff still need one hour, one and a half hours, and fourteen hours of training to meet the 40-hour requirement. Two staff have already documented all required trainings have been completed. The remaining six staff still need between one and three required trainings. All staff are on track, with a training plan in place, to receive all required trainings and hours by June 30, 2019.

All staff training files are maintained in individual folders. Each folder contains a training plan, documenting all trainings that have been completed, as well as hours, and a training calendar for the current training cycle. There is also a Participation in Training form completed for each training documented in the file. This form documents the employees name, date of training, title and description, name of trainer, agency providing the training, location, and the employees signature. In addition, there is also a certificate of completion, certification cards, and any other supporting documentation for each training documented in the employees file.

Exceptions:

No exceptions are noted for this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

The agency has a policy in place titled Program Reviews that addresses the requirements of this indicator. The policy was last reviewed June 1, 2018 by the Program Manager.

Quality Assurance conducts the quarterly program reviews, which evaluate 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 Manager for Quality Assurance schedules the dates for the program reviews with the Program Managers in the quarter in which the review is to occur.

Each program reviews their own programmatic files on an on-going basis. Additionally, the Program Manager for Accreditation and Quality Assurance completes internal reviews of randomly selected open and closed cases during the review period.

Quality Assurance examines risk management issues as part of the quarterly program review to assess the overall risk to clients served, the programs, the division and



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Orange County. Program Managers conduct and document quarterly risk management reviews using a risk management template.

All grievances or incidents involving persons served or program staff members will be evaluated as part of the quarterly program review by the Program Managers or Senior Program Managers.

The Service Verification review consists of a review of the written verification of client services and satisfaction that is compiled on a quarterly basis by each Program Manager.

The program had three quarterly case file reviews conducted in the last nine months. The case file reviews included a review of twenty 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 time frame, 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. Risk management issues and results from quarterly reviews are discussed at every monthly Supervisor meeting and then also discussed with all staff at the monthly staff meetings. Meeting minutes from the supervisor meeting and the all staff meeting for the last six months were reviewed and documented a review of all risk management issues and any corrective actions, if needed.

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, and satisfied families/youth obtained data on satisfaction survey.



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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.

Exceptions:

No exceptions are noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

The agency has a written policy in place that addresses all the key elements of indicator 1.06 Client Transportation. The policy was last reviewed and revised on July 28, 2018 by the Program Manager.

The agencies procedures state that the Youth Shelter ensures proper procedures are followed when transporting clients and or residents. Program Managers or their designees will ensure program and employee compliance with the following:

1. Employees transporting residents or clients must have a valid Florida Drivers' License per County Policy and Division SOP and are covered under company insurance policy.

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2. Employees must only transport clients in County issued vehicles. Transportation of clients in their personal vehicles is prohibited for any reason.
3. Employees transporting residents or clients cannot exceed the contractually required ratio of 1:6 in the vehicle. The vehicle passenger limit must also be maintained.
4. Employees are prohibited from transporting any persons in County vehicles who are not County employees, volunteers, residents, or clients.

Employees are to conduct safety checks of all County vehicles before transporting clients as indicated in the Vehicle Use and Maintenance Procedure and all passengers will use safety restraints (seat belts). Documents of the use of vehicles will include name or initials of the driver, purpose of travel and location, date, time, mileage and number of passengers.

When available, additional staff will assist with transportation. Employees prohibited from transporting a client of the opposite sex, without maintaining at least one other passenger in the vehicle during the trip. Exceptions to the procedure regarding transporting clients of the opposite sex must be approved by the Senior Program Manager, Program manager or designee, who will use the criteria below prior to granting approval:

1. No other reasonable alternative exists
2. The client's evaluations, history, personality, recent behavior and length of stay in the program indicates no inappropriate behavior is likely to occur.
3. The transporting employee's work performance and history, length of employment indicates no inappropriate behavior is likely to occur.
4. Travel is not outside Orange/Osceola Counties.

If approval is granted the following must occur:

1. A trip plan is completed
2. Transporter shall check in by cell phone at agreed upon intervals
3. The employee check-in shall be documented
4. Driver with concerns regarding safety shall keep an open phone line with the shelter

The agency has implemented a transportation policy with drivers approved by administrative personnel. The policy does prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip. If a 3rd party cannot be obtained for transport, the agencies supervisor or managerial personnel takes into consideration the client's history, evaluation, and recent behavior. There is also supported documentation that the program supervisor is aware prior to transport and consent is documented accordingly. There were 43 incidents during the review period where agency staff completed a single transport. All 43 incidents have



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documentation stating the destination, mileage, time of arrival, arrival check time, open line and who received the call, departure check time and who received the call, shelter arrival time, and signature of the person who reviewed the documents along with the supervisor who approved. Third parties are an approved volunteer, intern, agency staff, or other youth. There is documentation of use of the vehicle that notes the driver's name or initials, date and time, mileage, number of passengers, purpose of travel and location.

Exceptions:

No exceptions are noted for this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

The agency has a written policy in place that addresses all of the key elements of indicator 1.07 Outreach Services. The policy was last reviewed on July 28, 2018 by the Program Manager and was last revised on June 22, 2010.

The Youth Shelter actively seeks and participates in the development of community partnerships and collaboration to enhance and coordinate an integrated service delivery system and encourage early referral and assessment for the public. The Youth Shelter has established outreach activities, written agreements, and informal linkages with other entities. The interagency agreement includes a focus on Medical, Educational, Mental Health and/or Substance Abuse, Prevention/Early Intervention Programs, and Recreation and Leisure Activities. Outreach activities will be site specific. A specific staff will be designated to attend the outreach function. Activities include dissemination of printed material, presentations to audiences from low-performing schools, and prevention programs to neighborhoods where juvenile crime is high. The program works to increase community awareness in substance abuse, 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 regularly attends Outreach Services on an on-going basis. The agency is a member of the local Circuit 9 Juvenile Advisory Board. A representative of the agency attended the Advisory Board Meeting on 11/7/18, 1/9/19, and 3/13/19. All of which have minutes for review and evidence of attending the meetings.



