BUREAU OF QUALITY ASSURANCE

PROGRAM REVIEW FOR

Thompson Academy

Youth Services International, Inc.

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Review Date: June 19-23, 2006

This review focused on the performance of the program concerning nine standards, which covered such areas as Program Management, Living Environment, Case Management, Food Services, Mental Health & Substance Abuse, Program Security and many other functions. Performance indicators, used to measure each standard, were rated using the ten-point scale below, with nine representing the highest performance possible.

Superior Performance	7	8	9
Satisfactory Performance	4	5	6
Partial Performance	1	2	3
Non-Performance		0	

The review team used the following definitions of the above performance levels as a guide when rating performance indicators:

Superior Performance: The program is exceeding all elements required in the particular indicator with either an innovative approach or an exceptional, program-wide dedication to performance that is readily apparent. There is evidence of very few, if any, exceptions to this.

Satisfactory Performance: All of the requirements of the indicator are met almost all of the time. While the items, elements or actions necessary to accomplish the indicator are prevailing practice, minor exceptions may occur occasionally.

Partial Performance: Not all of the elements of the indicator are being accomplished or there are frequent exceptions to accomplishing the items, elements, or actions required to satisfy the requirements of the indicator. While there may be a policy in place, many staff are unaware of it or there is no policy or procedure in place although staff generally are accomplishing the indicator.

Non-Performance: The items, elements, or actions necessary to accomplish the indicator are missing or are done so poorly that they do not contribute to the accomplishment of the indicator or the overall standard.

Some indicators pertain to issues for which the program is either accomplishing or not accomplishing the function according to policy. These are compliance indicators and are rated according to the guide below.

Full Compliance	2
Substantial Compliance	1
Non-Compliance	0

The review team used the following definitions as a guide when rating compliance indicators:

Full Compliance: The program's policy, procedures and practice are in accordance with DJJ policy all of the time. (No exceptions).

Substantial Compliance: The program's policy, procedures and practice are in accordance with DJJ policy. All of the requirements for the indicator have been met with only minor exceptions.

Non-Compliance: The program's policy, procedures and practice are not in accordance with DJJ policy and/or there are numerous exceptions to the requirements of the indicator.

This report summarizes indicators that were rated superior, satisfactory, partial, non-performance or non-compliance and will not provide specific information on indicators, which were rated in the compliance range. Compliance and priority indicators are marked with a C and P respectively. (Numerical scores for individual indicators can be found in Appendix 1 of this report. For the overall program and compliance ratings, please refer to the attached Performance Profile.)

EXTERNAL CONTROL FACTORS

Factors that may seriously impair a program's ability to perform, but which are beyond its control, are identified as external control factors. These factors, and the degree to which they influence a program's performance rating on a standard, are identified as a part of the quality assurance process and are noted below.

During the summer of 2005, the program was affected by the numerous hurricanes that hit the South Florida area. Damage was sustained to various parts of the program's physical plant, in particular the area housing youth classrooms.

CRITICAL CONCERNS

None

STANDARD ONE: PROGRAM MANAGEMENT

Overview:

Thompson Academy is operated by Youth Services International, Inc. and is contracted with the Florida Department of Juvenile Justice to provide residential treatment services for Moderate-Risk male youth. Program operations are directed by written policies and procedures, which are implemented by program management, including the Facility Administrator and an Assistant Facility Administrator.

1.01 Program Planning and Evaluation: The program director is committed to the continuous improvement in the quality of services provided to the youth the program serves. **Satisfactory 5**

Program planning and evaluation policies and procedures were maintained by the program that outlined the program's philosophy, program description, maintaining a positive peer environment as a treatment approach, levels of intervention, thinking patterns, and educational programs. The program's policy also outlined the Facility Administrators and management team's responsibilities to identify, plan, and implement the program's quality improvement initiatives. The program had an established planning team consisting of key management staff, including direct care staff and one youth. The program maintained a Quality Initiative (QI) Plan that was revised in June 2006. The QI plan outlined the goals, action steps, persons responsible, target dates and completed tasks of the program. The program did not have documentation of meetings taking place in 2005 to address QI goals; however, there was a meeting conducted in May 2006 and one scheduled meeting for the end of June 2006.

1.02 Community Relations: There is citizen involvement in the program that bridges the gap between the program and the community. **Satisfactory 4**

Community relation's policies and procedures were maintained by the program that outlined the program's recruitment, development, participation of the Community Advisory Board, and coordination with community-based programs and services. The program had an established Community Advisory Board with a representative from the local police department, Florida Memorial Hospital, Broward Sheriff's Office, Cavalry Chapel, Home Builder's Institute, a local college, a city employee, and a community member. The program was in the process of recruiting a victim advocate to also serve on the Board. The program maintained documented meetings with agendas, minutes, and sign-in sheets for two quarterly meetings held in 2005. No documentation of quarterly meetings occurring in 2006 was available for review. During an interview with the Facility Administrator, it was noted that no meetings had occurred prior to this review in 2006; however, a meeting was scheduled for July 2006 and documentation was provided to support that members had been invited to attend. The program maintained documentation of active recruitment efforts to solicit volunteers for the program. The program distributed flyers to local libraries, colleges and area businesses. The program had developed links with two local churches in order to recruit volunteer services. At the time of the review, the program had three active volunteers.

1.03 Effective Communication: The program director and supervisors demonstrate good communication and information sharing with staff. **Superior 7**

Effective communication policies and procedures were maintained by the program that outlined the responsibility of the Facility Administrator to conduct monthly staff meetings in order to discuss the ongoing operations of the program. The program's management team consisted of the Facility Administrator, the Assistant Facility Administrator, Assistant Clinical Director, Case Management Supervisor, Registered Nurse (RN), Medicaid Billing Clerk, Trainer, Maintenance Supervisor, Human Resources (HR)/Payroll Clerk, Quality Assurance Coordinator, Guidance Counselor, Unit Managers, Clinical Director, Medical staff, and a representative from the Home Builders Institute staff. The program maintained documentation of at least monthly meetings from May 2005 through March 2006. Four

meetings were conducted in May 2006 and one meeting in June 2006. Agendas, minutes, and sign-in logs were maintained for these meetings. The program had no documentation of meetings occurring in April 2006. Logbooks documented shift-to-shift communications.

1.04 Policies and Procedures: Department of Juvenile Justice (DJJ) policies and facility operating procedures govern the operation of the program. **Satisfactory 5**

Program operational policies and procedures were maintained by the program that outlined the responsibilities of the Facility Administrator to develop, implement, maintain, and review annually the program's Facility Operating Procedures (FOPs). The program maintained FOPs that had been reviewed by the Facility Administrator on May 24, 2006. FOPs were maintained in each control room located on both dorms and in management offices. Staff were aware of the locations of the operating procedures and pointed their locations out during the facility tour. It was noted that the FOPs were not always representative of program practice. For instance, the program maintained FOPs that indicated that room restriction was utilized at the program; however, an interview with the Facility Administrator found that room restriction was not utilized. It was also noted that the FOPs referenced other programs; for instance, the program had FOPs that referenced 'Cypress Creek Correctional Facility', rather than Thompson Academy.

1.05 Employee Position Descriptions and Performance Reviews: Staff understand their specific job duties and are evaluated periodically to assure their acceptable performance in the delivery of services to youth. **Satisfactory 4**

Employee position descriptions and performance polices and procedures were maintained by the program that outlined the establishment of performance appraisals and position descriptions, performance reviews and staff incentives. The program maintained position descriptions that outlined job responsibilities, standards of performance, education and experience and work hours for each position on staff. Twenty individual employee personnel files were reviewed. All twenty files contained a signed and current position description. Two employees had received a promotion and both files contained updated position descriptions. Facility operating procedures outlined that employees will receive an evaluation at the completion of their six-month probationary period and annually thereafter. Eight of the twenty personnel files reviewed were not applicable due to employees still being within their six-month probationary period. Four files contained an annual performance review signed by the employee and supervisor. One file required that a probationary performance review be completed; however, there was no review in the file or documentation as to why it was not completed. Seven files did not contain a required annual review.

1.06 Bed Management: Program management monitors and manages the program's length of stay to ensure cost effectiveness and efficient utilization of placement beds. **Satisfactory 4**

Bed management policies and procedures were maintained by the program that outlined the Facility Administrator's responsibility for monitoring and managing the bed capacity of the facility and the length of stay of youth in placement. The program had a process in place for monitoring each youth's length of stay. The Facility Administrator prepared monthly reports to the Department of Juvenile Justice Residential Monitor notifying her of any youth who was kept beyond the designated length of stay. Documentation that notifications were completed every thirty days was reviewed. The monthly reports included the names of youth who had stayed beyond the designed length of stay as well as a targeted release date for the youth. The program did not have consistent documentation to support that monthly JJIS audits were being reported to the Chief Commitment Manager. The program had three JJIS reports available for review. Two reports were completed in June 2006; however, there was no documentation to support that the information was relayed to the Commitment Manager. One report reviewed for October 2005 documented that it had been sent to the Commitment Manager via fax.

1.07 Background Screening of Employees and Volunteers: Staff and volunteers working in direct and continuing contact with youth undergo a criminal history background screening to ensure they are not a danger to youth. **Substantial Compliance 1**

C/P Background screening of employees and volunteer policies and procedures were maintained by the program that outlined that new employees would complete a background-screening packet prior to being hired. Twenty individual employee personnel files were reviewed. Nineteen files had a completed background screening. One file documented that the background screening was completed; however, it was completed thirty days after the employees hire date. Of the twenty files reviewed, nine contained documentation that a driver's license check was conducted prior to the employee being hired. Eleven files contained documentation that the driver's license check was conducted after the employee had been hired and began working with youth. Eight of the eleven employees were hired in 2006.

1.08 Incident Reporting: The program demonstrates the importance of alerting the Department of Juvenile Justice when severe and serious incidents occur. **Substantial Compliance 1**

C/P Incident reporting policies and procedures were maintained by the program that outlined the steps employees should follow when documenting and reporting incidents. The program maintained a Central Communications Center (CCC) Incident Reporting Logbook. All significant incidents were documented in the logbook. A review of thirty random CCC reports was completed. Nineteen reports documented that a call was made to the CCC within two hours of the incident or within two hours of the program's knowledge of the incident. Ten reports documented that calls were not made within the required time frame. One report did not document a time of the incident or a time of the call; therefore, the reviewer was unable to determine if the time frame had been met. All reports were clearly typed with witness statements and supporting documents attached.

1.09 Abuse Free Environment: The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. **Satisfactory 4**

P Abuse free environment policies and procedures were maintained by the program that outlined the program's procedures for child abuse or neglect notifications, internal investigations, self-reporting, reporting procedures, immediate protective action, disciplinary actions, and staff training. The program maintained a Code of Conduct that prohibits abuse and is signed by employees upon hire. The Abuse Hotline and CCC telephone numbers were observed posted throughout the facility. Employees participated in Abuse Reporting training during orientation; however, there was no documentation of annual training being conducted. The program maintained a Child Abuse Reporting Logbook that documented calls made to the Abuse Hotline. Allegations of child abuse or suspected child abuse were reported to the Central Communications Center (CCC) as evidenced by reports maintained in the CCC Incident Reporting Logbook. Between January and June of 2006, the program documented fifty-three reportable incidents, of which twenty-three were for alleged reportable abuse issues. The program maintained documentation of management addressing incidents of abuse on youth.

1.10 Criminal Street Gangs: The introduction of criminal street gang activity in the program is deterred through the implementation of gang awareness and intervention strategies. **Partial 3**

Criminal street gang policies and procedures were maintained by the program that outlined the program's procedure for participating with local law enforcement agencies, sharing current information with staff, and the Facility Anti-Gang Initiative in order to ensure youth and staff safety. During an interview with the Facility Administrator, it was noted that he met with the Broward Sheriff's Office periodically to share information; however, agendas were not maintained for the meetings. The program had documentation of a meeting conducted in June 2006, where a process to share information was discussed. The program maintained a

Criminal Street Gangs binder that contained training information on gang related topics. The program maintained documentation of one staff meeting agenda and sign-in log from July 25, 2005 where some gang information was shared; however, there was no documentation in the meeting minutes or in the employee training files that this information was being disseminated to staff on a regular or on-going basis. The program had a strategy in place to address criminal street gang membership and activity within the program. The Facility Administrator noted in an interview that there had been no gang activity to address or document; however, during the facility tour, Latin King insignia was found in a youth's dorm room.

1.11 Key Personnel and Vacancies: The provider recognizes the importance of key staff in the successful management and operation of a residential program. **Full Compliance 2**

C/P

1.12 Program Cleanliness and Maintenance: Management takes appropriate action to ensure the program, including attached buildings and grounds, is clean, landscaped and well-maintained. **Partial 3**

Program cleanliness and maintenance polices and procedures were maintained by the program that outlined the program's procedures for assigning staff to perform daily housekeeping checks and making repairs as needed. During the facility tour, it was observed that furnishings were in good repair. The grounds were landscaped and flowers were planted in the courtyard area. Grass areas in the courtyard appeared overgrown. Graffiti was minimal on the walls, doors, and windows. Bathroom areas were noted as slightly dirty on the floors and walls. One bathroom was observed to have waste blocked up in the toilet. In a youth dorm, it was observed that an electrical outlet was missing the cover and the wires were exposed. The air conditioning grates were observed to have a build up of dust in the youth dorms. Holes were noted in the floors and peeling paint was observed in the youth dorms. Educational staff indicated that the classrooms were not well maintained and dirty. The DJJ Educational Specialist expressed a concern about a leak from an air conditioning (AC) unit in one classroom that had wires dangling above it and the cleanliness of the teacher's offices and classrooms. The AC leak was repaired during the review week. Classroom One had a broken window. In Classroom Seven, extra force was needed to close the door completely. In the Falcon dayroom, wires were observed dangling from the ceiling.

External Control Factors

None

STANDARD TWO: ADMISSION AND ORIENTATION PROCESS

Overview:

The program had an admission and orientation process for each youth at the time of intake that identified the safety and security risks, the individual needs, and the best applicable treatment approach for each committed youth. At the time of the quality assurance review the Case Manager Supervisor position was vacant. The program had six case managers responsible for overseeing the admissions and orientation process at the facility. They coordinated the intake process for each youth, including reviewing all appropriate admission and release paperwork for accuracy and accountability purposes. In addition to the case managers, staff from the medical department, the mental health department, and the education department participated in each youth's intake process. The program had a process in place to classify each youth in order to identify the most appropriate unit placement and room assignment. The youth were included on the program's alert list when physical health issues, mental health issues, security risk factors, or special needs were identified during or subsequent to the classification process. The program had an orientation checklist that was completed for each youth within twenty-four hours of admission, and signed and dated by both staff and youth. The program provided each youth with a handbook that covered all

aspects of the program, including the program rules, treatment offered, and the behavior management system. Each youth signed a form acknowledging receipt of the handbook. Orientation materials were translated verbally for those youth who did not speak fluent English. The facility maintained official youth case files which included information necessary for case planning and on-going treatment. The files were consistently organized, and each contained an admission card and a good quality photograph of the youth for identification purposes.

