Monitoring and Quality Improvement Standards for Detention Services FY 2019-2020

Office of Program Accountability

Promoting continuous improvement and accountability in juvenile justice programs and services.

The Department acknowledges the Monitoring and Quality Improvement (MQI) Standards are built upon Department rules, policies, procedures and manuals. As we continue to improve and refine our competitive procurement process, there may be instances in which requirements negotiated between the Provider and the Department exceed the MQI Standards. In instances where contractual obligations surpass requirement(s) set forth in the published Standards, the contract requirement will prevail.
# MQI Standards for Juvenile Justice Detention Services

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* The Department has identified certain key critical indicators. These indicators represent critical areas requiring immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area.
1.01 Initial Background Screening

Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible, and the employee does not demonstrate he or she exhibits any behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.

— CRITICAL —

Guidelines/Requirements: Background screening is mandatory for employees, volunteers, mentors, and interns with access to youth and confidential youth records to ensure they meet established statutory Level 2 screening requirements. The Department is mindful of its status as a criminal justice agency and its special responsibilities in dealing with the youth population and utilizes Level 2 Screening Standards, as required in s. 435.05, 985.644(3) and 985.66(3)(a) 3 F.S., to screen individuals prior to employment or volunteering and every five years of continued service.

New Screening Required:

Moving from the Department to a contracted provider, from a contracted provider to the Department, or from one contracted provider company to another is considered a new hire and a new background screening is required.

Screening documents (IG/BSU 002 and 005, a copy of driver’s license, Social Security Card, and IG/BSU 003) must be submitted to the BSU when a provider employee is screened in the Clearinghouse and wants to be hired by another provider. The hiring provider must submit also receive a completed copy of those screening documents prior to hiring the employee. (Note: Fingerprinting is not usually required.)

New Screening not Required:

Contracted/grant provider volunteers, mentors, and interns who assist or interact with provider youth on an intermittent basis for less than ten hours a month do not need to be background screened if an employee who has been background screened is always present and has the volunteer within his/her line of sight. (Note: Intermittent basis means the volunteer provides assistance on a noncontinuous basis or at irregular intervals; visiting no more than once a quarter.)

Current employees of the Department or a provider are not required to submit a new background screening request when they are promoted, demoted, or transferred within their organization, as long as there is no break in service.

A volunteer who has been hired by the center is not required to submit a new background screening, as long as there is no break in service.

a. Once the volunteer screening is completed, the volunteer is considered active as long as the fingerprints are being retained by FDLE/Federal Bureau of Investigation (FBI), the five-year rescreening/resubmission is being completed, and the volunteer is added to the Clearinghouse employee roster within ninety-days of completing the screening request.
Other Requirements:

Neither the Department nor contracted providers shall hire any applicant until:

a. An eligible background screening rating has been received, and the criminal history report has been reviewed.

b. An application with an ineligible/not eligible rating has received an approved exemption from disqualification from the Department, has received an eligible rating, and the criminal history report has been reviewed.

c. The provider has administered a pre-employment assessment tool to the direct-care position applicant prior to hiring and has determined what is a passing score. (volunteers are not required to take or pass the assessment tool).

d. The provider has placed a copy of the pre-employment tool and passing score in the applicant/employee record.

e. The provider has added the employee or volunteer to their Clearinghouse employment roster.

The provider is responsible for ensuring their hiring authority has reviewed the CCC Person Involvement Report, the Staff Verification System (SVS) module, Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) result, and completed any required agency personnel record reviews prior to hiring staff or utilizing a volunteer who will have contact with youth, or access to confidential youth records, with the exception of the SVS module for volunteers.

Annual Affidavit Requirement:

Teachers/Instructional personnel who are paid by the school board or who are paid through funding provided by the school board or Department of Education to provide instruction to youth in a program are not required to undergo background screening by the Department.

Certified law enforcement and security officers who are paid by their law enforcement or security agency to provide security service in a center are not required to undergo background screening by the Department.

a. Review records of all staff hired and volunteers starting since the last annual compliance review to determine a clearance was received prior to the employee being hired and volunteers starting. This includes all contracted staff (medical, mental health, designated health authority (DHA), designated mental health clinician authority (DMHCA), psychiatrist, and any education position hired by the center) and volunteers.

b. Confirm if an exemption was granted by the Department prior to hiring or utilizing any staff or volunteer currently working in the program who were rated ineligible/not eligible for employment by the Department’s Inspector General to continue employment.

c. Review documentation to determine whether the Affidavit of Compliance with Level 2 Screening Standards for the center, school, and law enforcement/security agency were submitted to the Background Screening Unit (BSU) prior to January 31 of the current calendar year. (Review spreadsheet sent from BSU.)

Reference:

- FDJJ-1800 and FDJJ-1800 PC, Background Screening Policy and Procedures
- F.S. 985.644, Departmental Contracting Powers; Personnel Standards and Screening
1.02 Five-Year Rescreening

Background rescreening/resubmission is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant’s personal profile page within the Clearinghouse.

Guidelines/Requirements: A rescreening/resubmission is completed every five years, calculated from the agency hire date (original date of hire). This date does not change when a staff transfers within a Department or provider program or when a staff member is promoted. Five-year rescreens/resubmissions shall not be completed more than twelve months prior to the employee’s five-year anniversary date.