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The agency attends monthly meetings with the Children’s Cabinet of Orange County. The attended dates during this review period include 1/25/19, 2/22/19, 3/29/19, and 4/26/19. All of which have minutes for review and evidence of attending the meetings.

The agency attends the Children and Family Service Board meetings. Meetings were attended on 2/25/19 and 12/3/18. All of which have minutes for review and evidence of attending the meetings.

There were thirty outreach activities documented in the last six months which include local schools, Devereux, Guidance Counselor Committee Meetings, Community Centers, Homeless Service Network of Central Florida, Human Trafficking Events, Orlando Youth Empowerment Summit, and Snap Outreach.

Exceptions:

No exceptions are noted for this indicator.

Standard 2: Intervention and Case Management

Overview

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. Ten 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 two Children's Services Counselors. The Program Manager and Counseling Service Supervisor are both Licensed Clinical Social Workers (LCSW). Two of the Senior Children's Services Counselors are Registered Mental Health Counselor Interns (RMHCI), one is a Registered Clinical Social Worker Intern (RCSWI), one is a Licensed Mental Health Counselor (LMHC), one is a Licensed Clinical Social Worker (LCSW) and a Certified Wellness and Health Coach, and the last one has a master's degree. One of the Children's Services Counselors has a master's degree and one has a master's degree.

2.01 Screening and Intake

Satisfactory

Limited

Failed

The agency has two policies in place titled Twenty-Four Hour Access to Services and Intake and Assessment Process of Youth that addresses the requirements of this indicator. The policies were last reviewed by the Program Manager on July 28, 2018.

The Youth Shelter is open for business 24 hours a day, every day of the year. In addition, the Youth Shelter provides access to a 24-hour national runaway hotline. The purpose of the 24-hour phone access by Youth Shelter staff is to screen calls for eligibility, determine severity of the current issues, and make appropriate referrals. Placement at the shelter is not considered appropriate. Supervisory staff is on call 24 hours a day via cell phones provided by the county for consultation purposes.

The Youth Shelter Caseworker or other assigned staff will complete a screening form via telephone or in person for each youth referred to the Youth Shelter to determine eligibility, crisis counseling, information, referral, and appropriateness for services. The screening begins the intake and assessment process. The youth and legal guardian will receive in writing service options, rights and responsibilities of youth and guardians, a



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handbook that includes the grievance process, and information about the CINS services (case staffing committee, petition, and adjudication). An initial intake assessment and admission process consists of multiple forms and information provided to the youth and guardians, including, but not limited to; client rights and responsibilities, release of liability/voluntary placement and youth shelter handbook.

A total of ten files were reviewed. The files reviewed consisted of five Residential files, two open and three closed; and five Non-residential files, three open and two closed. All ten files documented that contact was made within seven calendar days from the date of referral.

During intake, the youth and parents/guardians received a copy of the CINS/FINS services brochure that describes the case staffing committee, CINS petition process, and CINS adjudication. Additional material provided to the youth and family were regarding consent to treatment, client rights and responsibilities, grievance procedures, service availability options, and notice to privacy practices. All ten files reviewed documented receipt of the materials at intake, as evidenced by a signature from both the youth and the parent/guardian.

Exceptions:

No exceptions are noted for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

The agency has a policy in place titled Assessment Process and Service Plan that addresses the requirements of this indicator. The policy was last revised on July 1, 2014 and approved by the Program Manager on July 28, 2012 and last reviewed on July 28, 2018.

The procedure details the process for staff to follow for the completion of the Needs Assessment and states that the Needs Assessments should be initiated within 72 hours of admission to the program. Procedures also state that service plans are initiated at the face-to-face intake. The assessments are to be initiated within the required time frames and all Needs Assessments include a suicide risk screening section, screening form, demographics profile, client's rights and responsibility, voluntary placement agreement, release of information, and approved call list. The counselor or designee will complete a Comprehensive Needs Assessment Update on the form of that name within 72 hours of a youth's readmission to the shelter. A new Comprehensive Needs Assessment is required if the existing Comprehensive Needs Assessment on file is six months old or longer.



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A total of ten files were reviewed. The files reviewed consisted of five Residential files, two open and three closed; and five Non-residential files, three open and two closed.

All five residential files reviewed demonstrated that the Needs Assessments were initiated and completed within 72 hours of admission, in adherence with the required time frame. All five non-residential files also documented that Needs Assessments were initiated within the required time frame. All ten Needs Assessments reviewed were completed and signed by a master's or bachelor's level staff with a supervisor's review and signature upon completion.

There two residential files and two non-residential files that required a suicide risk assessment to be completed. In all four files the youth was assessed using a suicide risk assessment completed by a licensed clinical counselor.

Exceptions:

No exceptions are noted for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

The agency has a policy in place titled Service/Case Plans & Case Plan Review that address the requirements of this indicator. The date of last revision was July 28, 2015 and the policy was approved by the Program Manager on this date. The policy was last reviewed on July 28, 2018.

The assigned Youth Shelter Senior Counselor or Children Service Counselor will develop a Case/Service Plan with the youth and/or guardian within five working days of admission to the Youth Shelter.

All Case/Service Plans should include an initiated date, individualized and prioritized needs/goals of youth, frequency and location of services, target and completion dates, person responsible for service delivery, signature of youth and guardian, and signature of counselor and supervisor.