2.01 Youth Records: Youth records provide information necessary for case planning and ongoing treatment and are organized consistently so that information is readily available to staff. **Satisfactory 5**

The program maintained a written policy and procedures, which indicated that records which included information necessary for case planning and on-going treatment, were maintained for each youth. The policy indicated that each youth had an individual case management record, an individual healthcare record, and an individual mental health/substance abuse record. Documented practice reflected that the program maintained these records as described. A review of fourteen individual youth case management records confirmed that each youth had a uniformly organized record divided into six sections: legal, chronological, program information, correspondence, case management, and miscellaneous. Observation found that all the youth records were maintained in locked file cabinets located in the assigned Case Manager's office located on each unit. It was found that thirteen of fourteen youth records reviewed was marked 'confidential', as required. Each record reviewed had a DJJ Commitment/Transfer Packet Checklist signed and dated by the assigned Juvenile Probation Officer (JPO), the JPO Supervisor (JPOS), and the program's Case Manager. Four of the Commitment/Transfer Packet Checklists reviewed were found to be incomplete. In all of these cases, there were documented efforts by the program to obtain the missing items, including telephone contacts with the JPO requesting the missing documents, and documentation that the program sent each JPO a Commitment Packet Missing Document Request form. Each case record had a DJJ Admission Card form signed and dated by the Case Manager and the youth, that included the youth's current photograph as well as all the critical information required as outlined in the DJJ Residential Services Manual. A review of a sample of the individual healthcare records indicated that each contained a comprehensive physical assessment, immunization records, and Tuberculosis (TB) Skin Test results. There was no documentation found in any of the files reviewed to verify that monthly audits of the cases by the Facility Administrator or designee occurred.

2.02 Sexual Predator Screening: All youth are screened to ensure they are not considered a sexually violent predator needing involuntary civil commitment upon release. **Satisfactory 5**

P The program maintained written policy and procedures outlining that when a Jimmy Ryce Sexual Predator Screening Instrument is not provided to the program at the time of admission, the Case Manager completes a Jimmy Ryce Screening Sexual Predator Screening at the program. A review of fourteen individual case management records found that all youth were screened using the DJJ Jimmy Ryce Sexual Predator Screening Instrument to ensure they were not considered to be a sexually violent predator. All the applicable forms were included in the commitment packets. None of the youth files reviewed met the criteria for sexual predator classification. An interview with the Facility Administrator also found that none of the youth in the program met the Jimmy Ryce eligibility criteria. It was found that the program did not have a system in place for tracking to ensure that potential Jimmy Ryce eligible youth were not released without being properly screened and that Jimmy Ryce procedures were followed, as required.

2.03 DNA Testing: There is a process in place to identify youth who need deoxyribonucleic acid (DNA) testing. **Full Compliance 2**

C

2.04 Searches Upon Admission: Youth are searched upon admission to ensure contraband is not introduced into the facility. **Substantial Compliance 1**

C The program maintained written policy and procedures outlining that a strip search is conducted and documented for each youth at the time of admission to the program. A review of fourteen individual case management records found that twelve documented that a strip search was conducted at the time of admission. Two records did not have documentation confirming that the youth were searched upon admission. All staff surveyed indicated that a youth strip search was required at admission. Twenty-one of twenty-five youth surveyed indicated that they were strip searched at admission. Seventeen of the twenty-five youth surveyed indicated that program staff explained why they were searched, and seven said that they did not receive any explanation. Fourteen of the twenty-five youth surveyed indicated that only one staff member was present during the search, eight youth indicated that two staff members were present, and three youth did not answer the question.

2.05 Personal Property Inventory: The personal property of all youth is identified and safeguarded until release. **Full Compliance 2**

C

2.06 Parental Notification: Parents or guardians of newly admitted youth are informed of their son/daughter's admission to the program and provided important information about the program's treatment services and rules. **Satisfactory 5**

The program maintained written policy and procedures outlining that upon each youth's arrival to the program the youth's parent/guardian would be contacted by telephone within twenty-four hours, and that a personal letter signed by the Facility Administrator would be sent within forty-eight hours, as required. A review of fourteen individual case management records indicated that in thirteen cases the parents/guardians were contacted by telephone within twenty-four hours and informed of youth's admission. In one case, the contact was not documented. The review of the records also indicated that in eleven cases, a personal letter signed by the Facility Administrator was sent to the parents/guardians within the required time frame, and in three cases the letters were sent outside the time frame. All the letters completed were signed by the Facility Administrator, and contained all the required elements as outlined in the DJJ Residential Services Manual.

2.07 Other Notifications: Department of Juvenile Justice staff and the courts are informed of each youth's admission to the program. **Substantial Compliance 1**

C The program maintained written policy and procedures outlining that a letters would be sent to the DJJ Commitment Manager within twenty-four hours, and to the committing court and the JPO within five-working days for each youth admitted to the program. A review of fourteen individual case management records found that twelve cases documented that the DJJ Commitment Manager was notified within twenty-four hours, as required. The review of the fourteen records also found that in thirteen cases the courts and the JPOs were notified within the required five-working days of youth's admission. In one case, there was no documentation indicating that the notifications were completed.

2.08 Classification: The program demonstrates the goal to protect youth through a classification system that ensures the most appropriate unit assignment and sleeping room assignment. **Superior 7**

The program maintained written policy and procedures outlining that the program had a classification process in place to determine the most appropriate unit and room placement for each youth admitted. Documented practice reflected that the program classification process included a review of the commitment packet documentation and other information received

by the program. A review of fourteen individual case management records found that all contained a Youth Classification Sheet form, which was completed at the time of admission. The classification form contained an initial alert classification section that was color coded for special risks and the individual needs of the youth. Each Youth Classification Sheet reviewed was signed and dated by the staff members who completed the form, and included the unit and room assigned, as well as the reason for the placement. In two of the cases reviewed the youth had special alerts, and in both cases the alerts were identified and documented during the classification process. Six of the eight staff surveyed confirmed that the program used a classification process to determine a youth's unit and room assignment.

2.09 Orientation Process: Youth are given an opportunity to learn about the program and its expectations through a positive orientation process. **Superior 7**

The program maintained written policy and procedures that outlined that upon admission the Case Manager would meet with the youth to discuss each item listed on the Orientation Checklist form. In addition, the policy indicated that the orientation material was translated verbally for those youth who did not speak fluent English. A review of fourteen individual case management records found that all contained an Orientation Checklist form signed and dated on the same day of the admission by youth and the staff member that conducted the orientation. Each orientation form included the youth's name, admission date, a list of nineteen orientation items, as well as an orientation to the fire drills and evacuation procedures. The program's orientation also included a review of the program's Youth Handbook. All staff surveyed confirmed that youth orientation to the facility began within twenty-four hours of admission. Twenty-four of the twenty-five youth surveyed indicated that they received information about the rules, program schedule, education classes, and other services, when they arrived to the program.

External Control Factors

None

STANDARD THREE: RESIDENTIAL COMMUNITY

Overview:

The program provides a structured environment for the youth in its care, with many opportunities for education, treatment, recreation and other activities. Youth are encouraged to develop and practice good habits in hygiene and dress. The program allows youth controlled access to the mail and the telephone, as well as encourages visitation from approved family members. The program has a grievance system in place, as well as a behavior management system.

3.01 Daily Activity Schedule: Youth are involved in a broad range of activities that address their academic, physical, social, and emotional needs. **Satisfactory 4**

The program had written policy and procedures related to its daily activity schedule. Documentation reviewed found that the program has a written, posted master schedule that includes all program activities, including education, vocational training, social skills and life skills training, recreation, special treatment services, and leisure activity. Documentation reviewed in program logbooks regarding activities was found to be vague or inconsistent with scheduled times. Of twenty-five youth surveyed regarding whether the program schedule is followed, fourteen said 'yes' and eleven said 'no'. All staff surveyed indicated that the program schedule is followed. Observation of program activity found that the schedule was not consistently followed. For instance, observation of lunchtime found that it began between ten to fifteen minutes after scheduled.

3.02 Recreation and Leisure Activities: Youth are provided opportunities to participate in recreational and leisure activities that offer a variety of opportunities to acquire new **Satisfactory 5**

skills, enhance existing skills, and develop competencies in areas such as relationship building skills, teamwork, and leadership.

The program had written policy and procedures related to recreation and leisure activities. Logbook documentation reviewed found that recreation and leisure activities occur daily. Interview with staff and youth, as well as logbook documentation, found that indoor activities, such as board games, are used on days when the weather is inclement. Documentation reviewed and interview with staff found that youth with medical restrictions were not allowed to participate in contraindicated activities. Of twenty-five youth surveyed regarding whether they participate in daily recreational or leisure activities, sixteen indicated that they did and nine indicated that they did not. When surveyed regarding whether youth had input into the types of recreational activity done, thirteen indicated that they had input while twelve indicated that they did not have input. Of eight staff surveyed regarding whether youth had at least one hour of large muscle activity daily, seven indicated 'yes' and one indicated 'no'.

3.03 Faith and Community Based Opportunities: The program recognizes and responds to the expressed religious and spiritual needs of youth. **Satisfactory 5**

The program had written policy and procedures related to faith and community based opportunities. Interview with staff and youth, and documentation reviewed found that these types of activities are provided to youth in the form of religious services and Bible studies conducted by volunteers from Calvary Chapel. Documentation reviewed in the visitor logbook found that twice weekly religious volunteers visit the program and meet with the youth. It was noted that the daily schedule or the master program schedule does not include time allotted for religious services or classes. Of twenty-five surveyed regarding whether participation in religious services is voluntary, eighteen indicated that it is voluntary while seven indicated that it is mandatory.

3.04 Just Read, Florida: The program demonstrates a commitment to ensuring children in its care are given the opportunity to read to increase their reading skills. **Superior 7**

The program had written policy and procedures related to its efforts at encouraging reading and literacy among youth in the program. Observation of program practices, and interview with staff and youth found that that youth are encouraged to read books outside of the classroom. It was noted that the program has established two libraries accessible to youth after regular school hours. Inspection of the books found that many genres were included, such as fiction, non-fiction, classical, and contemporary. Documentation reviewed found that the program administrator completed a Quarterly Reading Activity Report for the first quarter of 2006, as required. All staff surveyed, and fifteen of twenty-five youth surveyed indicated that the program encourages youth to read.

3.05 Personal Hygiene: The program promotes good personal hygiene and grooming habits for all youths. **Satisfactory 6**

The program had written policy and procedures related to personal hygiene promotion among youth served. Observation of the youth in the program during the quality assurance review found that most were well groomed; some youth with excess facial hair were observed. Interview with staff and review of documentation for five youth found that youth receive hygiene articles, such as toothbrushes and combs, during the admission process. Review of the program master schedule found that youth are required to shower and practice dental hygiene daily. It was also noted that the program conducted education groups for youth on topics related to hygiene. Twenty-four of twenty-five youth surveyed indicated that the program provided them with grooming items. Twenty-two of twenty-five youth surveyed indicated that they receive clean towels daily.

3.06 Dress Codes for Youth: The program promotes a dress code for youth that instills pride **Satisfactory**

in personal appearance. **5**

The program had written policy and procedures related to youth dress requirements and restrictions. Observation of youth in the program during the quality assurance review found that most were properly clothed. There were some instances noted of youth with pants worn below waist level with underwear visible, with holes in their socks, and with shoes/slides that did not fit properly. Observations found several youth at outdoor recreation wearing sweat suits that were not climate-appropriate.

3.07 Visitation: The program encourages and enables visitation and communication between youth and their families or significant others. **Superior 8**

The program had written policy and procedures that outlined the required rules and protocols for visitation. Observations found that the visitation rules were clearly posted at the entrance to the facility, as well as in the cafeteria where visitation is held. A review of documentation for five youth found that the program sent letters to parents/guardians encouraging them to come to visitation and informing them of the related guidelines. Documentation reviewed in the visitor's logbook found that weekend visitation occurs regularly. It was noted that in the log book visitors consistently signed in but did not consistently sign out. Twenty-two of twenty-five youth surveyed indicated that their parents/guardians have visited them at the program. Of those who indicated that they have visitors, seven indicated that their parents/guardians visit every week, twelve indicated that their parents/guardians visit one or two times per month, and the rest indicated 'other' regarding the frequency with which they have visits. All staff surveyed indicated that the program encourages visitation by parents/guardians.

3.08 Correspondence: The program affords each youth opportunities to send and receive mail. **Superior 7**

The program had written policy and procedures that outlined the required rules and protocols for youth mail. Interview with staff and youth and documentation reviewed found that the program provided writing materials and postage for all youth. It was also found that all youth had an approved contact list with names and addresses of persons with whom they were allowed to have correspondence. Interviews and observation of program practice found that all outgoing and incoming mail was scanned by staff in the presence of youth for safety and security concerns. Interviews with staff found that the case manager was responsible for deciding if a youth could receive a letter if the sender was not on the approved list. Twenty-two of twenty-five youth surveyed indicated that the program provided them with writing materials and postage to mail at least two letters per week. Twenty-two of twenty-five youth surveyed also indicated that staff make sure that letters sent and received were from persons on their approved list. All staff surveyed indicated that mail is searched.

3.09 Telephone Access: The program affords youth the opportunity to make and receive telephone calls to and from their parents/guardians. **Superior 7**

The program had written policy and procedures that outlined the required rules and protocols for youth use of the telephone. Interview with staff and youth found that youth are allowed one telephone call per week. Documentation reviewed clarified that youth on Orientation Phase Level 1were allowed a ten-minute call, youth on regular Level 1 and two were allowed a fifteen-minute call, youth on Level 3 and four were allowed a twenty-minute call. Interviews and observation of program practice found that the case manager or staff was responsible for dialing the outgoing telephone number, after confirming that it was listed as an approved contact for the youth. It was also noted that staff monitor the youth while on the telephone in case of inappropriate language or topics of conversation. All staff surveyed indicated that youth are allowed at least one phone call per week to his parents/guardians. Of eight staff surveyed, four indicated that they review the approved telephone list; five indicated that they dial the outgoing phone number, and four indicated that they speak with the individual called first. Twenty-four of twenty-five youth surveyed indicated that they were

allowed to make at least one phone call per week. Twenty-three of twenty-five youth surveyed indicated that staff make sure that they speak only with persons on the approved list.