When a rescreening/resubmission is submitted to the Background Screening Unit (BSU) at least ten business days prior to the five-year anniversary or retained prints expiration date, but it is not completed by the BSU on or before the anniversary or retained prints expiration date, the screening shall meet annual compliance review standards.

a. Clearinghouse resubmissions must be initiated in the Clearinghouse portal at least ten business days prior to the Retained Prints Expiration Date.

b. Clearinghouse rescreening/resubmission request forms must be submitted to the BSU at least ten business days prior to the Retained Prints Expiration Date.

When a rescreening/resubmission is not submitted to the BSU at least ten business days prior to the five-year anniversary or retained prints expiration date and the BSU does not complete the rescreening prior to the anniversary or retained prints expiration date, the screening shall not meet annual compliance review standards.

Review the employee and volunteer roster to determine which staff and volunteers required a five-year rescreening/resubmission since the last annual compliance review. All eligible staff and volunteers should be reviewed.

Review records and Clearinghouse records of all applicable staff and volunteers hired five years since their initial hire date of employment to determine if a clearance was submitted at least ten days prior to the employee anniversary date of being hired within the agency (not promotional date) or to check retained prints expiration dates. This includes all contracted staff (medical, mental health, designated health authority (DHA), designated mental health clinician authority (DMHCA), psychiatrist and any education position hired by the center – not employees paid by the school board).

Reference:

FDJJ-1800 PC, Background Screening Policy and Procedures
1.03 Staff Code of Conduct

Center staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, “horseplay,” or personal relationships with youth.

Officers shall maintain the confidentiality afforded to all youth and shall not release any information to the general public or the news media about any youth in the center or who has been in the custody of the Department.

Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.

Officers shall not engage in or allow horseplay, either verbal or physical, with and/or between any youth.

Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.

Management takes immediate action to investigate or address all allegations or violations of the code of conduct.

Guidelines/Requirements: Staff should communicate and interact with youth in a manner providing a role model of socially accepted behaviors. Staff behavior should be respectful of others and reflect desired behaviors for youth.

Review documentation of acknowledgement of the code of conduct, disciplinary action, including violations of the code of conduct, and/or commendations.

Review superintendent, staff, and youth interviews.

Review incident reports for substantiated allegations of improper conduct by staff during the past six months.

Reference:

- Detention Services FOP 1.06, Staff Code of Conduct
1.04 Incident Reporting (CCC)

Whenever a reportable incident occurs, the center notifies the Department’s Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.

— CRITICAL —

**Guidelines/Requirements:** This indicator shall be rated “Non-Applicable” if the program has not had any reportable incidents during the scope of the annual compliance review. If there are no CCC reports for the past six months, the regional monitor(s) may review reports since the date of the last annual compliance review, but no longer than twelve months.

Incidents discovered and reported by the regional monitors during the annual compliance review shall be considered “Non-Applicable,” unless documentation exists the center was aware of the incident but failed to report it.

The purpose of the CCC is to provide a service to the Department, providers, and programs in maintaining a safe environment for the treatment, care, and provision of services to youth. The CCC activities are conducted twenty-four hours a day, seven days a week. The CCC telephone number is 1-800-355-2280.

Violations of criteria outlined in the Department’s FDJJ 1920 policy will be reported to the CCC for dissemination to the related program area and contracted providers.

The reporting of incidents shall be consistent with the Department’s requirements.

The regional monitor(s)/reviewer(s) shall be familiar with the Department’s incident reporting requirements and list of reportable incidents.

Review CCC reports for the past six months to determine compliance with CCC reporting procedures. Review internal incidents/grievances and logbooks to determine if additional incidents should have been reported to CCC.

Review superintendent interview results.

**Reference:**

- F.A.C. 63F-11, Central Communications Center
- Detention Services FOP 1.14, Incident/CCC Reporting
1.05 Protective Action Response (PAR)

The center uses physical intervention techniques in accordance with Florida Administrative Code. Any time staff uses a physical intervention technique, such as countermoves, control techniques, takedowns, or application of mechanical restraints (other than for regular transports), a PAR Incident Report is to be completed and filed in accordance with the Florida Administrative Code.

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” if the program has not used physical interventions or mechanical restraints during the scope of the annual compliance review.

Center staff should be familiar with Florida Administrative Rule 63H-1, which establishes the statewide framework to implement procedures governing the use of verbal and physical intervention techniques and mechanical restraints.

Review a sampling of PAR reports to determine if:

▪ A review by a PAR certified instructor/supervisory staff
▪ A post-PAR interview was conducted with the youth by the superintendent, or designee, within thirty minutes after the incident
▪ A review of the PAR incident report by the superintendent, or designee, within seventy-two hours of the incident, excluding weekends and holidays
▪ Statements were completed by all witnesses and participants
▪ The reports were completed on the same day the incident occurred
▪ The youth was referred to the licensed medical professional on-site or was taken off-site, as appropriate, should medical staff not be present, if findings of the post-PAR Interview indicate the need for a PAR medical review
▪ The techniques applied were approved by the Department

A PAR report shall be completed after an incident involving the use of counter moves, control techniques, takedowns, or the application of mechanical restraints. A PAR report is not required when mechanical restraints are used for the movement of youth outside of the secure area of operations or during transports.