If a Case/Service Plan needs to be revised, the revised plan must contain a statement of the problem, needs of the youth or guardian, measurable objectives that address the newly identified problems and needs, recommended services and treatment to be provided. The dated signature of the youth and guardian will evidence participation in and approval of the Case/Service Plan review.



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A total of ten files were reviewed. The files reviewed consisted of five Residential files, two open and three closed; and five Non-residential files, three open and two closed.

All ten files had a Case/Service Plan developed with the required time frames. All ten Case/Service Plans reviewed included: date initiated; individualized and prioritized goals; service type, frequency, and location; persons responsible; target and completion dates; and signatures of the youth, parent/guardian, counselor, and supervisor.

All applicable reviews were completed in all ten files 14- and 28-day reviews, or 30, 60, and 90 days in residential and non-residential respectively, as required.

Exceptions:

No exceptions are noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

The agency has four policies in place titled Provision/CINS/FINS Services/ Case Management, Coordination of Services, Case Staffing Committee, and Aftercare, Exit Planning, and Follow up Services that address the requirements of this indicator. All four policies were last reviewed on July 28, 2018 by the Program Manager.

As per policy, youth entering the program are assigned a counselor who will follow the youth's case until release and ensure delivery of services through direct provision and/or establishing referral needs. Case management includes, but is not limited to, crisis intervention and counseling, assessment services, individual, family, and group counseling, establishing and coordinating referrals to outside agencies, monitoring the youth in out of home placement if applicable, recommending and pursuing judicial intervention, continued case management monitoring to include referral updates, and case termination, and residential respite services. If a family or child needs assistance in court, the Program Manager or designee will delegate the appropriate person to assist with this. In regard to the coordination of services, all youth upon intake are assigned a counselor who will follow the youth's case and ensure proper referrals are provided to the family upon discharge. Staff will also inform and educate families about additional community resources that may be needed in the future. For non-residential youth, the agency has procedures in place to utilize a Case Staffing Committee in an attempt to obtain a solution when the Counselor is unable to assist in resolving a client's problem. The Case Staffing Committee is convened within seven working days from receipt of request.

A total of ten files were reviewed. The files reviewed consisted of five Residential files, two open and three closed; and five Non-residential files, three open and two closed.



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All ten files reviewed documented that a counselor or case manager was assigned, and established referral needs and coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs. All files reviewed provided written documentation of the counselor coordinating the service plan implementation and monitoring the youth's/family's progress in services and support to families.

Out of home placement was not warranted in any of the files reviewed.

One of the non-residential youth necessitated a case staffing. The case staffing meeting deemed that the youth needed further counseling services and family intervention services. All additional documentation for the case staffing was present in the file and completed within specified time limits including case staffing summaries, recommendations, and committee/parent/youth invitations. The recommendations made during the case staffing addressed the problems and needs of the youth and family as discovered through case monitoring by the counselor.

Youth that attended court were accompanied by parent/guardian and/or staff as applicable.

All applicable files contained case termination notes and thirty and sixty day follow ups.

Exceptions:

No exceptions are noted for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

The agency has a policy in place titled Counseling Services that addresses the requirements of this indicator. The policy was last reviewed on July 28, 2018 by the Program Manager.

Counseling services are provided in unity with the youth's service plan, which identifies the needs of the child during the Needs Assessment process. The policy addresses the development of the service plan, follow-up monitoring of youth's progress, and revised Service Plans as a result of the case staffing/adjudication. The shelter provides group, individual, and family counseling.

The youth's file has documentation of coordination between presenting problems, Needs Assessment, Service Plan reviews, case management, and follow-up. The file also contains all case notes documented by the counselor and the direct care staff. The



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files are marked confidential and remain behind a locked cabinet/door. The supervisors ensure that a clinical review of the files, case management, and documentation is being done correctly and in a timely manner.

Group counseling services are conducted at least five days a week and documented in each youth's file and the Program Manager, Supervisor, or designee coordinates the group schedule. The group topics include, but are not limited to: communication, problem solving, study skills, role performance, interpersonal conflict, inadequate resources, social relations, social transition, and others. Group participation is voluntary and strongly encouraged. Groups are held in a quiet place where distractions are at a minimum.

A total of ten files were reviewed. The files reviewed consisted of five Residential files, two open and three closed; and five Non-residential files, three open and two closed.

All ten files contained documentation that the youth and families received counseling services in accordance with the Service Plan. The program offers individual and family counseling to Non-Residential youth and group, individual, and family counseling to Residential youth.

The five Residential files reviewed included documentation of group counseling five days per week while youth were in shelter. This was supported with documentation from review of the group logbook. The files also provided documentation of compliance with the policy requirements of groups lasting at least thirty minutes, identifying a clear leader or facilitator, demonstrating a clear and relevant topic, and providing the opportunity for youth engagement. Upon review of the residential files, they also provided documentation of individual and family counseling.

Exceptions:

No exceptions are noted for this indicator.

2.06 Adjudication / Petition Process

Satisfactory

Limited

Failed

The agency has a policy in place titled Case Staffing Committee that addresses the requirements of this indicator. The policy was last reviewed on July 28, 2018 by the Program Manager.