3.10 Grievance Process: The program provides youth with clear, accessible, and fair avenues for lodging and resolving complaints and grievances, including the opportunity to appeal decisions. **Satisfactory 5**

The program had written policy and procedures related to its youth grievance process. The written procedures included all required time frames for phases involved in the grievance process, and included requirements for maintaining all grievances and findings in a central file for at least one year. Documentation reviewed and observation of program practice found that youth were informed of their right to grieve at orientation. A tour of the facility found that grievance forms were available to youth. Documentation reviewed in the program's central grievance file found that the program maintained grievance records for at least one year, as required. A review of randomly selected grievances found that many grievances processed prior to January 2006 contained vague documentation related to time frames and phases, and it was difficult to determine if requirements were adhered to consistently. It was also found that for those processed after January 2006; most were processed according to program and departmental requirements, including being signed by all involved parties. All eight staff surveyed indicated that youth were allowed to grieve and that they understood the grievance process. Of twenty-five youth surveyed, seven indicated that they had filed a grievance, and one indicated that staff had addressed his grievance. Of the youth surveyed who indicated that they had not filed a grievance, six youth indicated that they thought the grievance system was useless.

3.11 Behavior Management System: The program provides a system of rewards, privileges and consequences to encourage youth to fulfill the program's expectations and teach youth alternative pro-social means of meeting their needs. **Superior 7**

The program had written policy and procedures related to its behavior management system. Interview with staff, documentation reviewed, and observation of program practices found that the program utilizes a 'grading' system for youth. Youth are 'graded' twice daily, and can earn between zero to four points in seven different areas of behavior. It was found that scores were averaged weekly, and monthly, in order to determine the level earned for each youth. It was also noted that each level corresponded to different privileges. Interviews with staff and documentation reviewed found that youth's participation and progress in treatment also contributed to level achievement. Twenty-three of twenty-five youth surveyed indicated that they received written materials on the program's behavior management system at admission. All twenty-five youth surveyed indicated that they understood the program's behavior management system. All staff surveyed indicated that they had received training in the program's behavior management system. Seven of eight staff surveyed indicated that they understood the program's behavior management system and thought that it was effective.

3.12 Consequences and Sanctions: Consequences for violation of program rules are applied logically and consistently and are directly related in severity to the seriousness of the inappropriate behavior exhibited. **Partial 2**

P The program had written policy and procedures related to its use of consequences and sanctions. Interviews with staff and youth found conflicting versions of how consequences and sanctions are delivered. All staff surveyed indicated that consequences do not include the loss of meals, sleep, or school, and that youth are not allowed to punish other youth, and that they have not observed staff encouraging youth to beat up other youth. Nine of twenty-five youth surveyed indicated that consequences are not given on an individual basis, that group punishment is used. Nine youth surveyed also indicated that they had received consequences for rule violations and that they did not think the consequences were fair. Eleven of twenty-five youth surveyed indicated that they had meals, snacks, clothing and sleep taken away because of misbehavior. Two youth surveyed indicated that they have observed staff

encouraging youth to beat up other youth. Interviews with youth following tabulation of survey results found that accounts of group punishment were similar.

3.13 Room Restriction: Room restriction is used only as a response to the most serious incidents and, if used, youth are safeguarded against self harm. **NA**

The program had written policy and procedures, which indicated that room restriction is not utilized. No evidence was found otherwise; therefore, this indicator is rated 'Not Applicable'.

3.14 Behavioral Intervention Techniques: The program utilizes appropriate counseling, verbal intervention and de-escalation techniques prior to resorting to physical intervention. **Satisfactory 4**

P The program had written policy and procedures which outlined approved techniques for dealing with youth behavior issues and which stressed verbal intervention must be used prior to physical intervention. A review of documentation for twenty randomly selected Protective Action Response (PAR) reports found that the escalation matrix was followed and that verbal intervention was used. It was noted that mechanical restraints were used only for transportation purposes, as a precaution against escape and injury to self, others, or property. It was found that there was not a limited number of instance in which physical intervention was used. It was found that since January 2006, there was an average of twenty PAR incidents per month.

3.15 PAR Reports: Formal reports are completed, reviewed, and appropriate actions are taken when staff use countermoves, control techniques, takedowns, or mechanical restraints. **Satisfactory 6**

The program had written policy and procedures that included all departmental requirements and restrictions for the use of PAR techniques, including documentation requirements. Documentation reviewed for a ten randomly selected PAR reports found that all were completed, including being signed and reviewed by all required parties, within the required seventy-two hour timeframe. Two of the ten reports reviewed documented physical injury to the youth; both included documentation that the Central Communications Center (CCC) was notified, as required; it was noted, however, that the CCC was not notified within two hours of the incident, as required. Documentation reviewed found that a monthly summary of all PAR reports was submitted to the State Regional Director, as required.

3.16 Behavior Management Unit: A behavior management unit is used only when a youth's behavior significantly disrupts the program's residential community, endangers the safety of staff and other youth, or threatens major destruction of property and, when used, youth are protected from self harm. **NA**

The program had written policy and procedures that indicated that it does not utilize a Behavior Management Unit; therefore, this indicator was rated 'Not Applicable'.

External Control Factors

None

STANDARD FOUR: TREATMENT SERVICES AND CASE MANAGEMENT

Overview:

The program monitors the progress of each youth's overall performance, and the effectiveness of the program's on-going treatment services, through the case managers. Upon admission to the program, youth are assigned to a case manager. The program had six case managers that were primarily responsible for case management and for treatment team coordination and planning. At the time of the review the Case Manager Supervisor position was vacant. Formal and informal treatment team meetings are held for each unit. The formal review

involves the meeting of the treatment team to discuss each youth's progress. Informal review consists of the treatment team leader meeting with the youth on an individual basis. The program's multidisciplinary treatment team includes representatives from case management, program administration, mental health, direct care staff, education/vocation, each youth's Unit Manager, and other treatment staff as applicable. The treatment team conducts on-going assessments of the initial performance plan goals and objectives, and makes necessary revisions to the plan based on the current needs identified. The program uses the Balanced and Restorative Justice (BARJ) approach as a key component of every youth's performance plan, and provides Impact of Crime group sessions. The program provides Behavioral Health Overlay Services (BHOS), and is required to provide intensive mental health and substance abuse services. In addition, the Home Builders Institute (HBI), which is a nationally-recognized program for adolescent youth, serves twenty youth within the program by providing vocational, social, and life skills training to them, in the context of teaching building skills.

4.01 Treatment Approaches: Evidence-based theory or methods direct the program's treatment approaches. **Substantial Compliance 1**

C The program maintained policy and procedure outlining that the program's treatment methods were evidence-based. Documentation reviewed found that the program had a binder explaining Youth Services International, Inc.'s (YSI) Strategic Program Model. According to the documentation reviewed, the program's model was focused on education and development, and was based on the American Psychological Association's (APA) Commission on Violence, and the Florida-based research projects of Bishop and Winner. Observation found that the YSI Program Pyramid was posted throughout the program. The pyramid provides both a conceptual and operational framework for the program. According to the documentation reviewed, the YSI Program Pyramid incorporates up-to-date research on successful strategies with delinquent youth with theatrical principles of human learning, child-adolescent development and change process into a fully integrated model of intervention with high-risk youth. Although evidence that daily programming supported the treatment approach through the provision of structured therapeutic activities, it was found that most program staff could not articulate the basis of the treatment approaches.

4.02 Balanced and Restorative Justice: Youth are guided toward taking full responsibility for their criminal actions and antisocial behavior. **Satisfactory 6**

The program maintained written policy and procedures that outlined that the Case Manager Supervisor was the program's Restorative Justice Implementation Manager. At the time of the review the position of Case Manager Supervisor was vacant. However, a review of fourteen individual case management records found that various youth Individual Performance Plans included long-term goals and objectives related to the completion of Restorative Justice classes, as well as specific assignments from different chapters of the Impact of Crime Curriculum. The documentation reviewed found that the program provided regular Impact of Crime group sessions and activities related to the Balanced and Restorative Justice (BARJ) approach. Interviews completed with the program's Clinical Coordinator and a BHOS Counselor indicated that the direct care staff, under the supervision and training of the BHOS counselors, facilitate weekend Social Rehabilitation Groups for the youth in the program. The Social Rehabilitation Groups topics included Victim Empathy, Awareness, Alternative Ways of Behavior, and Relapse Prevention. Seven of the eight staff surveyed confirmed that the facility provided groups on Impact of Crime on Victims, and that the facility addressed victim rights with the youth. Twenty-two of the twenty-five youth surveyed indicated that they have groups on how crime hurts victims and the community.

4.03 Gender-Responsive and Culturally Responsive Treatment: The program provides a range of gender-responsive and culturally responsive treatment services. **Satisfactory 4**

The program maintained written policy and procedures that outlined that treatment services were gender-specific and culturally sensitive. In practice, observations and documentation reviewed found that there was little documented evidence of gender-responsive and culturally responsive treatment. The program had a Young Men's Work teen handbook, and staff interviewed indicated that multi-session groups related to that program were conducted; however, there was no available documentation to support that the groups were conducted. The program encourages cultural exploration and celebration by observing nationally recognized holidays, including the Martin Luther King Jr. Day. Documentation reflected that the BHOS counselors conducted groups that included parenting, feelings, and relationships, as well as groups that addressed youth issues about their girlfriends and domestic violence. The program has one BHOS Counselor that speaks Creole. Three of the staff members surveyed confirmed that the facility provided training in culturally and gender responsive treatment, while one staff surveyed indicated that the training was not provided, and three indicated that they did not know if the training was provided.

4.04 Assessment Process: The needs of youth are identified through a comprehensive review of all existing information about the youth and his family. **Satisfactory 5**

The program had written policy and procedures related to its assessment process. Interviews with staff and documentation reviewed found that the program staff reviewed all existing information about each youth and his family, and obtained updated information, as needed. It was noted that the program made attempts to involve the family in assessment and treatment by mailing to them a letter, with a self-addressed stamped envelope, requesting information, input, and proposals regarding performance plan goals. A review of fourteen youth files found that a needs assessment was completed in thirteen cases; in one case, for a youth admitted in January 2006, there was no documentation of a needs assessment having been completed at all. A review of the thirteen completed needs assessments found that twelve were completed within thirty-calendar days of admission, as required; in one case, for a youth admitted in December 2005, documentation reviewed found that the needs assessment had been completed in May 2006. In seven of the twelve cases in which a needs assessment was done, it was noted that the needs assessment was completed on the same day as admission. It was found that all thirteen completed needs assessments included background information pertaining to each youth, including relationships, academic skills, employability, life skills, social skills, recreational interests, physical health, sexual development, delinquency history, and community involvement. In one case, the youth was jointly served by the Department of Juvenile Justice and the Department of Children and Families (DCF); documentation reviewed found that in this case staff contacted the DCF Family Services Counselor, as required. Interviews with staff and documentation reviewed found that although the program did not accept sex offenders, attempts were still made to obtain Jimmy Ryce screening forms on all youth. Documentation reviewed found that all thirteen needs assessments identified staff designated to ensure that each youth's needs are met, and identified individuals responsible for keeping parents/guardians informed of each youth's progress. It was noted that one of the thirteen needs assessments available for review did not identify the youth's treatment needs, as required; the area of the documentation where treatment needs should have been documented was found to be completely blank. All eight staff surveyed indicated that they thought the treatment team considered the direct care staff's observation of the youth. Six of the eight staff surveyed indicated that they provided input to the treatment team regarding youth needs, while two indicated that they did not. Of twenty-five youth surveyed, twenty-one indicated that they were able to tell staff their suggestions for goals on their performance plan, while three indicated that they were not able to do so; one youth did not answer this survey question.

4.05 Performance Plans: Youth treatment is guided by an individual performance plan that is prioritized for the youth's needs and specifies goals that must be achieved prior to release from the program. **Satisfactory 4**

P The program maintained written policy and procedures requiring that the treatment team develop and prioritize the written goals within the initial individualized performance plan of each youth. The policy required that the initial individualized performance plan be completed within twenty-one calendar days. Documented practice and a review of fourteen individual case management records reflected that thirteen cases had completed performance plans that contained all the required elements. However, eight of the plans were completed within the required thirty calendar days of admission, while five were not. Three of the thirteen performance plans did not have signed sheets. None of the plan were signed by the parent/guardian, or significant others. Typically, plans contained five goals. One goal usually addressed the Balanced and Restorative Justice Approach. Performance goals did contain objectives that were measurable, related to the needs assessments, and had completion dates. Performance goals did identify the responsibilities of both the youth and staff. Twenty-two of the twenty-five youth surveyed confirmed that they know the goals that were on their performance plans.

4.06 Distribution of the Performance Plan: Parents/guardians, juvenile probation officers, the courts, and other pertinent parties are kept informed of the youth's goals and treatment provisions. **Non-Compliance 0**

C The program maintained written policy and procedures, which outlined that the program distributes the performance plan, with a transmittal letter, to all the required parties. A review of fourteen individual case management records found that one did not have a performance plan. The review of the other thirteen cases reflected that chronological notes did not documented that each youth received a copy of the performance plan. Further, six of the thirteen cases did not document that the committing court received a copy of the plan within the required ten working days of completion. Four of the thirteen cases did not document that the assigned JPO and the parents/guardians received a copy of the plan. One applicable DCF case documented that the DCF Counselor received a copy of the plan. Nine of the twenty-five youth surveyed confirmed that they received copies of their performance plans, and sixteen indicated that they had not received a copy of their plan.

4.07 Treatment Team Progress Reviews and Revisions to Performance Plans: Youths' progress is monitored and assessed by a multidisciplinary treatment team. **Satisfactory 4**

The program maintained written policy and procedures that indicated that each youth's multidisciplinary treatment team conducts on-going assessments of the initial performance plan goals and objectives, and makes necessary revisions to the initial plan based on the needs identified. Documented practice, observations, and a review of fourteen individual case management records found that the frequency of the staff participation in treatment team meetings varied. The only treatment team members consistently present were the case manager assigned and the youth. The required formal reviews were consistently completed by the program, but not the informal reviews; the latter were missing in three of the fourteen individual case management records reviewed. All the treatment team meeting documentation reviewed included each youth's name, the date of the review, and each youth's progress in the program. The majority documentation for the formal reviews included comments from the treatment team members. Although none of the performance plans reviewed contained new goals, one was revised when youth demonstrated lack of progress and anti-social behavior. Four of the eight staff surveyed confirmed that they regularly attended treatment team meetings, while three indicated that they did not attend, and one indicated that they sometimes attended. All youth surveyed indicated that they meet with their treatment team to discuss their goals and progress in the program.