Review the monthly summary of all PAR reports.

Review internal incidents/grievances and logbooks to determine if any additional PAR incidents occurred.

Review superintendent and staff interview results.

Reference:

▪ F.A.C. 63H-1, Staff Training, Basic Curricula (PAR)
▪ Detention Services FOP 3.10, PAR
1.06 Pre-Service/Certification Requirements

Staff are trained in accordance with Florida Administrative Code. Detention staff are to complete pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.

— CRITICAL —

Guidelines/Requirements: This training consists of two phases:

- Phase One: Workplace training, which consists of 120 hours, completed in the areas listed in F.A.C. 63H-2.007(2a).
- Phase Two: Training at the academy, which consists of 120 hours, completed in the areas listed in F.A.C. 63H-2.007(2c).

Detention staff are authorized to be in the presence of youth prior to the completion of Phase One and Phase Two; however, the following essential skills must be completed first:

- PAR trained (must be successfully completed within ninety days of hire)
- CPR/First Aid/AED Certification
- Mental Health and Substance Abuse
- Suicide Recognition, Prevention, and Intervention
- Safety, Security, and Supervision
- PREA
- Human Trafficking
- Department Detention Facility Operations
- Active Shooter Training

The trainee shall be assigned to a fully-certified juvenile justice detention officer (JJDO) until the trainee completes all other training requirements.

It is the expectation of the Department all training, both in-service and instructor-led, be documented in the Department’s Learning Management System (SkillPro).

Review a sample of training records in SkillPro.

Reference:

- F.A.C. 63H-1, Staff Training, Basic Curricula (PAR)
- F.A.C. 63H-2.007, Staff Training, Direct Care Staff Training
1.07 In-Service Training

All center staff, including food service and maintenance staff, are required to complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training.

Supervisory staff must complete eight hours of training (as part of the twenty-four hours of in-service training) in the areas specified in Florida Administrative Code.

Guidelines/Requirements:
All Center Staff:
The following are mandatory training topics that must be completed each year by detention staff. The only exception is first aid, in which case, training is only necessary as required by certification.

- PAR update (As required by PAR Rule Chapter 63H-1)
- CPR/AED (annually)
- First Aid (annually)
- Suicide Prevention
- Professionalism and Ethics
- Active Shooter

Supervisory staff shall complete eight hours of training in the areas of:
- Management
- Leadership
- Personal Accountability
- Employee Relations
- Communication Skills
- Fiscal

Review a sampling of supervisory/management staff training records on the Department’s Learning Management System (SkillPro).

It is the expectation of the Department all training, both in-service and instructor-led, be documented in SkillPro.

In-service training begins the calendar year after a staff completes certification training.

The center shall develop an annual in-service calendar which must be updated as changes occur.

Review training records and/or SkillPro for staff in subsequent years of employment to ensure training was completed, as required.

Review superintendent interview results.

This indicator shall be rated based on a review of training completed during the last full calendar year prior to the annual compliance review.
Reference:

- F.A.C. 63H-1, Staff Training, Basic Curricula (PAR).
- F.A.C. 63H-2.007, Staff Training, Direct Care Staff Training.
- F.A.C. 63H-1.012, Annual Training Requirement
1.08 Entering Alerts (JJIS) and Sharing of Alert Information

Superintendents shall ensure critical and special alerts are reviewed and responded to appropriately.

Upon completion of the Admission Wizard, the officer shall ensure all critical and special alerts are listed in JJIS.

The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.

If the electronic system is inoperable, for any reason, the juvenile justice detention officer supervisor (JJDOS) shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.

Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.

The responses and updates by medical, mental health, and other staff should be documented in JJIS alerts as they pertain to the specific alert.

JJDOSs shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.

— CRITICAL —

Guidelines/Requirements: The Department’s Juvenile Justice Information System (JJIS), in all of its components, provides a place to document information concerning the youth in the care of the center on an organizational level.

Review the Admission Wizard, logbook, and internal alerts to identify youth with medical, mental health, suicide, gang, and security issues. Review JJIS alerts to ensure the youth were appropriately entered into the system.

There must be processes in place to ensure alert information is kept up-to-date and accurate. Information regarding youth alerts must be made available to all staff.

All youth with Medical Grades of 2-5 shall be placed on the program’s Medical Alert System. The following medical conditions and issues warrant placement of a youth on Medical Alert:

(a) Allergies/Anaphylaxis;
(b) Medication interactions;
(c) Head trauma/injury;
(d) Pregnancy;
(e) Chronic medical conditions;
(f) Hearing, speech, visual, or physical impairment;
(g) Developmental disability or mental retardation;
(h) Medication side effects.
Review the center’s shift briefing minutes for identification of youth with alerts. Observe a shift briefing to validate the sharing of alert information.

Review the program’s internal alert system to determine if all youth alerts identified in the Individual Healthcare Record (IHCR) are captured in the center’s system. Youth in the identified sample must also have updated JJIS alerts if off-site transports have occurred.

Review the center’s process for updating alerts.

Review staff interview results.