The program utilizes a Case Staffing Committee in an attempt to obtain a solution when the counselor is unable to assist in resolving a client's problems. The committee is used when all other reasonable efforts to resolve the problem fail. A Case Staffing Committee is convened within seven working days from receipt of written request. A youth and/or

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family is taken to the Case Staffing meeting when: the youth and/or family have not demonstrated substantial progress in achieving goals specified in the Service Plan; the family or youth will not participate or do not agree in the services or treatment selected; the parent/guardian requests in writing a meeting with the Case Staffing Committee, if the parent/guardian verbally request a meeting, the counselor requests they put it in writing, and upon receipt of such request from a parent/guardian, the Case Staffing Committee must meet with the parent/guardian within seven working days. Within three days of the Case Staffing meeting, the counselor mails or personally delivers the written Case Staffing Committee recommendation report to the parent/guardian. Within seven days of the Case Staffing Committee, a written report is sent to the parent/guardian outlining the reasons for the committee's recommendation for or against a petition being filed by the committee chair, or designee. This report may or may not be in the form of a plan of services. If the Case Staffing Committee recommends modifications to the Service Plan, within five working days the counselor: makes the requested modifications, reviews the modifications with the youth and family, and has the youth and family sign the revised Service Plan. On the scheduled court date, the counselor reports to the court with the case file to testify about the case.

Upon review of the five Non-Residential files, two open files were reviewed for the Case Staffing process.

The agency has an established Case Staffing Committee that they regularly communicate with. Both files provided documentation of service initiation within the designated time. The person initiating the Case Staffing was documented and notification occurred to the family and committee no less than five working days prior to the staffing. A revised Service Plan was in place and provided to the family after the meeting, in both files. A written report was provided to the parent/guardian within seven days of the Case Staffing meeting, outlining recommendations and reasons behind the recommendations.

The Case Staffing Committee meeting included a local school district representative, a DJJ or CINS/FINS provider, a mental health representative, and law enforcement representative. A substance use and DCF representative was not necessitated for these reviewed files.

In both files reviewed, the agency initiated the Case Staffing meetings, not the parents/guardian.

Exceptions:

No exceptions are noted for this indicator.

2.07 Youth Records



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Satisfactory

Limited

Failed

The agency has two policies in place titled File Organization and Security of Case Records to address the requirements of this indicator. Both policies were last reviewed on July 28, 2018 by the Program Manager.

The contents of youth files are identified and separated according to an established format by the Residential Counseling Services Supervisor or designee. Contents include chronological sheet and youth demographics; intake assessment information; correspondence; Service Plans/reviews; comprehensive Needs Assessment; Service Plan; Exit Plan; Discharge Summary; and miscellaneous information. All files, both open and closed, are stamped "CONFIDENTIAL". All active files are kept in a locked file cabinet marker "confidential" in the intake office. All closed files are alphabetically arranged in the file room in cabinets marked "confidential", which is kept locked at all times.

All records that are transported are to be in an opaque container that is marked "confidential" and locked during transport.

A total of ten files were reviewed. The files reviewed consisted of five Residential files, two open and three closed; and five Non-residential files, three open and two closed.

All files reviewed were marked "confidential" and kept in a secure room or locked in a file cabinet that is marked "confidential". All records are maintained in a uniform manner are in order according to the agency's client file protocol.

Upon interview with staff, it was mentioned that when in transport, all records are locked in an opaque container marked "confidential". This container was observed during the review.

Exceptions:

No exceptions are noted for this indicator.

2.08 Sexual Orientation, Gender Identity, Gender Expression

Satisfactory

Limited

Failed

The agency has a policy in place titled Sexual Orientation, Gender Identity, and Gender Expression that addresses the requirements of this indicator. The policy was put into effect July 1, 2018.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or

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harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy. Areas in which youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

The shelter has copies of the Zine located in the main lobby for staff and visitors to take and read. There are also copies of the Zine in the dayroom for youth to take and read. At intake every youth is provided a bag with a copy of the youth handbook in it, a white t-shirt, a piece of bubble wrap the kids can use as a stress reliever or sensory tool if needed, and also included in the bag a copy of Zine for the youth to keep. There was documentation in the November 20, 2018 meeting minutes that all staff received training on the SOGIGE policy and also received a copy of this policy to keep.

The shelter has signage located throughout the shelter including in the boy's and girl's hallways, the dayroom, staff offices, the lobby, and the conference room indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. The Family Counseling Non-Residential program also has signage posted throughout their building, as well as copies of the Zine available for youth and parents.

Exceptions:

No exceptions are noted for this indicator.



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Standard 3: Shelter Care and Special Populations

Overview

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 a Trauma Inform Care Bag 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, two residential services supervisors, 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 Screening and Intake

Satisfactory

Limited

Failed

The shelter has multiple policies regarding the shelter environment all of which were reviewed and signed on July 28, 2018 by the Program Manager. The Shelter Environment policy ensures management takes the correct action to ensure the environment is clean, neat, and well maintained. The Key Control policy states the Youth Shelter governs the control and use of keys with specific emphasis on the monitoring of key movement. The Vehicle Security and Inspections policy outlines the staff are to maintain appropriate vehicle security and vehicles are to be inspected annually. The Flammable, Poisonous, and Toxic Control policy states the Youth Shelter maintains strict control of flammable, poisonous, and toxic items used in the facility. The Licensure Requirement policy asserts the facility must be licensed by the Florida Department of Children and Families. The Fire Drills policy requires the staff to conduct unannounced fire drills at least once a month. The Daily Schedule policy outlines the shelter must maintain a daily schedule which is routinely followed and posted. The

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shelter must provide structured daily programming to engage youth in activities and minimizes idle time.

The shelter must maintain a current DCF license and maintain an appropriate shelter environment. The shelter environment must include furniture in good repair, a facility which is free of insect infestation, dorms for youth including a bed, pillow, linens, and bedspread for each youth, and bathrooms which are clean and functional. Graffiti is prohibited throughout the shelter. In addition, the shelter requires annual health and fire safety inspections to be maintained.

The shelter requires staff be responsible for the safe and secure storage of their copies of program keys to ensure the security of the campus. Vehicle and other shared keys must be locked in a key box in the Intake Office and the movement of these keys is documented in a Key Logbook. If a staff has discontinued employment, keys must be turned in prior to receiving the final paycheck. Any lost or missing keys must be reported so appropriate action can be taken. The supervisor or designee is responsible for issuing keys and only the Program Manager can authorize the duplication of any keys.