4.08 Performance Summaries: Youths' overall progress in the program is summarized every 90 days and distributed to the courts, parents/guardians, probation officers, and other pertinent parties. **Partial 3**

The program maintained written policy and procedures that outlined that the Case Manager completes a performance summary every sixty-calendar days following the development of the performance plan, for each youth. A review of fourteen individual case management records found that in one case, for a youth admitted in December of 2005, there was no performance summary completed. In seven of the other thirteen cases, the performance summaries were completed as required, and in six cases, they were not. Further, in twelve of the thirteen cases, the summaries addressed all the required elements. None of the performance summaries reviewed had any youth comments, and three of the thirteen were not signed by youth. All the summaries reviewed were signed and dated by the assigned Case Manager and the Facility Administrator. Two of the thirteen summaries were not sent with a transmittal letter to the commitment court, and three were not sent to the JPO or parent/guardian. Twenty-one of the twenty-five youth surveyed indicated that they were allowed to read and sign their performance summaries. Sixteen of the twenty-five youth surveyed indicated that staff reviewed the performance summaries with them.

4.09 Family Involvement: The program recognizes the importance of a youth's family in the treatment process and pro-actively seeks opportunities to involve them. **Superior 7**

The program maintained written policy and procedures that ensure that the facility promotes family involvement that prepares the youth for return to the community. Documented practice indicated that the program fostered family involvement in many cases from the date of admission. The program strongly encouraged the family to participate in each youth's treatment process, where possible. The program sent a parent survey, and a map of the facility to the parent/guardian, attached to the parent's admission notification letter. The surveys requested parental input into the youth's needs and goals. The youth record chronological notes documented staff attempts to regularly contact the parents/guardians. In addition, an interview with the Clinical Director indicated that the family was contacted initially for the input and participation in each youth's Bio-Psychosocial Evaluation. The Clinical Director and one BHOS Counselor interviewed indicated that approximately half of the youth families attended monthly family therapy sessions by telephone, or in person whenever possible. The program also had parenting classes available. Seven of the twenty-five youth surveyed indicated that their parents/guardians participate in their treatment team meetings either at the program or by telephone. Twenty-four of the twenty-five youth surveyed indicated that their families participate in family counseling sessions at the program or by telephone.

4.10 Life and Social Skill Training: The program provides life and social skill training and experiential opportunities for youth to learn and practice life and social skills that will prepare them to be responsible, productive members of their home communities. **Superior 7**

The program maintained written policy and procedures that outlined that the facility provides youth with life and social skill training and experiential opportunities for youth to learn and practice these skills. Documented practice indicated that the facility provides life and social skills training as well as experimental opportunities for youth to learn and practice life and social skills. The program utilized the Personal Social Skills curriculum to teach youth life and social skills. An interview with the Clinical Director indicated that staff delivering the curriculum was trained in its application. It was noted that school personnel also conducted daily Personal Career and School Development classes that covered life and social skills. Further, the Home Builders Institute (HBI) offered vocational training to twenty youth who had reached level three or level four status within the program. All the twenty-five youth surveyed confirmed that the program taught them life and social skills. Ten youth surveyed indicated that the life and social skills groups were very helpful; twelve indicated that it was somewhat helpful, and three indicated that it was not helpful.

4.11 Coordination of Services for Youth Jointly Served by the DJJ and the Department of Children and Families: The program recognizes the importance of coordinating services for youth who are jointly served by the DJJ and the Department of Children **Satisfactory 4**

and Families.

Documentation reviewed found that the program maintained an up-to-date roster of all youth in the program who were jointly served by DJJ and DCF. At the time of the quality assurance review, there were four such youth in the program. A review of the youth records for the four applicable youth found documentation of the program having required monthly communicating with the JPO and the DCF Family Services Counselor in three cases. It was noted that the DCF Family Services Counselor was invited by the program to participate in the transition and exit conference; it was also noted that their overall participation in these events was irregular and sporadic. Interviews with the four youth, as well as a review of youth records and log books, found that the DCF Family Services Counselor maintained contact with the youth by face-to-face visits in two cases and by telephone in three cases. It was noted that one youth had both face-to-face and telephone contact, while one had face-to-face contact only, and two had telephone contact only.

4.12 Transition Planning: Planning for a youth's successful transition to the community begins upon program admission. **Satisfactory 4**

P The program maintained written policy and procedures that required that a transition plan be completed on each youth prior to their release. Documented practice in fourteen individual case management records reviewed indicated that in nine cases the treatment team identified transition needs and goals during the initial performance plan, while in five cases this was not done. A review of eight closed youth records indicated that in seven the conditional release counselor/JPO assigned participated in the youth's transition planning. In one case, there was no documentation available to review. Five of the twenty-five youth surveyed confirmed that they have been on a home visit.

4.13 Release Determination: Release is based upon the youth's successful completion of the youth's individual performance plan goals. **Substantial Compliance 1**

C/P The program maintained written policy and procedures that outlined that the multidisciplinary treatment team based each youth's release from the program upon the youth's successful completion of his performance plan. Documented practice and a review of eight closed records indicated that seven were applicable to the indicator since one was a direct release. A review of the seven applicable cases indicated that in five cases the program documented youth successful completion of the individual performance plan goals, while in two cases the required documentation was not available for review.

4.14 Release Notification Requirements: The juvenile probation officer, parent/guardian, crime victim, if applicable, and educational staff receive formal notification of the anticipated release of all youth in residential placement. **Satisfactory 4**

The program maintained written policy and procedures that indicated that the program provides release notification to all the required parties prior to a youth's release from the program. A review of eight closed records indicated that seven were applicable to the indicator since one was a direct release. A review of the seven applicable cases indicated that in four cases, the pre-release notification forms were sent to the assigned JPOs sixty days prior to release, and in three cases the forms were sent to the JPOs approximately thirty days prior to release. An interview with the Juvenile Justice Education Specialist indicated that educational staff in the program were notified prior to release to prepare the necessary transcripts of each youth's progress and to make recommendations for grade placement.

4.15 Jimmy Ryce Release Requirements: The program ensures youth committed as sexually violent predators are not released unless approved by the court or the Department of Children and Families. **NA**

C None of the youth at the program met the Jimmy Ryce eligibility criteria; therefore, this indicator was rated 'Not Applicable'.

4.16 Exit Conference: Program staff conduct a formal conference with youth at least 14 days prior to release to coordinate release procedures and prepare the youth for conditional release supervision, post commitment probation, or direct discharge. **Satisfactory 6**

The program maintained written policy and procedures that outlined that the program provides an exit conference at the facility to coordinate release procedures and prepare the youth for conditional release supervision or direct discharge. A review of eight closed records indicated that seven were applicable to the indicator since one was a direct release. A review of the seven applicable records indicated that six cases had an exit staffing form completed within the required time frame, which was also signed and dated by the youth, Case Manager, Mental Health Counselor, Conditional Release Provider, JPO assigned, and parent/guardian. In one case, the documentation of the exit staffing form was not available. Form letters issued in advance confirmed appropriate notifications were completed.

4.17 Transfer of DJJ Records and Education Portfolio: Information necessary of the continuation of service delivery is provided to receiving service providers when youth are transferred or released to the community. **Substantial Compliance 1**

C The program maintained written policy and procedures that outlined that each youth's official individual management record, the educational portfolio, and other applicable documentation are sent to the youth's DJJ JPO, or receiving program, within five working days of release. Although the review of eight closed records documented that the program transferred the records to the required parties, there was no documentation available to verify that the records were sent within the required five working days of youth's release. The mail receipts that indicated the date on which the records were sent were not available, as required by the program's procedure.

4.18 Closed Files: The program maintains closed files on all youth released for at least six months. **Full Compliance 2**

C

External Control Factors

None

STANDARD FIVE: MENTAL HEALTH AND SUBSTANCE ABUSE

Overview:

The program receives funding for the provision of Behavioral Health Overlay Services (BHOS) and provides mental health and substance abuse treatment services to the youth in its care. The program has a total of 136 youth beds, which includes 120 youth beds designated for BHOS (identified as Thompson Academy on JJIS) and 16 beds designated for substance abuse treatment (identified as Thompson Academy Choices on JJIS). The program has a Designated Mental Health Authority, responsible for coordination and delivery of services. In addition, the program has two Assistant Clinical Directors and fourteen BHOS clinicians.

5.01 Designated Mental Health Authority: A designated licensed mental health professional is responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services. **Full Compliance 2**

C

5.02 Clinical Coordinator: A clinical coordinator is responsible and accountable for coordinating and verifying implementation of mental health and substance abuse services in programs with less than 100 beds and do not have beds designated for specialized treatment services. **NA**

C The program has 136 youth beds, including 120 Behavioral Health Overlay Services (BHOS) beds and sixteen substance abuse treatment beds. As the program has more than 100 youth beds and because the program receives funding for specialized treatment services, it is required to have a Designated Mental Health Authority (DMHA). The DMHA is a psychologist, licensed pursuant to Chapter 490, Florida Statues. The program does not qualify for a position of Clinical Coordinator, as described in the QA Standards. Therefore, the program is being rated for 5.01 above, while 5.02 is being rated as 'Not Applicable'.

5.03 Comprehensive Plan for Mental Health and Substance Abuse Services, Crisis Intervention, Suicide Prevention, and Emergency Care: The program has written a comprehensive plan for mental health and substance abuse services, crisis intervention, suicide prevention, and emergency care that delineates the processes and procedures to be followed. **Satisfactory 5**

The program had a written plan for mental health and substance abuse services, crisis intervention, suicide prevention, and emergency care.

The plan was comprised of several separate documents, dated between 6/2/06 and 6/8/08, and was included within program policy and procedures for this Standard. A review of the plan found that it included required components, including details related to mental health and substance abuse services, screening and assessment procedures, treatment planning, suicide prevention, documentation requirements, communication requirements, the alert system, the referral process, and crisis intervention. It was also noted that there were required components not included within the plan, including transition planning procedures and details of staff training requirements. In addition, there were three sections of the plan, which included an area for the signature of the DMHA and the Program Director; all these areas were found to be unsigned by both parties.

A review of the plan also found that it was not presented in an easy-to-follow or logical manner in various areas. It appeared that segments of the plan were 'cut-and-pasted' together, as they were formatted differently or were of a different font and size than surrounding text, and steps included within the plan did not clearly outline procedures to carry out a policy or service. It was also noted that many areas of the plan were repetitive; for instance, the plan included two six-page segments on suicide prevention, both of which were identical to each other, word-for-word.

These concerns were communicated to the DMHA by the quality assurance team. As a result, the plan was revised on 6/20/06 into a single integrated document and to include previously missing components related to transition planning; however, details related to staff training requirements remained absent from the plan. The revised plan included signatures of both the DMHA and the Program Director in all sections that had an area for signatures. It was noted that the revised plan was not presented in an easy-to-follow or logical manner in various areas, as before, and contained the same typographical and procedural issues as stated above. The revised plan did, however, exclude all areas that were previously repetitive.

5.04 Mental Health, Substance Abuse Screening, and Suicide Risk Screening: The mental health and substance abuse needs of youth are identified through a comprehensive screening process that ensures appropriate referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk. **Satisfactory 5**

P Interview with the DMHA and review of program policy and procedures found that the program utilized that Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) for screening purposes when youth are first admitted to the program and when youth that have been on inactive status re-enter the program.

A review of fourteen youth files found that twelve contained documentation that a MAYSI-2 was administered at the time of intake and scored using the Department's Juvenile Justice Information System (JJIS). Documentation reviewed found two youth who were applicable for re-screening due to re-admission to the program after being on inactive status related to

being hospitalized under the Baker Act; documentation reviewed found that one of these two youth received a MAYSI-2 re-assessment while the other youth did not.

Documentation reviewed found that only one staff had completed the Department's training module, "Using the MAYSI-2 to Screening for Mental Health and Substance Abuse Problems". An interview with the DMHA found that the MAYSI-2 assessments were generally administered by case management staff rather than by mental health staff. Of the twelve MAYSI-2 instruments completed, eight were administered by case managers, while four were administered by either the DMHA or the Assistant Clinical Director.

All fourteen youth files contained documentation that staff reviewed the youth's commitment packet information for information regarding suicide risk, mental health issues, and substance abuse issues.

An interview with the DMHA and program staff, as well as documentation reviewed, found that the program referred all youth entering the program for immediate mental health services, regardless of 'hits' on the MAYSI-2.

5.05 Suicide Precautions: The program has a process in place for supervising, observing, monitoring, and housing youth who have been identified through screening or assessment as having suicide risk factors. **Partial 2**

P A review of fourteen youth files found two youth with documentation of placement on Suicide Precaution six times in less than four months. The Report of Suicide Precautions form was initiated, but also incomplete, in all six cases; items not completed included youth demographic information (such as date of birth and JJIS number), program name, signatures of staff, supervisors, and the Program Director, designation of safe housing areas of the program, and details of disposition activities. In addition, a review of the program's logbooks found no documentation of youth placement on Suicide Precautions or related activities.

A description of the findings for each of the six cases follows:

In the first case, the youth was placed on Precautionary Observation following re-admission to the program after returning from being involuntarily hospitalized under the Baker Act. It was noted that the youth did not receive a MAYSI-2 screening at re-admission (as outlined in 5.04 above). The youth remained on Suicide Precautions for six days, including one day on Precautionary Observation and five days on Close Observation. An Assessment of Suicide Risk and Follow-Up Assessment of Suicide Risk instruments were administered, as required. Documentation reviewed found time logs completed for four of the six days that the youth was on Suicide Precautions. In addition, supervisory review of the time logs available was found to be inconsistent. A review of the youth's mental health file found documentation of only one face-to-face individual counseling session for the six days that the youth was on Suicide Precautions.

In the second case, the youth was placed on Precautionary Observation following verbalizations of suicidal ideation. The youth remained on Suicide Precautions for less than a day; there was no documentation that the youth was placed on Close Observation as a step-down precaution. Documentation reviewed found no evidence that an Assessment of Suicide Risk instrument was administered at the time the youth was placed on Precautionary Observation; an Assessment of Suicide Risk was administered, however, prior to the youth's return to the general population. No documentation that time logs were completed during the entire time the youth was on Suicide Precautions was found.