Reference:
- Detention Services FOP 2.04, Alerts
- F.A.C. 63N-1.006 Suicide Risk Alerts & Mental Health Alerts
- JJIS Business Rule 00-003, Critical – Special Alerts
### MQI Standards for Juvenile Justice Detention Services

#### Standard 2: Youth Management

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* The Department has identified certain key critical indicators. These indicators represent critical areas requiring immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area.
2.01 Admission

All youth are admitted to the program in accordance with Florida Administrative Code through a process, at a minimum, addressing the following:

1. Review of required paperwork from law enforcement and screening staff.
2. All youth shall be electronically searched, frisk searched, and stripped searched by an officer of the same sex as the youth.
3. All youth shall be allowed to place a telephone call at the center’s expense to his/her parent/guardian and the call shall be documented on all applicable forms, or document refusal to make a telephone call.
4. If the admission process is completed two hours or more before the serving of the next scheduled meal, youth shall be offered something to eat.
5. All youth shall be screened to identify medical, mental health, and substance abuse needs.

Guidelines/Requirements: Admission is a critical process, giving center staff the opportunity to set the tone for all newly admitted youth. Professional interaction between detention staff and youth during the admission process can help all youth feel emotionally and physically safe. A positive admission process will give all youth a sense of belonging and help to increase individual center adjustment, thus reducing safety and security risks.

No youth presented to secure detention shall be accepted if they are in need of emergency medical care, require mental health crisis intervention, or are under the influence of any intoxicant. If a youth in crisis is mistakenly accepted for admission, the supervisor shall make the necessary arrangements for the youth to see the center’s medical and/or mental health staff or shall ensure the youth is transported for off-site care.

Review the Department’s Juvenile Justice Information System (JJIS) Admission Wizard for completion of all required elements for admission.

Observe an admission, if possible.

Reference:
- Detention Services FOP 2.01, Admissions
2.02 **Orientation**

The orientation process shall occur within twenty-four hours of a youth being admitted into the center and documented according to Facility Operating Procedures. During the orientation process, youth must be advised, both verbally and in writing, at a minimum, of the following:

1. Center rules and regulations
2. Grievance procedures
3. Visitation
4. Telephone calls
5. Available medical, mental health, and substance abuse services and how to access them
6. How to access the Florida Abuse Hotline (or CCC for youth eighteen years old or older)
7. Expectations for behavior and related consequences
8. Possible new law violations for destruction of property
9. Youth rights

**Guidelines/Requirements:** Orientation is a critical process which gives center staff the opportunity to set the tone for all newly admitted youth, and gives all youth an opportunity to learn about the center and its expectations. Professional interaction between center staff and youth during the orientation process can help all youth feel emotionally and physically safe. A positive orientation process will give all youth a sense of belonging and help to increase individual center adjustment, thus reducing safety and security risks.

Orientation may be provided to youth in a variety of ways. Some centers will conduct orientation during admission, in a day room setting using a video presentation or the youth orientation manual, while others may use a classroom setting.

Review orientation documents to ensure all required topics were included and within the required time frame.

Observe youth orientation, if possible.

Review youth interviews related to the orientation process.

**Reference:**

- Detention Services FOP 2.05, Orientation
2.03 Classification

All youth admitted to the center shall be classified to provide the highest level of safety and security. Considerations shall include, at a minimum:

1. Physical characteristics (e.g. sex, height and weight);
2. Age and level of aggressiveness;
3. Special needs (mental illness, developmental disabilities, and physical disabilities);
4. History of violent behavior;
5. Gang affiliation;
6. Criminal behavior;
7. History of sexual offenses;
8. Vulnerability to victimization; and
9. Suicide risk, identified or suspected.

Youth shall be assigned to a room based on their classification and are reclassified if changes in behavior or status are observed. Youth with a history of committing sexual offenses or have been a victim of a sexual offense are not to be placed in a room with any other youth. Youth with a history of violent behavior shall be assigned to rooms where it is least likely they will be able to jeopardize safety and security.

All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang. In the event gang involvement is suspected, center staff should enter the “other suspected gang affiliation” alert into JJIS along with as much detailed information within the alert note as possible.

Guidelines/Requirements: Center staff must make every effort to separate youth with a history of violent behavior or of committing sexual offenses from those youth who do not. The purpose of a classification system is to ensure each youth is protected from harm, violence, and victimization. In addition, it serves to alert center staff of any special needs a youth may have before the youth is assigned to a room or introduced into the general population.

Staff must pay very close attention to younger youth and youth with developmental disabilities. Although some youth may have sexual battery charges reduced to battery, or another less offense, staff must use sound professional judgment when classifying these youth. This is critical to ensuring the protection of other youth in the center. Housing sexual offenders in single occupancy rooms, or if single occupancy rooms are not available, in the day room area, is consistent with national standards for residential sexual offender programs.

The superintendent remains informed of how to identify and address local youth gangs. Updated gang information is provided to staff so youth can be appropriately classified during admission and gang-related problems can be averted.

Review classification documents to ensure the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) is completed and used in the classification.

Review classification documents to ensure all required topics were reviewed and considered prior to making a room assignment.
Review classification documents on the Department’s Juvenile Justice Information System (JJIS) Admission Wizard to ensure all required topics were reviewed and considered prior to making a room assignment.

Review the detention FOP to determine if the center utilizes supplemental forms to gather additional information for classification.