The shelter requires all vehicles on-site to be locked and any program vehicles to maintain first aid kits, a fire extinguisher, unbroken safety glass on all windows, an inside rearview mirror, and seat belts. Vehicle keys must be stored in a locked cabinet in the Intake Office when not in use, which is inaccessible to youth.

To control hazardous materials the supervisor or designee must maintain a list of all flammable, hazardous, and toxic chemicals used in the shelter and ensure all items are locked in a storage cabinet. A weekly perpetual inventory of chemicals must be completed.

The shelter must be equipped with fire alarms and security systems to ensure appropriate response from emergency services. The alarm system includes an option to conduct a drill which allows the shelter to conduct drills at least once a month which follow all requirements. The shelter must be inspected on an annual basis by a designated fire inspector by the Orange County Fire and Rescue Department.

The shelter operates based on a youth schedule which is posted publicly and easily accessible. The staff provides meaningful and structured activities for the youth seven days a week during awake hours. The youth must be allowed one hour of physical activity daily. Faith based activities are provided for youth who wish to participate; alternative non-punitive activities are provided to youth who do not wish to participate in faith-based activities. Youth are encouraged to read by making books easily accessible and allowing youth to read in their rooms. The shelter counselors plan, schedule, and provide life skills classes, based on approved curriculum, at least five days a week and individual counseling at least once a week.

A tour was conducted of the shelter's campus and found all furnishings and bedding in good repair, grounds were well-maintained, buildings were free from inspect infestation,

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there was no graffiti, bathrooms were clean and functional, lighting was adequate, exterior areas were free from debris, grounds were free from hazards, and the garbage containers were covered. The shelter reported they received new furniture this year and are able to replace items as needed. The interior areas were found to be free of hazards and contraband. Each youth had their own pillow, covered mattress, linens, and bedding. The washer and dryer used for youth was functional and clean. Postings were found for the Florida Abuse Hotline, map and egress plans of the facility, client rules, DJJ incident reporting, and the shelter's DCF Child Care license. All doors to the shelter and vehicles were found to be locked. The staff had permanent issue key cards and keys used to access the buildings and rooms. Additional keys to the program vans and other areas are kept in a locked key box inside the control room. If youth have belongings they wish to be locked up, the program packs the belongings in a locked cabinet in the kitchen. Valuable items are stored in a cabinet in the control room in which only supervisors have the keys to access. The shelter has three vans each of which were equipped with a first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter, and air bag deflator. Chemicals are maintained in two areas of the shelter; daily use chemicals are locked in a cabinet in the dayroom and the stock chemicals are kept in the shelter's locked file room in a locked cabinet. Inventories were found for each week for the last six months except for the inventory of the area with chemicals listed as Windex through Dial Soap for February 23-March 1. The inventory for Windex through Endust for March 30 to April 5 was missing a signature. A MSDS was found for each chemical the shelter has on-site.

The shelter is compliance with all fire safety requirements and maintained an annual facility fire inspection, which was completed November 29, 2018 by the Orange County Fire Department and reported no violations. Fire drills were found for each shift each month for the last six months and each was under two minutes. All fire safety equipment is inspected by Safety Solutions on an annual basis with the last inspection occurring March 27, 2019. The shelter also maintained a Satisfactory Residential Group Care inspection report from the Department of Health, which occurred on October 31, 2018 and found only two violations, a hole in the wall and a stained ceiling tile, both of which had already been reported and had active work orders. The shelter dining hall and kitchen is located on the campus and includes a separate dining and food preparation area. The dining hall and kitchen were found to be extremely clean and well-maintained. All food was properly labeled and stored. The food storage areas were each maintained at required temperatures, monitored by multiple thermometers, and observed to be clean and organized. All appliances were in working order. The shelter had a current Satisfactory Food Service inspection report from the Department of Health, completed on August 21, 2018 with no violations found. A current menu signed by a Licensed Dietician was found posted in the dining hall.

The shelter operates on a daily schedule which was found posted an accessible to youth. The schedule provided ample opportunity for youth to be engaged in meaningful, structure activities seven days a week during awake hours, which minimized down time. Daily programming includes opportunities for youth to complete homework and access appropriate reading material. The shelter maintains both a library in the school and

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bookshelves with reading material in the dayroom for youth to access. The shelter has a monthly activity schedule which outlines daily recreation offerings. Further, the shelter reported the youth receive their one hour of physical activity during the school day during the fifteen-minute break in the morning and after they finish lunch; however, the physical activity is inconsistently documented in the youth activity binder and logbook. On the activity schedule, “church” is listed every Sunday; however, documentation was only found once in the logbook on December 9 and once in the youth activity binder on March 11 of youth being offered faith-based activities.

Exceptions:

No exceptions are noted for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

The shelter has two policies to address youth orientation, both of which were reviewed and signed by the Program Manager. The Orientation policy, which was reviewed on July 20, 2018, requires caseworkers to provide orientation to each youth within twenty-four hours of admission to the shelter. The Intake and Assessment Process policy, which was reviewed on July 28, 2018, outlines each youth must receive a screening and preliminary interview upon referral to the shelter.

The staff must provide orientation to the shelter within twenty-four hours of admission using the orientation checklist, which includes a tour, overview of policies, and are given linens for their sleeping quarters. The checklist further outlines staff must provide youth a handbook, review dress code information, review the behavior management system consequences and rewards, review procedures for medical care, review emergency procedures, and review telephone use procedures.