In the third case, the youth was placed on Precautionary Observation following re-admission to the program after returning from being involuntarily hospitalized under the Baker Act. The youth remained on Suicide Precautions for four days, including two days on Precautionary Observation and two days on Close Observation. Documentation found that an initial Assessment of Suicide Risk instrument was administered prior to placement of the youth on Suicide Precautions; however, no documentation was found to suggest that any Follow-Up Assessment of Suicide Risk instruments were administered. While there were time logs available for all the days that the youth was on Suicide Precautions, it was noted that supervisory review of the time logs was found to be inconsistent. A review of the youth's

mental health file found documentation of only one face-to-face individual counseling session for the four days that the youth was on Suicide Precautions. Further, although the youth had just returned from being 'Baker Acted' and placed on Suicide precautions, the weekly summary section in the youth's file indicated "no significant events occurred this week".

In the fourth case, the youth was placed on Suicide Precautions for four days, including two days on Precautionary Observation and two days on Close Observation. Documentation reviewed found that an Assessment of Suicide Risk and Follow-Up Assessment of Suicide Risk instruments were administered, as required. Documentation reviewed found time logs completed for two of the four days that the youth was on Suicide Precautions. In addition, supervisory review of the time logs available was found to be inconsistent.

In the fifth case, the youth was placed on Suicide Precautions for four days, including two days on Precautionary Observation and two days on Close Observation. Documentation found that an initial Assessment of Suicide Risk instrument was administered prior to placement of the youth on Suicide Precautions; however, it was found that Follow-Up Assessment of Suicide Risk instruments were administered inconsistently, including none completed prior to the youth's removal from Suicide Precautions. While there were time logs available for all the days that the youth was on Suicide Precautions, it was noted that supervisory review of the time logs was found to be inconsistent, and in some instances, there was no documentation of staff initials and no entries regarding the behavior of the youth for several shifts at all.

Finally, in the sixth case, the youth was placed on suicide precautions for four days, including two days on Precautionary Observation and two days on Close Observation. Documentation reviewed found that an Assessment of Suicide Risk and Follow-Up Assessment of Suicide Risk instruments were administered, as required. Documentation reviewed found time logs completed for two of the four days that the youth was on Suicide Precautions. While there were time logs available for all the days that the youth was on Suicide Precautions, it was noted that supervisory review of the time logs was found to be inconsistent, and in some instances, there was no documentation of staff initials and no entries regarding the behavior of the youth for several shifts at all.

An interview with the DMHA and the Assistant Clinical Director found that the program did not have a system in place to track the frequency and proper implementation of Suicide Precautions.

The program's written policy and procedures indicated that Secure Observation is not utilized as a Suicide Precaution. No documentation was found to suggest otherwise.

5.06 Suicide Risk Assessments: Youth identified with suicide risk factors or who are considered to be a possible suicide risk are assessed by or under the direct supervision of a licensed mental health professional. **Superior 7**

P An interview with the DMHA and review of program's written policy and procedures found that all youth are screened for risk of self-harm at intake, regardless of prior history or MAYSI-2 findings. A review of fourteen youth mental health files found that all fourteen were evaluated during the admission screening process using an Assessment of Suicide Risk instrument. In addition, the all fourteen youth were also evaluated at intake using the Suicide Probability Scale (SPS) psychological testing instrument. It was found that in all fourteen cases these assessments were conducted by, or under the direct supervision of, a licensed mental health professional. It was noted that the instruments utilized by the program for this purpose met all departmental requirements; the instrument included documentation of the reason for and method of assessment, mental status examination, indication of degree of danger to self and level of suicide risk, supervision recommendations, and recommendations for treatment and follow-up.

It was also noted that there is a system in place to ensure an assessment of youth when there is a concern regarding risk of self-harm. Observations of program practice by the quality assurance team and documentation reviewed noted that when a youth voiced suicidal ideations to the program medical staff, the mental health staff were quickly notified and an Assessment of Suicide Risk instrument was administered very shortly thereafter.

5.07 Comprehensive Mental Health Evaluations: The mental health needs of youth are identified through a comprehensive mental health evaluation process. **Superior 7**

A review of fourteen youth files found that all youth received a predisposition comprehensive evaluation prior to entering the program. Documentation reviewed also found that mental health staff reviewed this document, along with the rest of the youth's intake commitment packet, at the time of intake.

Interview with the DMHA and documentation reviewed found that the program does not utilize an updated comprehensive mental health evaluation. Rather, it was found that the program administers assessments and develops a new comprehensive mental health evaluation for all youth.

A review of fourteen youth files found that all fourteen were assessed using the Beck Depression Inventory – Second Version (BDI-II) and a Brief Clinical Biopsychosocial Evaluation at the time of intake. It was also found that information from these instruments; along with findings from interviews with the youth, the family, and other parties, as well as findings from substance abuse assessments (described below, in 5.08) were combined into one document – a Comprehensive Mental Health and Substance Abuse Biopsychosocial Evaluation.

A review of fourteen youth files found that all had a Comprehensive Mental Health and Substance Abuse Biopsychosocial Evaluation completed within the first thirty days, as required. A review of the Comprehensive Mental Health and Substance Abuse Biopsychosocial Evaluation found that they were detailed, well-written, and included all required elements. In addition, all fourteen were found to have been reviewed and signed by a licensed mental health professional, either the DMHA or either of the Assistant Clinical Directors, as required.

5.08 Comprehensive Substance Abuse Evaluations: The substance abuse needs of youth are identified through a comprehensive substance abuse evaluation process. **Superior 7**

A review of fourteen youth files found that all youth received a predisposition comprehensive evaluation prior to entering the program. Documentation reviewed also found that mental health staff reviewed this document, along with the rest of the youth's intake commitment packet, at the time of intake.

Interview with the DMHA and documentation reviewed found that the program does not utilize an updated comprehensive substance abuse evaluation. Rather, it was found that the program administers assessments and develops a new comprehensive substance abuse evaluation for all youth.

A review of fourteen youth files found that all fourteen were assessed using the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2) at the time of intake. Interview with the DMHA and review of documentation found that the program also administered the American Society of Addiction Medicine patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2) diagnostic instrument to youth with identified substance abuse issues. Twelve youth were applicable for requiring an ASAM PPC-2 based on this criteria; documentation reviewed found that all twelve had received an ASAM PPC-2 assessment. It was also found that information from these instruments; along with findings from interviews with the youth, the family, and other parties, as well as findings from mental health assessments (described above, in 5.07) were combined into one document – a Comprehensive Mental Health and Substance Abuse Biopsychosocial Evaluation.

A review of fourteen youth files found that all had a Comprehensive Mental Health and Substance Abuse Biopsychosocial Evaluation completed within the first thirty days, as required. A review of the Comprehensive Mental Health and Substance Abuse Biopsychosocial Evaluation found that they were detailed, well-written, and included all required elements. In addition, all fourteen were found to have been reviewed and signed by a licensed mental health professional, either the DMHA or either of the Assistant Clinical Directors, as required.

5.09 Mental Health and Substance Abuse Treatment Plans: Mental health and substance abuse treatment is guided by an individualized treatment plan. **Satisfactory 6**

A review of fourteen youth files found that all contained an initial mental health and substance abuse treatment plan. Seven of fourteen initial treatment plans reviewed were found to be generic and did not include information based upon the findings of the MAYSI-2, the Brief Clinical Biopsychosocial Evaluation, and other assessments administered at the time of intake. It was also noted that the same seven of fourteen initial treatment plans mentioned above did not identify an initial Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) diagnosis, and generically identified only "Orientation to Thompson Academy" as each youth's "Problem Description/Symptoms". The other seven initial treatment plans included an initial DSM-IV diagnosis, and clearly identified the reason for referral and the presenting symptoms. All fourteen initial treatment plans identified initial treatment methods and initial treatment goals and objectives. It was noted, as mentioned above, that for half of the initial treatment plans reviewed, the initial treatment goals and objectives were generic and identical. All initial treatment plans were signed and dated by the youth and a mental health professional on the day of intake. Nine of fourteen initial treatment plans reviewed were completed or signed as a reviewer by a licensed mental health clinician, as required. None of the initial treatment plans reviewed were signed by other treatment team members.

A review of fourteen youth files found that all contained an individual mental health and substance abuse treatment plan. Documentation reviewed found that all individual treatment plans were developed within thirty days of completion of each youth's comprehensive mental health and substance evaluation, as required. Documentation reviewed found that all individual treatment plans included identification of youth strengths, DSM-IV diagnoses, specific and detailed symptoms for treatment, and individualized treatment goals and objectives which were related to the diagnoses and based on findings from the assessments conducted. All fourteen individual treatment plans reviewed included treatment interventions and target dates for completion of each objective. Documentation reviewed found that ten of the fourteen youth files reviewed were applicable for requiring inclusion of psychiatric services needs (for youth receiving psychotropic medication or other psychiatric services). It was noted that eight of these ten youth files included goals and objectives related to the youth's psychiatric services needs, as required. Documentation reviewed found that all fourteen individual treatment plans reviewed included signatures of the youth and the mental health clinical staff person that prepared the plan. Ten of fourteen individual treatment plans reviewed included signatures of other treatment team members. Eleven of fourteen individual treatment plans reviewed included signatures of, or documented efforts to obtain signatures of, youth parents/guardians.

An interview with the DMHA and mental health staff found that group therapy provided does not exceed ten participants with mental health diagnoses and fifteen participants with substance abuse diagnoses, as required for programs that provide specialized treatment services (BHOS). According to the DMHA, all treatment groups at the program are limited to a maximum of ten youth.

A review of fourteen youth files found that most contained documentation of a review of the individualized treatment plans every thirty days, as required. In one case, one treatment plan review for one thirty-day period was missing; a note in the youth's file indicated that the treatment plan had been reviewed, but that the documentation related to this was lost. In all other cases for all other youth files reviewed, documentation was found to verify that the treatment plan had been reviewed; this amounted to fifty-three treatment plan reviews done for fourteen youth over the last six months. Documentation reviewed found that in all cases the treatment team assessed the youth's progress toward treatment goals and objectives, and closed goals and objectives or modified target dates as needed. Documentation reviewed found that in all cases the treatment plan reviews were signed and dated by a mental health clinical staff person and that treatment plan reviews were signed as a reviewer by a licensed

mental health professional within ten days, as required.

5.10 Specialized Treatment Services: Programs with specialized beds can demonstrate specialized treatment services according to the specific specialized funding received. **Full Compliance 2**

C

External Control Factors

None

STANDARD SIX: HEALTHCARE SERVICES

Overview:

The program provides medical services to all of the youth residing in the program. The program had a contract with a licensed Advanced Registered Nurse Practitioner (ARNP) who serves as the Designated Health Authority (DHA). The DHA has a professional collaborative practice agreement with a licensed physician. The program has a Registered Nurse who serves as the Nurse Manager and supervises three Licensed Practical Nurses (LPNs) and oversees the day-to-day operations of the medical clinic.

6.01 Designated Health Authority: The program is committed to providing healthcare services which are provided by and/or supervised and monitored by a healthcare professional who has the knowledge and expertise for this function. **Substantial Compliance 1**

C The program maintained written healthcare policy and procedures outlining that each youth will be provided a preliminary physical, mental health and substance abuse screening at the time of admission to ensure that the youth has no medical conditions mental health or substance abuse issues of any nature that renders admission unsuitable or unsafe. The program maintained a written collaborative practice agreement with an Advanced Registered Nurse Practitioner (ARNP); license number ARNP1737192, to serve as the program's Designated Health Authority (DHA). The ARNP's clinical specialty is in the area of Family Practice. The collaborative practice agreement outlined all required elements with the exception of the treatments that may be initiated by the ARNP and the drug therapies that the ARNP may prescribe, initiate, monitor, alter or order. In addition, the agreement did not spell out the number of on-site hours, days of the week and times, extent of availability of emergency services and specific on-call responsibilities, and specification of other duties as agreed upon by the program and the licensed physician. There is a written collaborative practice agreement between the ARNP and a Florida licensed physician that included all required elements with the exception of the Drug Enforcement Agency (DEA) number of the physician. Not all parties had reviewed the collaborative practice agreement annually. The last documented review between the licensed physician and the ARNP was dated July 8, 2004. There was an Agreement for Professional Services between the ARNP and Youth Services International, Inc. reviewed and dated on July 20, 2005.

6.02 Healthcare Policies and Procedures: The Florida Department of Juvenile Justice policies and facility operating procedures effectively govern the healthcare delivery system of the program. **Substantial Compliance 1**

C The program maintained written healthcare policies and procedures outlining the healthcare delivery system. The Designated Health Authority (DHA) reviewed each written policy and procedures on April 13, 2006 and again on June 21, 2006, as evidenced by her signature. The program maintained pre-written health treatment guidelines and pre-dated physician standing orders. Each youth file reviewed had a pre-date of March 24, 2005 physician standing order prescribing over-the-counter medications (Sudafed, Tylenol, and Pepto-Bismol) on an as needed or PRN basis even though all of the youth were admitted after this date. The ARNP

signed off on the physician standing orders. Observations found that the medical clinic maintained the 2005 facility operating procedures (FOPs) and not the new 2006 FOPs. There was no documentation available for review to validate the healthcare staff were oriented to the healthcare policies and procedures. However, documentation was found to validate that the 2006 quality assurance standards were reviewed through an in-service training on April 26, 2006.

6.03 Healthcare Admission Screening: Youth are screened for health related conditions at the time of admission to identify health concerns that need immediate action and referral for further assessment by healthcare staff. **Satisfactory 6**

P The program maintained written healthcare policy and procedures outlining that all youth are screened for any urgent healthcare need. A review of fourteen individual youth healthcare files found that the licensed healthcare staff, upon admission, screened all youth by using the required DJJ Facility Entry Physical Health Screening form. The program modified the form to include hemophilia and post head injuries within the past two weeks. Documentation reviewed indicated four youth were identified with a medical condition requiring that the DHA be notified to obtain instructions and/or treatment orders. The DHA was notified within the required time frame for three of the four youth. Documentation reviewed indicated that the DHA was notified in thirteen hours; however, the program's registered nurse (RN) initially screened the youth. Program policy and procedures did not outline that the RN may act as the DHA for this notification. All four youth were examined by the ARNP within one week of each youth's admission into the program. Documentation reviewed found that the nursing staff completed a new Facility Entry Physical Health Screening form each time a youth left the physical custody of the program.