Review JJIS alerts for gang members, suspected gang members, and associates of gang members.

Review superintendent interview results.

Reference:

- Detention Services FOP 2.02, Classification
- JJIS Business Rule, 00-003, Critical - Special Alerts
2.04 Notification of Juvenile Probation Officer Circuit Gang Representative

Each center shall identify the juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity.

A referral for youth with suspected gang involvement shall be shared, by e-mail, with the circuit gang representative, indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.

Center staff should include in the e-mail pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was “flashing.”

Guidelines/Requirements: The superintendent actively works with the Department and other agencies, sharing information for the gang database, which is maintained by the Florida Department of Law Enforcement.

Review the center’s process for sharing gang information with the juvenile probation officer (JPO) assigned as the circuit gang representative.

Additional records maybe reviewed to obtain a sample of youth who were identified with suspected gang involvement.

Interview the staff identified to serve as the gang representative to determine the process for sharing information with the JPO.

Reference:

- Detention Services FOP 2.02, Classification
2.05 Admission of Youth Personal Property

The center takes possession of each youth’s personal property during admission. In the presence of each youth, staff inventories all personal property in the youth’s possession and records each surrendered item on the Property Receipt Form.

Guidelines/Requirements: The youth’s personal property must be inventoried to ensure all property is returned to the youth or parent/guardian upon release or residential placement.

All money and personal items of value shall be verified and secured in a clear tamper-proof property bag. The description of these items on the Property Receipt Form shall include the item described is “in the safe.”

Information on the clear tamper-proof property bag shall include, at a minimum, the date, the youth’s name, the youth’s Department identification (DJJID) number, a listing of the items in the bag, the youth’s signature, and the signature of the staff who placed the items in the property bag and sealed it.

After the youth has signed the Property Receipt Form and the clear tamper-proof property bag, the bag shall be placed in the drop safe. This action shall be recorded in the drop safe bound logbook to include the date, time, youth’s name, youth’s DJJID number, printed name of the officer who secured the property, and the officer’s initials.

In the event a youth refuses to sign the Property Receipt Form, the booking officer shall notify a supervisor and the supervisor shall document the youth’s refusal on the form.

The booking officer shall have the youth sign a Letter of Acknowledgement in which the youth acknowledges and understands unclaimed personal property is deemed abandoned and subject to disposal.

Other personal property, including the youth’s clothing, shall be placed in an assigned locker/bag, as documented on the Property Receipt Form. This form is then placed in the youth’s active record.

Review a sample of open records for documentation of:

- The Personal Property Receipt Form
- The Valuable Property Receipt Form, if applicable
- The Letter of Acknowledgement of Unclaimed Property

Observe the storage area for personal property; note whether the bags contain a completed inventory form.

Observe admission process, if possible.

Review youth interview results.

Review superintendent interview results.

Reference:

- Detention Services FOP 2.10, Youth Property
2.06 Storage of Youth Personal Property

The center safeguards each youth’s personal property until it can be returned to the youth and/or parent/guardian.

**Guidelines/Requirements:** The youth’s personal property must be controlled and safeguarded during their stay in secure detention. Money and valuables should be secured with access limited. Observe the storage and security of valuable and personal property.

The superintendent shall ensure a drop safe for the initial storage of youths’ valuables is under video surveillance.

The superintendent shall ensure all locations for the storage of youth property are secure. The superintendent shall also ensure staff will not receive or have personal use of any youth property or money, unclaimed or otherwise.

The superintendent or designee shall notify the Central Communications Center (CCC) and file a report when a youth’s personal property is alleged to have been stolen or lost from the facility by a Department or contracted staff member, intern, or volunteer.

Review CCC reports for the center for the past six months to determine if any incidents regarding youth property have been reported.

Review superintendent interview results.

**Reference:**

- Detention Services FOP 2.10, Youth Property
2.07 Release

When releasing youth from the center, the releasing officer shall verify the court’s authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth.

All releases from the center are court-ordered, with the exception of deaths, escapes, and expirations of detention time periods. In the absence of a written order, documentation of a verbal order in open court may be used for release.

The on-duty JJDO Supervisor reviews all paperwork prior to a youth’s release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.

Questions concerning release are presented and addressed by the superintendent, or designee, prior to release.

The releasing officer shall verify the identification of the youth.

Guidelines/Requirements: Ultimate care must be taken to ensure youth are not inappropriately released from secure detention. When there are multiple court orders in a youth’s record, staff must take care to read thoroughly to ensure the youth is eligible for release.

The releasing officer reviews documentation from the assigned juvenile probation officer (JPO) to determine if the youth is being released to the appropriate person (unless the youth is eighteen years old or older).

In the absence of this documentation, the superintendent or designee determines if the person to whom the youth is being released to is a parent/guardian or responsible adult. The person to whom the youth is being released to must present photo identification, which is photocopied and placed in the youth’s record. (Review the youth’s face sheet for individuals the youth may be release to.)

The youth changes into his/her own clothes upon release.

The youth and the person to whom the youth is being released to are reminded of any future court dates.

The required parties sign all applicable release forms.

Review documents for release procedures.

Observe release process, if possible.

Review CCC reports for the past six months to determine if there were any unauthorized releases.