There were five open youth files reviewed. Each file documented the youth received orientation to all required topics within twenty-four hours of admission. Orientation included receipt of the youth handbook, disciplinary actions, grievance procedures, emergency procedures, contraband rules, physical facility layout, and daily activities. Each youth was assigned a room based on the orientation and intake process. The youth’s parent/guardian signed required forms and each youth and parent/guardian were provided the Florida Abuse Hotline number. One of the five files reviewed was applicable for an alert regarding suicide prevention. The youth’s screening documented the youth required an Assessment of Suicide Risk, which was administered within the required time frame, and placed on standard supervision without requiring additional follow-up. The youth’s contact notes documented the youth was to be on site and sound until the assessment could be administered.



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Exceptions:

No exceptions are noted for this indicator.

3.03 Room Assignment

Satisfactory

Limited

Failed

The shelter has two policies in place to address the classification of youth, both of which were reviewed and signed by the Program Manager on July 28, 2018. The Classification and Group Assignment policy requires staff to interview youth at intake to make an effort to determine the most appropriate sleeping quarters for the youth and to increase staff awareness of classification of the youth. The Alert Procedures policy outlines the provision for an alert system to inform staff of a youth's medical, mental health, substance abuse, allergy, prescribed medication, food, and other condition alert.

Youth are to be interviewed and intake and evaluated for a room assignment based on classifications which include: physical characteristics, suicide risk, presence of disabilities, level of aggression and past aggressive behavior, attitude upon admission and initial interactions/observations, review of collateral information, and exposure to trauma. If a youth is identified with an alert, the alert must be entered into the program's alert system. The alert system is color coded and the alerts are placed on the front of the youth's file and on the population board.

There were five open youth files reviewed. 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 classification included a review of the youth's history and exposure to trauma, age, gender, history of violence, disabilities, physical size, gang affiliation, suicide risk, sexually aggressive or reactive behavior, and gender identification. The classification took into account collateral contacts where available as well as initial interactions and observations of the staff. Each of the five youth files documented alerts identified and the alerts were reflected in the youth contact notes, through colored dots on the front of the youth's record, and on the population board. Each colored dot represents a different type of alert; red for medical, yellow for mental health, blue for substance abuse, green for allergies, and orange for trauma.

Exceptions:

No exceptions are noted for this indicator.

3.04 Log Books



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Satisfactory

Limited

Failed

The shelter has a policy in place for Logbooks, which was reviewed and signed by the Program Manager on July 20, 2018, and requires staff maintain a permanent bound logbook in the control room to document daily operation and shift information. Direct care and supervisory staff must review the logbook at the beginning of each shift.

The shelter logbook is maintained in a permanent bound book in which all pertinent information is to be recorded. All entries must include the date/time of the incident, staff and youth involved, brief statement, and name of the person making the entry. All entries must be completed in ink with no erasures or white out and all errors must be struck through with a single line, initialed, and dated. Entries which could impact the safety and security of the program must be highlighted according to the type of incident; pink for medical alert, blue for intake, yellow for release, green for AWOL, and orange for other important information. The Program Manager or designee must review the logbook every week and document the review with any corrections, recommendations, or follow-up. All direct care and supervisory staff must also review the previous shifts (one working shift for supervisors and past two shifts for direct care staff) and document their review in the logbook.

The shelter maintains a permanent bound logbook which was reviewed for the last six months. Safety and security issues are documented, and pertinent issues are highlighted in colors specific to the type of incident. All entries are brief, written in ink, and most are legible. Some of the entries were difficult to read. Each incident included the time, date, youth and staff involved, and who wrote the entry. All errors were struck through with a single line and the staff making the correction initialed and dated the error. Reviews were found for direct care staff, supervisors, and the program manager as required. Anytime youth are off campus, including for home visits, as well as outside people coming in to visit youth is documented in the logbook. There is no documentation in the logbook of supervision or youth population counts; however, the shelter documents populations on the shift change form after each shift.

Exceptions:

No exceptions are noted for this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

The shelter has two policies in place regarding Behavior Management strategies which were reviewed and signed by the Program Manager. The policy for the Behavior Management System, which was reviewed on July 20, 2018, outlines the provision for a behavior manager system based on positive reinforcement and logical consequences.

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The behavior management system is to be designed not only to gain compliance with program rules but to change youth behavior and increase accountability. The policy for Crisis and Behavioral Intervention, which was reviewed on July 28, 2018, requires staff to utilize the least amount of force necessary to address situations and ensure the basic rights of youth are not violated.

The shelter utilizes a behavior management system which promotes positive behaviors in the youth through the application of logical consequences applied in a caring and humane manner. Youth are to be oriented to the system during the intake/orientation process and are given a handbook which outlines the system. The use of group punishment, room restriction, youth control over other youth, and corporal punishment is prohibited. The program rules are to be applied logically and consistently. The shelter will not deny a resident their basic rights under a circumstance. The behavior management system includes a detailed list of the structure, rewards, appropriate consequences, and expected behaviors. The consequences must be applied immediately and match the severity of the behavior. All staff must be trained in the system, provided feedback based on their use of rewards and consequences, and evaluated based on their performance using the system. The staff are required to use the least amount of force necessary to deal with any situation. In the event physical intervention is needed, the shelter has designated CPI as the approved physical intervention method.

The shelter operates a detailed behavior management system (BMS) which outlines a level system whereby youth can earn a wide variety of incentives and privileges through good behavior. The BMS promotes order, safety, security, respect, fairness, and protection of rights. The BMS is designed to gain compliance with program rules, influence positive behavior, increase accountability, and encourage participation. The BMS includes constructive consequences for negative behaviors which include loss of points and privileges and match the severity of the consequence. The use of group punishment, room restriction, youth control over other youth, and corporal punishment is prohibited. Nine staff training records were reviewed and each included evidence of training in behavior management. Further, the shelter provided documentation of training on the BMS which occurred during an all-staff meeting in January. The shelter utilizes performance evaluations to provide feedback for staff on their use of the BMS.