6.04 Comprehensive Physical Assessment and Health Related History: The program demonstrates effective planning for the "well care," routine, acute and chronic healthcare needs of youth. **Satisfactory 5**

The program maintained written healthcare policy and procedures outlining that all youth admitted into the program should have a current Comprehensive Physical Assessment (CPA) and Health Related History (HRH). Policy indicated that if a youth is admitted and did not have a CPA within the last two years, the facility nurse would schedule one with the ARNP. Policy did not differentiate between medical grades; whereas, the CPA for medical grad one is valid for two years and the CPA for medical grades two-five is valid for only one year. A review of fourteen individual youth healthcare files found that all had a completed HRH on file completed prior to or at the same time as the CPA. All HRHs completed prior to the youth's admission documented the program's nursing staff review. Each filed reviewed had a current CPA on file documenting the appropriate medical grade. Credentials of the person conducting the CPA were documented in ten of the fourteen CPAs reviewed. The date was documented on each of the CPAs; however, no time was recorded. The height and weight of each youth was recorded in all fourteen CPAs reviewed; however, only ten documented full vital signs. Only one of the fourteen CPAs reviewed documented the body mass index and no CPA recorded Tanner Staging. All sections of the review of systems on the CPA was completed in five of the fourteen reviewed. For those youth deferred for services, no documented reasons were present. All applicable files reviewed documented an update to the youth's Problem List each time a new issue was identified.

6.05 Vaccinations: All youth receive recommended vaccinations in accordance with national standards published by the Center for Disease Control. **Satisfactory 5**

The program maintained written healthcare policy and procedures outlining that a history of each youth's immunizations is obtained during the initial screening process, and that immunizations are up-to-date as outlined by the Department of Health. A review of fourteen individual youth healthcare files found that each contained immunization records. All records documented the nurse's review to ensure the vaccinations were up-to-date of which four were

not up-to-date. Procedures were followed as outlined in DJJ policy and in the DJJ Health Services Manual informing the parents/guardians with the exception of informing them of the ten-day window to respond to the certified mail. Two files documented that a Mantoux (PPD) was administered and then the Parental Notification of Health Related Care: Vaccination/Immunization form was sent to the parents/guardians afterwards. However, there was no documentation to indicate that the Vaccination Information Statements (VIS) was sent. Interviews with nursing staff and observations of VIS would indicate that this was performed. As no vaccines are maintained on-site at the program other than Mantoux, two youth files documented that each was taken to the Department of Health for the required vaccinations. One youth was administered the vaccination out of the statutory time frame. The documentation indicated that the nursing staff attempted to get parent/guardian approval several times within the required time frame.

6.06 Continuity of Medications: All youth who are prescribed medications receive them as ordered without lapses. **Superior 7**

The program maintained written policy and procedures outlining all youth admitted into the program who are receiving medications require the healthcare staff to determine the actual medication regimen and make every effort to continue that regimen so that there is no lapse in receipt of the medication by the youth. A review of fourteen individual youth healthcare files found that five youth were receiving prescribed medications at the time of admission or upon return from a Baker Act admission. There was no reason to further verify the medication or the authenticity in four of the five; however, procedures were in place should the nursing staff need to do so. One file documented the medication was verified through the parent/guardian upon the youth's admission. Documentation reviewed indicated that the program utilized Rxperts Pharmacy Services, Inc. from Hollywood, Florida. Policy incorrectly outlined that Colonial Pharmacy was utilized for the procurement of medications; however, practice demonstrated that the nursing staff utilized Rxperts Pharmacy Services, Inc. with no delays. Procedures outlined that medications are paid through Medicaid and YSI corporate office.

6.07 Pharmaceuticals: Storage, Security, Access, Inventories, and Disposal: Medications and sharps are secured, inventoried, stored, and disposed of safely and in a manner which ensures accountability for all individuals who have access to them. **Full Compliance 2**

C

6.08 Medication Administration: The program director and designated health authority are committed to the goal of ensuring that all youth are administered their prescription medication in a safe and timely manner. **Satisfactory 6**

The program maintained written healthcare policy and procedures outlining the administration and documentation of each dosage of medication by the licensed nursing staff. A review of fourteen individual youth healthcare files found that ten youth were receiving or had received prescribed medications since their admission into the program. All youth healthcare files documented a valid physician's or ARNP written order. A review of the Medication Administration Records (MARs) indicated that administration of each dosage was documented and initialed by the nursing staff providing the medications. Youth were not required to initial the MAR as the licensed healthcare staff administers all medications. Youth and staff surveyed validated that nursing staff are the only staff to administer medications. The most commonly occurring side effects and/or precautions were observed listed on the MARs consistently in eight of the ten healthcare files reviewed. Prevailing practice in the last few months has greatly improved as Rxperts Pharmacy Services, Inc. provides the program with pre-printed MARs with all common side effects and youth allergies listed. The only staff designated to administer medications are the licensed nursing staff. No youth can self-administer medications. The only exception is the youth who require an inhaler. Inhalers are stored on each unit assigned to a youth in need. In emergencies, youth can self-administer

this medication. There were no missed doses of medications documented, with the exception of one youth, who refused to take his medication for two days. The physician discontinued the medications after the second day.

6.09 Chronic Conditions ("Periodic Evaluations"): A proactive health program exists that provides care for chronically ill youth and developmentally disabled youth who require close medical supervision and multidisciplinary care. **Superior 7**

The program maintained written healthcare policy and procedures outlining youth identified with a chronic condition would receive closed medical supervision and multidisciplinary care. A review of fourteen individual youth healthcare files found that eleven youth were identified as needing close medical supervision. Documentation reviewed indicated these eleven youth were re-evaluated at least every ninety-days by a physician or ARNP. There were four youth identified as receiving anti-tuberculosis medications and each file reviewed documented weekly side effect monitoring even after the first month. Six of the fourteen youth healthcare files reviewed indicated the youth were receiving psychotropic medications. Weekly side effect monitoring was conducted for year youth. Documentation reviewed indicated the physician re-evaluated each youth monthly. All psychotropic medication appointments documented the required minimum information as outlined in the DJJ Mental Health and Substance Abuse Services Manual.

6.10 Medical Alert Process: Information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent treatment information is communicated to staff. **Satisfactory 4**

P The program maintained written healthcare policy and procedures outlining that information concerning a youth's medical and/or mental health condition, including medications, allergies and other pertinent information, is communicated to staff. The nursing staff completed a medical alert form on each youth identified with a specific concern. The form was a checklist identifying medical condition, psychotropic medications, allergies to food or medications, and a list of five areas for staff to watch (head trauma, seizure disorder, diabetic, asthma, antibiotics). The form did not include side effect information of medications other than psychotropic. In addition, the form did not address foods and medications that are contraindicated. The medical alert form was revised during the quality assurance review to include these and to include medication versus other medication contraindications. The practice was for the nursing staff to complete the individual medical alert and had deliver it to the appropriate unit where the youth resides and explain to the Unit Supervisor the concerns and to place the alert in the Medical Alert binder. Policy did not address how often the Medical Alert binder was to be reviewed by the nursing staff as to remove all outdated alerts for youth discharged from the program or no longer on the alert. Nurse interviews indicated that the Nurse Supervisor attempts to review the binders each month for this purpose. There was no documentation available to validate this practice. In addition, nursing staff completed a separate dietary alert and had delivers it to the contracted food service personnel. Staff surveyed indicated that half are aware of what to do if a youth has an adverse reaction to a medication. Nineteen of twenty-five youth believe that staff are aware of their medical problems, allergies or medications prescribed.

6.11 First Aid and Emergency Care (Episodic Care): The program has an effective rapid response component to address medical and dental emergencies. **Satisfactory 4**

P The program maintained written healthcare policy and procedures outlining the program's rapid response component to address medical and dental emergencies. Policy outlined that youth are provided on-site episodic care. The names, addresses and telephone numbers of individuals to be notified, and/or services, such as ambulance and hospital to be used for emergency care should be readily accessible to all personnel and be posted in the reception control room of each of the three units. Observations of each unit found that the emergency numbers were posted in two units. The Nurse Supervisor posted the numbers in the other

after it was found missing. There were no basic procedures available for review outlining on-site first aid care to include dental trauma. However, most staff has been certified in basic first aid and cardiopulmonary resuscitation and each first aid kit contained sting relief swabs. The program did maintain Epipen; however, the medication expired and all were thrown away. The Nurse Supervisor indicated that a new Epipen would be ordered. There were no emergency procedures for insect bites or bee stings. Quarterly medical drills were conducted on all shifts since the last quality assurance review with the exception of the night shift. One documented quarterly drill was missing for this shift. The nurse conducting the drill critiqued the medical drill; however, there was no documentation to indicate that the management staff was involved in the review or whether the information was shared with all program staff and medical staff. A review of fourteen individual youth healthcare files found that two youth required emergency care and all procedures were followed as outlined in the policy and procedures. The program utilized Memorial West Hospital in Pembroke Pines, Florida for twenty-four hour emergency care. Holy Cross Hospital in Fort Lauderdale, Florida was utilized for orthopedic cases. Staff surveyed indicated that half has participated in a mock medical drill in the past three months.

6.12 Infectious and Communicable Diseases: Staff, the program director, and the designated health authority recognize the potential severity of communicable diseases, and are well equipped to prevent and/or treat them. **Full Compliance 2**

C

6.13 Sick Call: Youth are provided effective sick call including timely access to referrals. **Superior 7**

The program maintained written healthcare policy and procedures outlining the opportunity for youth to voice healthcare concerns and be evaluated by the nurse to determine the severity of their concerns. Sick call is scheduled from 4:15 pm to 5:30 pm Monday through Friday and is administered by the licensed nursing staff. During a review of the facility, it was observed that two of the units did not have blank sick call request forms in the sick call box available for youth. Youth interviews indicated that the boxes are usually left empty; however, youth can request a form from staff. Youth surveys validate that the forms are available to the youth. A review of fourteen individual youth healthcare files found that thirteen youth had documented sick call requests. All sick call complaints were recorded on the Sick Call Index and the Sick Call Log. No youth presented the same sick call complaint within a two-week period. Six youth had documented dental complaints of which each received an examination by the contracted dentist. In addition, all youth admitted into the program were referred and examined by the dentist. One youth had a blank Sick Call Index; however, episodic care was provided and all documentation was completed as outlined in the DJJ Health Services Manual. All youth surveyed indicated that they can be placed on sick call whenever requested and all indicated that they could be seen within twenty-four hours of the request.

6.14 Human Immunodeficiency Virus (HIV): Confidential HIV testing is conducted when testing is recommended based on a clinician's assessment, when testing is recommended based on risk assessment, or when youth requests testing. **Superior 7**

The program maintained written healthcare policy and procedures outlining Human Immunodeficiency Virus (HIV) testing shall be made available to all youth in the program. The Broward County Health Department conducts all HIV testing including pre-test and post-test counseling. A qualified representative comes to the program approximately every two months to conduct the pre-test counseling and swabbing. Two weeks later the same representative returns to provide post-test counseling with the test results. A review of fourteen individual youth healthcare files found that all youth were provided health education regarding HIV/AIDS. All youth were provided the opportunity to be tested of which nine accepted. All test results were securely sealed in an envelope marked "confidential" and

placed in the youth's individual healthcare file. Youth surveyed indicated all are aware of being able to request a HIV test.

6.15 Authority for Evaluation and Treatment and Notification of Care: The program is committed to fulfilling the statutory and community standards for notification to parents when new prescription medications are prescribed, and when changes in healthcare occur. **Satisfactory 5**

The program maintained written healthcare policy and procedures outlining that the program shall maintain a written parental authorization for healthcare services documented on the DJJ Authority for Evaluation and Treatment (AET) form. A review of fourteen individual youth healthcare files found that each contained a signed original or copy AET form. However, only four AETs were the March 2005 edition that included the revised DJJ policy on parents/guardians of significant changes in the youth's condition and/or when new psychotropic medications were prescribed. Twelve youth were identified as being prescribed non-psychotropic medications and ten had documentation of the parental notification. The other two youth were eighteen years of age and requested in writing for their parents/guardians not to be notified. Seven youth were identified as being prescribed psychotropic medications and all had documentation of parental notification. However, it was difficult to determine if each was sent by certified mail as copies of receipts were missing in a few youth files. All copies of the letters were filed in chronological order behind the AET in the youth's healthcare file. Three youth were identified as requiring a medication change or a change in health status and the parental notification letter included the name of the medication, reasons the mediation was prescribed and potential side effects. There was no documentation of potential adverse effects.

6.16 Health Education: A continuum of health education that reflects health topics for the adolescent population is provided to youth at the program. **Satisfactory 5**

The program maintained written healthcare policy and procedures outlining that all youth shall receive health education and documentation shall be maintained on the DJJ Health Education Record. A review of fourteen individual youth healthcare files found that all youth received health education in the prevention of communicable diseases, gender-specific education, AIDS education, general information on prevention of alcohol, nicotine products and substance abuse, prevention and self-treatment measures for overweight/obesity, and basic hygiene measures. Eleven youth Health Education Records documented the importance of exercise and no file documented first aid measures and prevention of accidents or basic hygiene when preparing and/or handling food. Youth surveyed validated that health education is being provided at the facility.

6.17 Health Records: Each youth at the program shall have a confidential, aggregate individual healthcare record (IHCR) maintained. **Satisfactory 6**

P The program maintained written healthcare policy and procedures outlining that an Individual Health Record is maintained for each youth in the program. A review of fourteen individual youth healthcare files found that ten of the fourteen files were observed marked "confidential" and included the allergies on the outside of the file. The four missing "confidential" stamps were corrected during the quality assurance review. Each of the "core healthcare profiles" were reviewed and documentation indicated that all files contained the Problem List, Authority for Evaluation and Treatment, Sick Call Index, Immunization Records, most recent Comprehensive Physical Assessment, Health Related History and Health Education Record. All files contained the Health Related Common Registration; however, the second page was left blank in all files reviewed. In addition, all files contained chronological progress notes, on-site physician orders, prior Medication Administration Records, Facility Entry Physical Health Screenings, miscellaneous records, mental/behavioral healthcare, and dental healthcare. Eleven applicable files contained summaries of off-site care. Four applicable files contained laboratory tests and radiological tests. Each file

reviewed was not consistently set up in the same fashion. Some of the files had dividers to easily move from one section to the next. It was difficult to determine if the cumulative individual healthcare record was sent to the appropriate Juvenile Probation Officer due to lack of documentation available.