Reference:

- Detention Services FOP 2.06, Releases
2.08 Release of Youth Personal Property

Upon a youth’s release from the center and retrieval of personal property, the releasing officer, the youth, and the youth’s parent/guardian shall review and sign the Property Receipt Form and account for all of the youth’s personal property.

Guidelines/Requirements: The youth and his/her parent/guardian (unless the youth is eighteen years old or older) account for all of the youth’s personal property upon release, then reviews and signs the Property Receipt Form.

A copy of the signed Property Receipt Form which acknowledges the return of youth’s personal property shall be placed in the youth’s record.

Unclaimed personal property is property left in the possession of the center for more than thirty days after the parent/guardian has been notified to either retrieve, or make arrangements to retrieve, the property. The Letter of Acknowledgement, in which the youth acknowledges understanding unclaimed personal property is deemed abandoned and subject to disposal, is sent to the parent/guardian if property is not taken by the youth at the time of their release or retrieved by the parent/guardian with seven calendar days of youth being committed to a high or maximum risk residential program.

Review Property Receipt Forms in closed records for youth and/or parent/guardian signatures. (Note: Release forms can be reviewed in the Release Wizard.)

Observe examples of process, if possible.

Reference:

- Detention Services FOP 2.06, Releases
2.09 Release of Medication, Aftercare Instructions

The center ensures there are provisions in place to ensure prescribed medication, along with medical instructions, accompanies detained youth upon release.

Guidelines/Requirements: Youth continuity of care in the community upon release or in residential placement is critical to continued physical and mental health.

The program ensures prescription drugs are given to the person to whom the youth is being released. The individual acknowledges receipt of the medications by signing a receipt, which is placed in the youth’s Individual Healthcare Record.

The youth and the person to whom the youth is being released are reminded of any health or welfare issues, including, medical, mental health, and/or substance abuse needs and any pending appointments.

The required parties sign and date all applicable release forms.

Review process for youth released who are taking prescription medications.

Review examples of acknowledgement receipts, if available.

Reference:

- Detention Services FOP 2.06, Releases
2.10 Review of Youth in Secure Detention

Detention reviews are conducted by the center on a weekly basis to ensure proper management of youth placed in secure detention and the appropriate sharing of information. The superintendent appoints an appropriate staff to coordinate detention reviews.

**Guidelines/Requirements:** The purpose of weekly detention reviews is to provide a means to screen all youth who may be able to be transferred to a less restrictive placement or to their designated commitment placement expeditiously. Detention reviews may be combined with the mini-treatment team meetings.

Each weekly detention review addresses every youth reflected on the Department’s Juvenile Justice Information System (JJIS) census for secure detention. The purpose of detention reviews is to monitor each youth’s case, ensure it proceeds expeditiously, and to share information regarding physical or behavioral issues, as necessary.

All appropriate parties are encouraged to attend, including, but not limited to, center medical and mental health staff, education staff, probation and community corrections (intervention) staff, and residential staff (such as commitment managers, if applicable).

Documentation of each weekly detention review is maintained by the center, including a list of participants, notes on what was discussed, and tasks assigned for follow-up and who is responsible.

Observe weekly detention review process, if possible.

Review documentation of weekly detention review for past six months.

Review superintendent interview results.

**Reference:**

- Detention Services FOP 1.09, Detention Reviews
2.11 Daily Activity Schedule

Youth are provided the opportunity to participate in constructive activities which will benefit the youth and the center. The superintendent or designee develops a daily activity schedule, which is posted in each living area and outlines the days and times for each youth activity.

Guidelines/Requirements: Youth activities benefit the center by keeping youth constructively involved. It is commonly recognized unstructured time jeopardizes the safety of the officers and youth and the security of the facility. The activities for youth in the center are related primarily to protections and rights afforded to them by statute and the expectations of center programming.

Non-clinical staff may implement life and social skill interventions or instructions, except when instructional materials are specifically designed for use by clinical staff.

Required elements of the Daily Activity Schedule include:

- **Wake Up/Personal hygiene**
- **Meal times**
- **Visitation at a minimum of twice a week**
- **Education, in accordance with F.A.C. 6A-6.0528 and 6A-6.05281**
- **Recreation and physical activities, to promote physical growth and development, including at least one hour of daily large muscle exercise outdoors**
- **Indoor activities promoting educational, problem-solving, and/or life skills, to include appropriate reading and audiovisual programming**
  - **Shift change**
  - **Bed times**
  - **Groups**
  - **Open program time (reading, art, movies, games, etc.)**

Review youth and staff interview results.

Observe postings of daily activity schedule.

Reference:

- Detention Services FOP 3.06, Daily Activity Schedule
2.12 Adherence to Daily Schedule

Center staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs.

The on-duty supervisor must approve any significant changes in the activity schedule and shall document the reason for the change(s) in the shift report.

Any cancellation of visitation shall be approved by the superintendent.

Guidelines/Requirements: Youth activities benefit the center by keeping youth constructively involved. It is commonly recognized unstructured time jeopardizes the safety of officers and youth, as well as the security of the facility.

Outdoor and indoor activities may be canceled, postponed, or moved indoors (for outdoor activities) at the discretion of the supervisor for reasons related to weather, safety, or security. Reasons for cancellation or modifications should be documented on the shift report.