Exceptions:

No exceptions are noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

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The agency has a written policy in place that addresses all the key elements of indicator 3.06 Staffing and Youth Supervision. The policy was last reviewed on August 22, 2018 and revised on April 1, 2019 by the Program Manager.

Youth shelter staff are always required to monitor the children. The ratio to staff and youth during awake times should not exceed six youth to one staff. The ratio during sleep time should not exceed twelve children to one staff. During the overnight shift there will be at least two staff members present regardless the number of youths. Every provision possible is made to ensure there will be at least one staff member on duty of the same gender as the youth served. The Sr. Children's Service Counselor will prepare and visibly post the staff schedule. If an unforeseen event or emergency arise, an overtime roster with staff home telephone numbers will be in place to ensure coverage is obtained. The program has a surveillance system that is instituted and in operation 24 hours a day, 7 days a week. The system can capture and retain video photographic images which must be stored for a minimum of 30 days. Staff observe youth at least every 15 minutes while they are in their sleeping room, either during sleep period or at other times. This does not supersede requirements 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.

The agency maintains a minimum staffing ratio as required by Florida Administrative Code and contract. One staff to six youth during awake hours and community events; one staff to twelve youth during sleep hours. The majority of the overnight shifts contained three staff but always had at least two. Program maintains at least one staff on duty of the same gender as the youth on each work shift including all overnight work shifts.

The program staff schedule is provided to staff and posted in the control room. There is also a holdover overtime rotation roster that includes contact numbers to reach staff when additional coverage is needed.

The agency is equipped with functioning surveillance cameras. All of which are well positioned and capture thirty plus days of backup. Staff observe youth and document every fifteen minutes while the youth are in sleeping rooms. Three dates were reviewed for a total of twelve bed checks, all of which had checks done within the fifteen-minute time frame.

Exceptions:

No exceptions are noted for this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

The agency has a written policy in place that addresses all the key elements of indicator 3.07 Special Populations. The policy was last reviewed on July 28, 2018 and revised on August 10, 2015 by the Program Manager.

Staff Secure

Staff Secure youth must meet the legal requirements outlined in Chapter 984 F.S. Staff will be specifically assigned to monitor and mentor the youth. The youth will be given an in-depth orientation. The staff designation by shift will be indicated 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. Families will be encouraged to visit the youth at least once a week and will be encouraged to be actively involved in service planning, counseling, and aftercare planning. All staff are informed and made aware of the need for extra supervision and the appropriate level of intervention is emphasized to prevent the youth from running away.

Probation Respite:

All probation respite youth that are referred to the Youth Shelter must meet the following criteria:

1. Referrals should come from DJJ Probation
2. Youth must be on Probation with Adjudication Withheld
3. Appropriateness for placement depends on seriousness of past charges/history, behavior history, current population, bed availability, etc.
4. The Florida Network must be contacted for approval before admission takes place.
5. The length of stay should be determined at the time of admission.
6. It is anticipated that the length of stay will be fourteen to thirty days. Placement beyond 30 days requires the approval of the JPO, CPO, and FN.
7. There is evidence that all case management and counseling needs have been considered and addressed.
8. Services provided to these youth should be consistent with all other CINS/FINS program requirements.
9. Youth with DCF involvement are eligible.
10. All probation respite referrals should be submitted through the Probation respite Referralator via the member's page on the Florida Network website at time of admission.

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11. Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release.

Domestic Violence Respite:

All DV Respite youth that are referred to the Youth Shelter must meet the following criteria:

1. Must have a pending DV charge
2. Screened by the JAC/Detention and doesn't meet secure detention criteria
3. Youth length of stay not to exceed 21 days
4. Documentation in the file of transition to CINS/FINS Respite placement, if appropriate
5. Case Plan reflects goals of aggression management, family coping skills, or other interventions designed to reduce propensity for violence in the home
6. Services provided to these youth will be consistent with all other CINS/FINS program requirements
7. Youth with DCF involvement are eligible

Domestic Minor Sex Trafficking:

Domestic Minor Sex Trafficking (DMST) services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. All requests may be approved for a maximum of seven days. Approval for support beyond seven days may be obtained on a case-by-case basis. Staff assigned to youth under this provision are to enhance the regular services available through direct engagement with the youth in positive activities designed to encourage the youth to remain in shelter.

There were no Staff Secure, Domestic Minor Sex Trafficking, or Family/Youth Respite Aftercare Services for this reporting period. The agency is not contracted to provide Intensive Case Management Services.

Probation Respite

The agency does have applicable Probation Respite policies and procedures in place. There were three closed files reviewed for this reporting period. All three of the files had a referral that came from DJJ Probation and all youth referred on probation regardless of adjudication status. The length of stay for two of the files was no more than fourteen to thirty days. The other file had a stay longer than thirty days but there was evidence of approval from the JPO and CPO. All case management and counseling needs were considered and addressed. All services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements.

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The agency does have applicable Domestic Violence Respite policies and procedures in place. There were three closed files reviewed for the reporting period. All three files had evidence of youth admitted to DV Respite placement having a pending DV charge and have evidence of being screened by JAC/Detention but didn't meet criteria for secure detention. Youth in the program didn't stay more than 21 days. All three case plans reflect goals focusing on aggression management, family coping skills, or other interventions design to reduce the reoccurrence of violence in the home. All other services provided were consistent with all other general CINS/FINS program requirements.

Exceptions:

No exceptions are noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

The agency has a written policy in place that addresses all the key elements of indicator 3.08 Video Surveillance System. The policy was last reviewed on August 22, 2018 and revised on April 1, 2019 by the Program Manager.