6.18 Gynecological Services: The program has a comprehensive system for providing gender-sensitive ands trauma –informed primary, obstetrical, and gynecological services to girls. **NA**

C The program serves only male youth; therefore, this indicator was rated 'Not Applicable'.

External Control Factors

None

STANDARD SEVEN: FOOD SERVICES

Overview:

The program provided meals for the youth in its care. Meals were prepared off-site and delivered to the program from a contracted provider. Meals served are required to follow a pre-approved menu. All areas in which food is prepared, consumed, or stored are required to be kept clean and inspected regularly.

7.01 Sanitation, Cleanliness, and Food Service Inspections: Food service areas are clean, sanitary, and well maintained. **Partial 3**

P The program had written policy and procedures related to kitchen cleanliness and food service inspections. Observations, interviews with staff, and documentation reviewed found that all meals were prepared off-site by an outside source contracted to provide meals. It was noted that youth and staff were responsible for cleaning the kitchen and dining area after each meal. Documentation reviewed found that the program had a valid food service certificate posted in the kitchen area. Documentation found that the program conducted an internal weekly inspection. Documentation reviewed found that inspections were also done by the local health department; however, documentation of only two inspections was available for review, rather than four, as required. A tour of the facility found that the kitchen and dining area required cleaning. It was found that the floor was not clean, and required to be swept and mopped. It was found that grates in the kitchen counter, when removed, revealed hidden food remnants. It was found that there was a walk-in freezer in the kitchen area that was inoperable and that it was being used as a storage space. Observation of the freezer contents found boxes of food, including fruit, which smelled spoiled.

7.02 Nutritionally Balanced Meals: Nurtitionally balanced meals are planned and provided to youth. **Satisfactory 4**

P The program had written policy and procedures related to nutritionally balanced meals. Documentation reviewed found that a weekly-cycle menu was in place, and posted for youth. Comparison between the menu and meals actually served found that there were discrepancies. Interview with program administrators found that the program had recently changed its contracted food provider and had neglected to update the posted menus. It was also noted that the menus from the new contracted food provider, although signed by a registered dietician, were expired. Observation of meals served and review of the program schedule found that there were no more than fourteen hours between the evening meal and the morning meal, as required. It was also found that at least two of the three meals served daily were hot, as required.

7.03 Meal Quality: Youth regard meals as having a pleasing flavor, texture, temperature, appearance, and palatability. **Satisfactory 4**

Observation and sampling of meals served found that they were of a satisfactory nature. Of twenty-five youth surveyed, five indicated that they food was ‘good’; twelve indicated that it was 'fair', and eight indicated that it was 'poor'.

7.04 Special Diets: Special diets are provided to youth as prescribed by appropriate medical or dental personnel or when religious beliefs require the adherence to religious laws. **Satisfactory 5**

The program had written policy and procedures related to provision of meals to youth with special dietary needs. Interview with staff, documentation reviewed, and observation of program practice found that the program nurse provided the food service manager with written notification of dietary restrictions for various youth. It was unclear how the food service manager was notified for youth with special dietary requirements for non-medical reasons, such as for religious reasons. Documentation reviewed and observation of program practice found that alternative meals were prepared and served to youth with special dietary needs. Of twenty-five youth surveyed regarding whether the program makes substitutions for youth with allergies to certain foods, seventeen youth indicated 'yes', two youth indicated 'no', and six youth indicated 'sometimes'.

7.05 Food Service Manager Certification: The food service program is supervised by an individual with special training and experience. **Full Compliance 2**

C

7.06 Security of Kitchen and Eating Utensils: Kitchen and eating utensils are controlled to ensure youth safety and security. **Satisfactory 4**

The program had written policy and procedures related to kitchen and eating utensil security. It was noted that the written policy was not clear regarding the storage location of utensils; a 'locked cabinet' was identified, but no further specification was made. Observation of program practice found that serving utensils were kept in an office area just outside the cafeteria. Documentation reviewed found that the program kept a written inventory of kitchen utensils. It was also noted that the program documented the number of eating utensils given to and collected from youth at mealtime. A tour of the facility, however, found that kitchen utensils were not always secured; this was evidenced by the observation of a large, metal cooking or serving spoon left unsecured in the cafeteria.

7.07 National School Lunch and Breakfast Program: Provisions are taken to ensure effective implementation of the National School Lunch and Breakfast Program. **NA**

The program does not participate in the National School Lunch and Breakfast Program; therefore, this indicator is rated 'Not Applicable'.

External Control Factors

None

STANDARD EIGHT: PROGRAM SAFETY AND SECURITY

Overview:

The program has persons designated as the Safety and Security Coordinator and as the Tool Control Manager. The program has written polices and procedures in place related to safety and security concerns. The program utilizes on-going monitoring of youth, including random youth counts, room searches, log book documentation, tool control, emergency equipment, staff training, and other methods in order to provide a safe environment for youth and staff. There have been some issues, including damage to the physical plant by recent hurricanes, and two escapes within the last year.

8.01 Safety and Security Coordinator: A safety and security coordinator oversees the **Satisfactory**

program's safety and security systems. **6**

The program had written policy and procedures that addressed the requirements for a Safety and Security Coordinator. The position description for the Coordinator fulfilled all departmental requirements. Documentation reviewed and interview with staff found that the Facility Administrator designated the Assistant Facility Administrator as the Safety and Security Coordinator. Documentation reviewed found that the program had a Security Operations Manual that outlined various departmentally required security issues. Shift reports reviewed revealed that safety and security checks were conducted during each shift, documenting deficiencies found for follow-up by management. There was documentation found that indicated that the Coordinator reviewed all policies related to safety and security. It was also noted that the Coordinator was involved in the emergency drills and had reviewed documentation of the drills. Documentation reviewed was complete and thorough, and indicated that the Coordinator consistently monitored systems and processes associated with safety and security.

8.02 Staff-to-Youth Ratios: The program maintains appropriate staff-to-youth ratios. **Partial 3**

P The facility had written policy that outlined its system to ensure the staff to youth ratios are maintained. Interview with staff and observation of practice found that direct care staff were designated as a "point or alternative point person" on the staff schedule. This employee was the "holdover" staff to provide coverage should the need arise. The person designated as the point person was scheduled as the holdover on the day prior to their being scheduled off, thereby eliminating the possibility that a staff would have to work a double shift, then have to return to work another shift eight hours later. During the review week, while there were an adequate number of staff on-site at the facility to maintain required ratios, it was observed that there were numerous occurrences of staff to youth ratios of 1:16 and 1:14. It was also observed that at times youth were not properly supervised, and were left in a classroom area or hallway alone. A review of the logbooks and staffing schedules for at least six months reflected that the staff to youth ratios were not met for several months during the reviewed period. It was noted that prior to February 2006, many staff terminated employment and the program experienced great difficulty in hiring adequate personnel. Twenty-one of the twenty-five youth surveyed indicated that they feel safe, while four indicated not feeling safe. Of the four stating that they did not feel safe, written reasons given were that the program was "dirty" and that "staff swing on you", indicating physical abuse. Staff surveys reflect pre-assignment of staff to be held over is in place and used. Six of eight surveyed stated that there was enough staff to provide for the safety and security of the youth, while two stated there was not enough.

8.03 Key Control: The facility has a system in place to govern the control and use of keys. **Satisfactory 5**

The program had written key control policy that defined the system in place to ensure key control in the facility. Observation found that staff keys were stored in designated key lock boxes and were signed out by staff through the master control operator during the hours of 7am-11pm everyday, at the beginning of each shift, by requiring staff to exchange personal keys for assigned keys and sign the keys back in at the end of the shift. It was noted that master control was not manned during the 11pm-7am shifts, leaving the shift supervisor with the responsibility to address key control issues. Documentation reviewed and observations of staff on duty found that sign in sheets and key logs were completed. It was noted that there was an awareness of key control by staff, as well as a chain of custody/control over facility keys. However, it was also observed that staff were often sharing keys among themselves, and that key control issues with teachers leaving keys unattended in classrooms with youth. Key types were standard commercial grade and key rings were metal brazened rings, each of which had a brass numbered tag. The Maintenance Supervisor was designated as the Key Control Officer, and was responsible for repair and replacement of keys and locks, when

necessary. The Assistant Facility Administrator was designated as the Assistant Key Control Officer. Visitors were required to surrender their keys upon entry to the facility in exchange for a numbered chit that corresponded to a key slot in the visitor key box. Six of eight staff surveyed indicated not having a key to all program doors, while only two staff indicated that they had access to all program doors. Seven staff indicated not having a key to juvenile personal property. Seven indicated no staff or visitors were allowed to have personal keys in areas where youth frequent.

8.04 Emergency Use of "9-1-1": Program staff, contracted employees, teachers and volunteers have the right and responsibility to contact "9-1-1" if a situation exists that is of a potentially life –threatening nature involving youth. **Full Compliance 2**

C/P

8.05 Logbooks: Routine information, emergency situations and incidents are communicated shift-to-shift through the use of permanent bound logbook(s). **Satisfactory 5**

The program had written policy and procedures that addressed the requirements for facility logbooks. The logbooks reviewed were hardbound books with numbered pages. Safety and security issues were highlighted in yellow marker, allowing staff to readily identify important information when arriving on their work shift. A review of the facility logbooks found that there were pages with no dates, some entries with no staff signature, but most with dates on top of the page. It was found that staff would sign using their initials for log entries. There was documentation in the logbooks that staff conducted population counts at each shift, bed checks, any transport of youth and security checks. Documentation that the logbooks were being reviewed weekly by the facility administrator or designee was not consistent or not recognizable. Late entries were highlighted as "late entry"; however, highlighting of the entire entry was not done the majority of the time. There was no evidence of erasures or "white out areas". It was also noted that there were numerous entries that were difficult to read due to the illegibility of writing. Master control logbooks were thorough; however, it was noted that during the review several movements of youth occurred that were not recorded in the master control logbook. Six of eight staff surveyed indicated having been trained on the proper documentation required in the logbook. Eight indicated that reviewing the logbook gives them the information about the previous shift, while six stated they receive information during shift briefing.

8.06 Youth Counts and Census Tracking: The program ensures youth are accounted for at all times through a system of physically counting youth at various times each day. **Satisfactory 5**

The program had written policy and procedures related to youth counts and census tracking. Documentation reviewed found that youth counts were recorded in program log books at the beginning and end of each shift. It was also noted that additional youth counts were done before and after activities, drills, movements, and other important events. Documentation reviewed found that the program maintained a daily census and youth information report, as departmentally required. Observation of program practice found that youth counts were done several times throughout the course of each day. It was noted based on observation, however, that staff and youth movement during youth counts resulted in repeated miscounts and subsequent required recounts on several occasions. Of eight staff surveyed regarding when youth counts occur, seven indicated 'various times per day', seven indicated 'at the beginning of each shift', four indicated at 'admission', three indicated at 'release', four indicated at 'offsite activities', five indicated at 'outside recreation', five indicated at 'changing of classes', six indicated 'before and after meals', and seven indicated at 'the end of each shift'; four of eight staff indicated 'all of the above'. All eight staff surveyed displayed knowledge of when emergency counts occur. One of eight staff surveyed indicated that they had 'experienced problems with the facility youth counts'.

8.07 Physical Plant Safety and Security: There are viable safety and security processes in place to facilitate a safe and secure environment. **Satisfactory 5**

The program had written policy and procedures that addressed all requirements related to physical plant safety and security. Logbooks reviewed documented perimeter checks on a consistent basis. Other safety and security checks were found to be completed in a timely manner, recorded on the shift report, and documented deficiencies that required follow-up by management. Some doors, facility locks and buildings were found to be not in good working order. There was no camera system. The program consists of five buildings that are connected, were de-obligated from the State to the City of Pembroke Pines. Program maintenance was shared with the property management. The program has responsibility for interior issues, while the property management handles such issues as air conditioning, landscaping and roof, as well as structural issues. The entrance-building doorbell was inoperable throughout quality assurance review, causing persons to have to knock on the door to alert master control staff, if not previously observed approaching. The electronic buzzer for the interior door from the vestibule area was inoperable for three days during the review, causing either master control staff or another staff to have to unlock the door with a key manually. The program has made considerable interior upgrades to the living areas and designated 'Honors Rooms' to promote its behavioral management system. Staff received radios as part of the shift change. The number of radios passed from shift to shift was not documented in the log consistently. Observations revealed that all but three direct care staff were assigned a radio. A concern noted was that at least two egress door locks were 'sticky', indicating that keys were cut incorrectly. A facility walk-through during the review found that the egress door to classroom seven was damaged and could close properly unless additional force was applied. A windowpane in classroom one was found to be missing, which also indicated a waste of energy. All eight staff surveyed reported that they documented any problems that may impact program safety and security in the logbooks or on security checklists.

8.08 Public Safety: The program responds with immediate and appropriate action in the event that a youth escapes or absconds from the program. **Superior 7**

P The program had written policy and procedures related to youth escapes. Since the last quality assurance review, the program has incurred two youth escapes. Review of all documentation associated with the incidents reflected that notifications were made within requirements and that corrective actions were taken. The second escape incident, which involved the same youth from the first escape, revealed that staff did not implement preventive measures with a youth who was known as an escape risk. Eight staff surveyed acknowledged being trained on the escape response plan.

8.09 Public Safety: There have been no escapes from the program since the last QA review. **Non-Compliance 0**

C Since the last review, the program has incurred two escapes, involving two youth.

8.10 Contraband and Searches: The program has developed and implemented a system to prevent the introduction of contraband into the program. **Satisfactory 6**

Logbook entries reviewed indicated that youth were frisk searched prior to and after each activity to control contraband within and into the program. This practice was observed throughout the review; however, instances of lack of thoroughness of the search were observed. Searches were done at varied, unannounced times to ensure youth were not able to ascertain a time frame. All eight staff surveyed indicated all three types of searches were conducted. Furthermore, all eight staff reported that room searches were conducted at least once per day. Ten of twenty-five youth surveyed indicated room searches and facility search occur all the time; fourteen suggest often, while one stated that they rarely occur. Nineteen youth indicated frisk searches occur at all different times and locations within the program.

Only one youth reported strip searches occurred when returning from off campus activities, while nine reported that they occur when items were missing from the program, and six stated that they occur after visitation.