Activities such as free weights, softball, baseball, tackle football, and horseshoes are prohibited activities due to safety concerns. Officers shall not participate in any physical activity with youth, but may direct or otherwise instruct youth in an activity.

Review daily schedule and compare to logbook for adherence to the daily schedule.

Observe daily activities to determine if schedules are followed.

Review youth and staff interview results.

Reference:

- Detention Services FOP 3.06, Daily Activity Schedule
2.13 Educational Access

The center shall integrate educational instruction (career and technical education, as well as academic instruction) into the daily schedule in such a way which ensures the integrity of required instructional time.

Guidelines/Requirements: Department education programs operate on a year-round basis. Youth are required to participate in educational and career-related programs for 250 days of instruction distributed over twelve months; a minimum of twenty-five hours of instruction weekly. Detention center instructional staff may use ten of these days for teacher training and/or planning.

Given the limited school day, the skills developed in the career training and education programs need to be supported by the academic courses to the maximum extent possible.

Youth enrolled in educational programs will have the opportunity to earn course credit for completion of the education and training experience.

Review the center’s daily schedule, school instructional schedule, and logbook to ensure minimal interference of educational instruction.

Review youth, staff, and superintendent interview results to ensure minimal interference of education instruction.

Reference:

- F.A.C. 63B-1.003 (3) Career Related Programs, Career and Vocational Programming
- F.A.C. 63B-1.006 Career Related Programs, Cooperative Agreement
- Rule 6A-6.05281, Educational Programs for Students in Department of Juvenile Justice Detention, Commitment, or Day Treatment Programs, Florida Administrative Code
2.14 Career Education

The center shall collaborate with the school district to ensure implementation of a career education competency development program.

Guidelines/Requirements: The center must define career education programming which is appropriate based upon the age, assessed educational abilities and goals of the youth to be served, and the typical length of stay and custody characteristics at the center to which each youth is assigned.

The career education programming must include:

- Type 1—Programs teaching personal accountability skills and behaviors appropriate for students in all age groups and ability levels and leading to work habits that help maintain employment and living standards.

Career Education programming shall include communication, interpersonal, and decision-making skills.

All programs must be at least a Type 1. Life skills group, activities, and instruction meet this requirement.

Reference:

- F.A.C. 63B-1.002 (5) Career Related Programs, Definitions
- F.A.C. 63B-1.003 Career Related Programs, Career and Vocational Programming
2.15 Behavior Management System

The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center’s expectations.

Each center shall implement and maintain a behavior management system to meet the needs of the youth and the center. The system shall include rewards for positive behavior and consequences for inappropriate behavior.

The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.

Guidelines/Requirements: A behavior management system (BMS) shall provide clear guidelines and consequences, both positive and negative, for the behavior of youth. It shall be used as a tool to provide rewards for positive socially acceptable behavior and consequences for rule and law violations. The fair and consistent implementation of a BMS enhances safety and security as it relates to youth behavior. The BMS shall be shared and consistent with related support services, including but not limited to, on-site educational, mental health, and medical services.

Consequences for the behavior of youth shall be outlined in the BMS of each center.

Review the center’s FOP on the BMS to ensure compliance with the components outlined in the center’s policies and procedures.

Observe daily activities to determine implementation of the BMS.

Observe for postings of the BMS, rules, norms, and expectations in living areas.

Review documentation to ensure rewards and consequences are given in accordance with the BMS.

Review superintendent, youth, and staff interview results.

Reference:

- Detention Services FOP 3.02, Behavior Management System
2.16 Unauthorized Use of Punishment

The center’s behavior management system (BMS) restricts certain types of penalties on youth who demonstrate negative behaviors.

Group punishment shall not be used as a part of the center’s BMS. However, corrective action taken with a group of youth is appropriate when the behavior of a group jeopardizes safety or security, and this should not be confused with group punishment.

Corporal punishment shall not be used. All allegations of corporal punishment of any youth by center staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center (CCC).

The use of drugs to control the behavior of youth is prohibited. This does not preclude the proper administration of medication as prescribed by a licensed physician.

— CRITICAL —

Guidelines/Requirements: Consequences for a youth’s negative behavior should serve as both a positive and learning experience. However, certain types of punishments should never be applied as a consequence for a youth’s negative behavior. Group and/or corporal punishment shall never be used as part of a behavior management system (BMS). The use of drugs to control a youth’s behavior is also prohibited.

Review the interview responses from youth and staff to determine whether any unauthorized use of punishment is alleged.

Review the center’s behavior management policy and procedures.

Reference:

- Detention Services FOP 3.02, Behavior Management System
2.17 Grievances

The grievance procedures establish each youth’s right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes:

1. Informal phase, wherein the juvenile justice detention officer (JJDO) attempts to resolve the complaint or condition with the youth using effective communication skills;

2. Formal phase, wherein the youth submits a written grievance resulting in a response from a JJDO supervisor by the end of the shift (if possible), or otherwise within twenty-four hours; and

3. Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.

Guidelines/Requirements: Each youth has the right to grieve the actions of center staff and conditions and circumstances in the center related to the violation or denial of the basic rights. Therefore, each center shall develop and implement a facility operating procedure to ensure each youth’s right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their constitutional rights are protected.