The shelter has a video surveillance system that is in operation 24/7 to monitor and capture a recording of happenings to ensure the safety of all youth, staff, and visitors. The video system will assist to deter any misconduct and ensure that any allegations of incidents are recognized through recorded visual means but not limited to:

1. System can capture and retain video photographic images which must be stored for a minimum of 30 days.
2. System can record date, time, and location; maintain resolution that enables facial recognition.
3. Back-up capabilities consist of cameras' ability to operate during a power outage.
4. The locations of the cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters.
5. Video surveillance system is only accessible to designated personnel (a list is maintained which also includes off-site capability per personnel).
6. Supervisory review of video is conducted a minimum of once every 14 days and noted in the logbook. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts. All cameras are visible to persons in the area and a written notice is conspicuously posted on the premises for security.

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7. The process of third-party review of video recordings after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.

The agency has a video surveillance system in operation 24/7. A written notice is placed outside the shelter doors in the lobby. Cameras are in the interior and exterior of the shelter where youth and staff congregate and where visitors exit and enter. All cameras are visible, and none are placed in the bathrooms or sleeping quarters. System can capture and retain video photographic images including facial recognition. The video system can record date, time, location and store video for more than thirty days. Cameras operate during a power outage via backup batteries placed throughout the shelter. The Program Manager, Divisional Manager, and Sr. Program Manager are the only individuals able to access the video surveillance system. The Divisional Manager is the only staff with off-site video review capability. Supervisory review of video is conducted a minimum of once every fourteen days and noted in logbook. The reviews assess the activities of the facility and include a review of random sample of bed checks. The agency has a process for third party review of video recordings after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.

Exceptions:

No exceptions are noted for this indicator.



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Standard 4: Mental Health/Health Services

Overview

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 Med Station 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

The agency has a policy in place for Healthcare Admission Screening. The policy was last reviewed on July 1, 2018 by the Program Manager.

It is the policy of Orange County Youth and Family Services Division to provide a physical health screening to all youth at the time of admission. 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 required immediate attention or might render admission to the shelter unsafe to the youth or others. The following will be reviewed at that time: issues related to medications, symptoms of tuberculosis, physical health problems, allergies, recent injuries or illness, or any other potential presence of pain or other physical distress, substance abuse, and/or intoxication. The following chronic medical conditions will be reviewed, and

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medical care referrals will be made for all identified conditions: diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, and head injuries (occurring during the previous two weeks). 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 five youth files reviewed. All files reviewed had a health care admission screening that showed current medications, existing medical conditions, allergies, recent injuries or illnesses, observation for illness, injury, pain, presence of scars, tattoos or other skin markings. Other chronic medical conditions checked at intake are diabetes, pregnancy, seizure disorder, cardiac disorder, asthma, tuberculosis, hemophilia, and head injuries. In all files reviewed, there was no needed coordination for medical or mental health follow up. Program also has procedures to include a thorough referral process and a mechanism for any necessary follow up medical care for youth admitted with chronic medical conditions. All five files documented the registered nurse (RN) reviewed the health care admission screening within five working days.

Exceptions:

No exceptions are noted for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

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 1, 2018 by the Program Manager.

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/herself 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.



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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 three closed youth files reviewed. In all files the suicide risk screening occurred at intake. All youth were placed on appropriate supervision based on the results of the suicide risk assessment. Sight and sound log was completed for all youth placed on supervision. Supervision for youth was changed based on the results of the suicide risk assessment. There was also a staff person monitoring each youth and documented youth behavior at fifteen-minute intervals. No supervision level was changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed further assessment or a Baker Act by local law enforcement.

Exceptions:

No exceptions are noted for this indicator.

4.03 Medications

Satisfactory

Limited

Failed

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, 2018 by the Program Manager.

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



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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.

All medications are stored in the Pyxis and the agency has a minimum of two Super Users for the Med Station. Oral medications and topical medications are stored in the Pyxis machine separately by cubie. There is a locked refrigerator onsite in the file room that has a temperature of 36-48 degrees F for the storage of medications. There were no refrigerated medications at the time of the review and the shelter has no injectable medications including epi pens. Shift to shift counts are conducted and documented for all medications except over-the-counter medications which are done on a weekly basis. There are no syringes and sharps within the shelter. The agency does not accept youth currently with injectable medications. The agency also does have documentation of non-licensed staff that can use the epi-pens as well as those that can have access to secured medications with limited access to controlled substances. Medication Distribution Logs are used consistently for the distribution of medication by non-licensed staff. The Registered Nurse (RN) runs various reports on a monthly basis to review medication management in the shelter. All staff including the RN verify medications through contacting the pharmacy. The delivery process of medications is consistent with the Florida Network policy and medication discrepancies are cleared each shift.

Exceptions:

No exceptions are noted for this indicator.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

The agency has a policy in place for Alert Procedures. The policy was last reviewed on July 28, 2018 by the Program Manager.

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.



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There were five 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.

Exceptions:

No exceptions are noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

The agency has a policy in place for Medical and Dental Procedures (Episodic/Emergency Care). The policy was last reviewed July 28, 2018 by the Program Manager.

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 were three incidents reviewed of off-site emergency medical care. In each case an incident report was submitted for the medical care and the CCC was notified. Upon the youth returning to the shelter there was verification of a receipt of medical clearance via discharge instructions with follow-up care. The parent/guardian was notified in each case and there was a log maintained for all incidents.

The staff were trained in emergency medical procedures in CPR and first aid. The knife for life, wire cutter, and first aid kit supplies were located in the control room within a locked cabinet.

Exceptions:

No exceptions are noted for this indicator.