8.11 Vehicle Safety and Security: All vehicles that transport youth are maintained in a safe manner and kept secured when not in use. **Full Compliance 2**

C

8.12 Room Checks: Staff observe youth at least every 10 minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. **Full Compliance 2**

C

8.13 Tool and Sensitive Item Control: The facility has an effective tool management system to prevent youth from using equipment and tools as weapons or as a means of escape. **Satisfactory 6**

The program had written policy and procedures related to tool control. It was noted that the program recently hired a new maintenance mechanic who was designated as the Tool Control Manager. It was observed that the Home Builders Institute (HBI) program has installed shadow boards for all Class A tools and all Class B tools, except mops and brooms. Foodservice was catered and brought into the facility everyday; program staff completed their own inventories of kitchen utensils and knives daily. Youth do not use tools outside of HBI, other than brooms and mops. Youth and staff reported that youth were not allowed to use Class A tools unless in the Home Builders Institute program, which is under staff supervision. During the review, the maintenance van was found unlocked; it contained a flat-head screwdriver that was not inventoried on the facility tool inventory, and it did not have the facility etching.

8.14 Controlled Observation: Youth are protected from self-harm when placed in a secure controlled observation room for behavior that imminently and substantially threatens the physical safety of others. **NA**

The program has a written policy indicating it does not use controlled observation. Therefore, this indicator is rated 'Not Applicable'.

8.15 Off Campus and Temporary Release Activities: The program balances the need for youth to participate in community activities and home visits with the need to protect the community when youth are considered to be a risk. **Satisfactory 5**

The program had written policy that described procedures for off campus and temporary release activities. It was noted that a risk assessment was completed on youth prior to an outside activity or temporary release. The staff to youth ratio of 1:5 was found to be maintained, and was sometimes exceeded, when program staff accompanied HBI staff on off campus activities. It was found that youth were assessed prior to taking part in these activities. The program has recently initiated temporary release and home visits. The reviewed documentation of five youth files reflected that appropriate notifications and approvals were executed, and the youth were within the placement timeframes to participate.

8.16 Disaster Preparedness: The program has a Disaster Plan to address responses to potential disaster or emergency situations. **Satisfactory 4**

P The program had written policy and procedures related to disaster preparedness. It was noted that the facility maintained a thirty-day food supply, a thirty-day clothing supply, and an emergency log, which contained all contact information. The disaster plan was posted in the facility, and was available to staff, youth, or visitors. The facility COOP plan was found to have been sent electronically to the DJJ COOP Coordinator for approval. Key or essential personnel were listed. There was no staff training record documentation that staff were

trained on disaster procedures during orientation. Youth files reflected they were given related instructions during their orientation to the facility. Mandatory checks were found to be completed to ensure emergency equipment was in proper working order. It was noted that corrective action took place as deficiencies were noted. Fire Drills were found to be conducted on all shifts monthly. It was found that local fire officials signed off on the fire evacuation and prevention plans. Placement of equipment was throughout the facility and all had current inspection tags. Evacuation routes were posted in each wing of the facility. Staff indicated they were trained annually in fire prevention and youth were informed of their responsibilities during orientation, however no documentation was available to confirm. An updated Disaster Plan was reviewed, however there was no evidence that the DJJ Regional Residential Services Director had reviewed the plan. There was no documentation available for review to support staff training on disaster plan. All surveyed youth reported knowing what to do it there was a fire. Seven staff surveyed reported being trained on the disaster plan/COOP plan, and in the various related areas. Six staff reported to knowing where the plan is located; while all eight indicated that they knew where the fire equipment was located. All eight staff indicated that fire drills occur monthly.

8.17 Flammable, Poisonous and Toxic Control: The program maintains strict control of flammable, poisonous and toxic items. **Satisfactory 4**

The program had written policy related to control of chemicals. Observations during the review revealed that all inventories were kept away from youth and were located in secure areas. It was noted that, in cleaning, staff applied chemicals to surfaces and youth wipe or mop; youth do not handle chemicals directly. Documentation reviewed indicated that daily use logs were not always consistent. The unit logbooks had consistent indication of clean up events. There was no current documentation of disposal of hazardous chemicals. Material Safety Data Sheets (MSDS) were in place, categorized alphabetically by brand name. Information sheets were easy to follow, giving precautions concerning the health risk, as well as first aid information. During the review, observation found that a yellow storage cabinet outside behind the dining room, containing two red gas containers, one containing gasoline, was unlocked and readily accessible to others. Youth and staff surveyed indicated that youth do not use these items without staff oversight.

8.18 First Aid Kits and Emergency Equipment: The facility maintains first aid equipment and supplies that are approved by the designated health authority or designee and are available at all times in designated areas of the facility. **Full Compliance 2**

C/P

8.19 Water Safety: Programs that choose to participate in water related activities develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. **NA**

The program had written policy indicating it does not allow the youth to participate in water activities. Documentation reviewed and staff and youth surveyed confirmed this. Therefore, this indicator is rated 'Not Applicable'.

8.20 Prevention of Heat Stress Injuries: The program takes appropriate precautions in order to prevent heat stress injuries through adherence to accepted heat stress and exercise tolerance guidelines. **Partial 3**

The program had written policy and procedures related to the prevention of heat stress injuries. Documentation reviewed found that staff received training on heat stress injuries, how to identify those who may be at risk, and precautions to take to minimize this type of injury. No documentation was available for review to confirm the practice that environmental conditions were checked and posted prior to outdoor activities. During the quality assurance review, youth were observed playing on the hard surface recreation yard. It was observed that

drinks were available to youth and that staff were monitoring the activity. Observation revealed youth had the ability to rest, if needed, during activities. During the review, youth were observed exercising outdoors; it was noted that the weather was very warm, yet the youth participating were wearing sweat pants. It was noted that this uniform was not appropriate for the weather conditions. An interview with the facility nurses found that they retrieve the heat index information from local news weather reports and the national weather service for the facility zip code area. The nurses then notify master control and each dorm of the findings and whether it is safe for youth to engage in outdoor activities. There was not significant documentation available for review to indicate consistent practice, although staff surveyed reported being informed of the weather/heat information each day. Twenty-two youth surveyed reported that a change of recreational activities was made when it was very hot or humid outside. All eight staff indicated being informed throughout the day of the heat index. Seven staff indicated receiving training in the signs and symptoms of heat illness.

External Control Factors

During the summer of 2005, the program was affected by the numerous hurricanes that hit the South Florida area. Damage was sustained to various parts of the program's physical plant, in particular the area housing youth classrooms.

STANDARD NINE: TRAINING AND STAFF DEVELOPMENT

Overview:

The program provided opportunities for its staff to receive initial and ongoing job-related training, including trainings required by the department. The program had a Master Training Plan, and maintained staff training files on each employee.

9.01 Master Training Plan: The program has a current written master training plan that specifies minimum and additional training necessary to ensure staff have the competencies needed to effectively perform their job functions. **Satisfactory 4**

Master training plan policies and procedures were maintained by the program that outlined the contents of the training plan to include: the minimum training requirements for all employees, specialized training, a schedule for training individual employees, and procedures to incorporate training mandated by the Department of Juvenile Justice. The program maintained a Master Training Plan that included training for all staff types, orientation training, in-service training, specialized training, topics of training, Protective Actions Response (PAR) training, Cardiopulmonary Resuscitation (CPR) and First Aid training. The plan did not identify statutorily mandated trainings, CORE LMS trainings, or projected dates to complete training. The program maintained documentation that the Facility Administrator reviewed the Master Training Plan at least annually.

9.02 Orientation Training: All newly hired staff and volunteers receive orientation training within the first 15 days of employment. **Satisfactory 4**

Orientation policies and procedures were maintained by the program that outlined the program's procedure for new employees to complete orientation training within the first fourteen days of employment. Twenty employee-training files were reviewed. Eight files were applicable to requiring orientation training. Five files documented that orientation training was completed within the required timeframes. One file documented that training was completed after the initial fourteen days. Two files did not have orientation documentation dated; therefore, the reviewer was unable to determine if the training was completed within the required timeframes. Orientation training addressed all of the required trainings outlined by the Department of Juvenile Justice.

9.03 Pre-Service Training Requirements: All program staff complete the pre-service **Partial**

training as well as specific training for staff required by the provider's contract with the Department. **3**

Pre-service training requirement policies and procedures were maintained by the program that outlined the pre-service courses that each staff would take during the orientation process. Twenty individual staff training files were reviewed. Eight were applicable to needing pre-service training. Seven files contained documentation that the staff had received Protective Action Response (PAR) training. Six of the eight files documented that staff had received their Cardiopulmonary Resuscitation (CPR) and First Aid certifications. Two files had no documentation of the CPR/First Aid class being completed or certifications received. None of the files documented that staff had received training for "Promoting Professional and Appropriate Staff Conduct (Red Flags)", "Suicide Prevention", or "Emergency Procedures" training as required. Training Records/Logs were not consistently maintained in all files to document pre-service training.

9.04 In-Service Training: In-service training is provided to all staff annually. **Partial 2**

In-service training policies and procedures were maintained by the program that outlined the training coordinator's responsibility to schedule and post-mandatory trainings for all full-time and part-time staff. Twenty individual employee-training files were reviewed. Twelve files were applicable to needing in-service training. Nine files maintained documentation that staff held a current CPR certification. Two files had expired certificates and one file had no documentation of a current certification or training. Ten files maintained documentation that staff held a current First Aid certification. One file had an expired First Aid certification and one file contained no documentation of a current certification or training. Seven files maintained documentation of PAR update training. Five employee files contained no documentation that the staff had completed the required PAR update. None of the files showed documentation that the staff had completed additional required in-service training or CORE LMS training. Additional trainings and CORE LMS trainings were not included on the Master Training Plan schedule.

9.05 Other Trainings: The program provides other training activities required by the Department. **Partial 1**

Other trainings were incorporated into the in-service policies and procedures that were maintained by the program. The procedures did not include Restorative Justice, Disaster Preparedness, COOP training, Fire Prevention and Fire Extinguishing Procedures, Riot Training, Behavior Management System training, Gender Specific training and specialized population trainings. Twenty individual employee-training files were reviewed. None of the files documented training received in Restorative Justice, Gender Specific training or specialized population training. Seven files maintained documentation of other-type trainings received during the orientation process to include Disaster Preparedness, COOP training, Riot training, Fire Prevention and Fire Extinguishing Procedures, or the Behavior Management System. Other trainings were not incorporated into the Master Training Plan and were not on the Master Training Plan schedule to be completed at a future date.

9.06 Supervisory Training: Supervisory staff successfully complete twenty-four hours of training annually in topics applicable to their job duties. **Partial 1**

Supervisory training policies and procedures were maintained by the program that outlined the program's procedure for supervisors to complete an eight hour Personal Accountability Training within one year of employment. The program's policy did not include Employee Relations, Communication Skills training or Fiscal training incorporated into their training requirements. Twenty individual employee-training files were reviewed. Three files were applicable to requiring supervisory training. None of the files documented that supervisors had begun taking the required courses. The Master Training Plan schedule did not reflect that these courses were scheduled for later in the training year.

9.07 Training Records: The program documents all training to ensure effective tracking of staff training hours and certifications. **Satisfactory 4**

Training records policies and procedures were maintained by the program that outlined the training coordinator's responsibility to input courses into the on-line CORE Learning Management System (LMS) and to maintain employee training files. Twenty individual employee-training files were reviewed. All twenty files were neatly organized with a table of contents outlining the included documents. The files did not have consistently maintained Training Record/Logs. Nine of the files contained training agendas, test results and other related training materials. None of the files had required training events recorded in CORE LMS.

External Control Factors

None

STANDARD TEN: CONDITIONAL RELEASE

Overview:

Thompson Academy does not provide a Conditional Release component; therefore, this standard is rated Not Applicable.

10.01 Field Notes: Upon receipt of a case for conditional release supervision, field notes are developed by conditional release staff. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.02 DELETED

10.03 Pre-Release Contracts: Once a youth has been assigned to a conditional release program, the assigned conditional release staff must make monthly contact with the youth either face-to-face or telephone, with the youth's parent/guardian. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.04 Transition Planning: The conditional release staff participates in the youth's transition planning process. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.05 Transition Phase Contacts: During the transition phase, conditional release staff makes a face-to-face contact at the youth's home. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.06 Initial Contact Upon Release From Commitment Programs: The conditional release staff makes a face-to-face contact with the youth within 24 hours (excluding weekends and legal holidays) of the youth's return home from the residential program. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.07 Educational and Vocational Services: If educational services or vocational school are part of the supervision plan. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.08 Individualized Supervision Plan: Within 14 calendar days of the youth being placed on supervision, the JPO/contracted case manager develops an individualized supervision plan with the youth and parent/guardian. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.09 Monthly Reviews of Supervision Plans: Staff review the supervision plans with the youth every 14 calendar days and with the youth and parent/guardian every 30 calendar days. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.10 Supervision Contact Requirements: The conditional release staff makes the appropriate number of contacts consistent with the youth's level of commitment. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.11 Mental Health and Substance Abuse Services: Written policy, procedure and practice document that if a youth needs mental health or substance abuse services, the conditional release staff refers the youth for services within 7 working days of receipt of the comprehensive assessment. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.12 Supervisory Review of Assigned Cases: Written policy, procedure and practice document that the supervisor reviews each case with the assigned staff 30 calendar days after the youth is placed on conditional release supervision or assigned to the conditional release program. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.13 Transportation: Written policy, procedure and practice provide that the conditional release staff facilitates and/or provides transportation assistance for the youth to and from the program (or makes arrangements for such transportation), to job interviews, medical appointments, recreational activities, etc. in the home community as required. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.14 Grievance Process: Written policy, procedure and practice document that the program has a grievance process that allows youth or parents to grieve, in writing, the actions of program staff or the youth's peers, or conditions or circumstances of care and treatment. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.15 Flexible Work Schedules: The program maintains a weekly schedule for conditional release supervision staff that indicates flexible workdays and 24-hour day availability. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.16 Contacting the DJJ Juvenile Probation Officer: Written policy, procedure and practice provide that the conditional release staff informs the assigned DJJ Juvenile Probation Officer and the parents of all important occurrences in the case. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.17 Absconders: The JPO/contracted case manager submits an affidavit or request for an order to take into custody within 72-hours (three working days) to the court once it has been determined that a youth has absconded from supervision. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.18 Transfer Staffing: Written policy, procedure and practice specify that prior to transferring a youth, the case is staffed with the supervisor and the JPO/contracted case manager notifies the youth and parent/guardian of the request for transfer by sending them copies of the performance transfer summary. **NA**

Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

10.19 Release Determination: Written policy, procedure and practice document that a youth's release date is determined by the assigned conditional release staff in collaboration with the assigned juvenile probation officer. **NA**

P Thompson Academy does not provide a Conditional Release component; therefore, this key indicator is rated Not Applicable.

External Control Factors

None

EDUCATIONAL SERVICES