Review the center’s formal grievance process, as outlined below:

- The supervising officer(s) shall issue both a grievance form and a pencil to any youth who wishes to file a grievance. An officer not involved in the grievance shall assist any youth who is visibly angry or not in control in completing the grievance form and filing the grievance.

- Paper and pencil shall not be issued to any youth who is visibly angry or out of control.

- The completed grievance form shall be transcribed into FMS. (Hard copies are not required.)

- If the grievance is not resolved by the supervising officer, the grievance shall be submitted within two hours to the on-duty supervisor.

- The supervisor shall document his or her finding by the end of the shift or within twenty-four hours, should there be circumstances preventing the supervisor from completing during the shift.

- Any action that may involve disciplinary proceedings against an officer shall not be reported to the youth.

Review sample of grievances for the last six months to determine adherence to Florida Administrative Code requirements.

Review youth, staff, and superintendent interview results.

Reference:
- Detention Services FOP 2.09, Youth Grievances
2.18 Trauma-Informed Care

The center is incorporating trauma-informed practice into current operations to deliver services and to provide care to youth in custody, acknowledging the role that violence and victimization play in the lives of most of the youth entering the center.

Trauma-informed practice has many characteristics, which include the following:

- A recognition of the high prevalence of trauma
- Recognition of culture and practices which may be re-traumatizing
- Collaboration of caregivers
- Training of staff to improve trauma knowledge and sensitivity
- Increased staff understanding of the function of behavior (rage, self-injury, etc.) as an expression of trauma
- Use of objective and neutral language (avoids labeling of youth).

Guidelines/Requirements: Center staff should be able to show or identify the trauma-informed practice incorporated into the operation of the center. This may be in the form of additional training for staff, a change in youth behavior management, a physical softening of the center’s appearance, development of a soft room, confinement reductions, etc.

Review center’s practice of implementing trauma-informed care.

Interview the superintendent regarding implementation of trauma-informed practices.

Reference:

- Detention Services FOP 3.02, Behavior Management System
**Standard 3: Mental Health and Substance Abuse Services**

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3.01 Designated Mental Health Clinician Authority (DMHCA) [Contract Provider]

A designated mental health clinician authority (DMHCA) is required in each center. The DMHCA is responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services in the center and shall promote consistent and effective services and allow the superintendent and staff a specific source of expertise and referral.

Guidelines/Requirements: The center has a single licensed mental health professional designated as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services.

The DMHCA is a licensed psychiatrist under Chapter 458 or 459, who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination, or licensed psychologist under Chapter 490, licensed mental health counselor, licensed clinical social worker, or licensed marriage and family therapist under Chapter 491, or a psychiatric nurse as defined in Section 394.455(23) F.S.

At a minimum, the DMHCA must be on-site weekly for a sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse services is taking place.

A copy of the DMHCA’s license and agreement or position description is available for review.

Review the contract/job description for the DMHCA.

Interview the DMHCA, ask about his/her role at the center.

Reference:

- DJJ Rule 63N-1.0035 Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.02 Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider]

The superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.

— CRITICAL —

Guidelines/Requirements: Staffing shall be in accordance with contract and Rule 63N-1, F.A.C. If the center does not have any other licensed clinical staff other than the designated mental health clinician authority, this indicator shall be rated non-applicable.

Licensed Mental Health Professionals

- A licensed mental health professional is a psychiatrist licensed pursuant to Chapter 458 or 459, F.S., who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination, a psychologist licensed pursuant to Chapter 490, F.S., a mental health counselor, marriage and family therapist, or clinical social worker licensed pursuant to Chapter 491, F.S., or a psychiatric nurse as defined in Section 394.455(23), Florida Statutes.

- A copy of license is available for review.

Licensed Qualified Professional (for Substance Abuse Services)

- A physician or physician assistant licensed under Chapter 458 or 459, a psychologist licensed under Chapter 490, or a licensed clinical social worker, licensed marriage and family therapist, or licensed mental health counselor under Chapter 491, Florida Statutes who is exempt from Chapter 397 licensure pursuant to Section 397.405. See Rule 65D-30.003(15) F.A.C., condition (c) and (d).

Review licenses of licensed mental health professionals and licensed qualified professionals. (Make copies for the review file.)

Reference:

- DJJ Rule 63N-1.002(46) and (47), Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff
[Contract Provider]

The superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.

Guidelines/Requirements: Staffing shall be in accordance with contract. Verification of education is required for non-licensed clinical staff.

Non-Licensed Mental Health Clinical Staff
A non-licensed mental health clinical staff must have one of the following:

- A master’s degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. A related human services field is one in which major course work includes the study of human behavior and development, counseling and interviewing techniques, and individual, group, or family therapy; OR
- A bachelor’s degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field and have two years clinical experience assessing, counseling, and treating youth with serious emotional disturbance or substance abuse problems; OR
- A bachelor’s degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field and have fifty-two hours of pre-service training, described in Rule 63N-1, F.A.C., prior to working with youth. The fifty-two hours of pre-service training must include a minimum of sixteen hours of documented clinical training in their duties and responsibilities. When pre-service training has been successfully completed, the non-licensed staff may begin working with youth, but must receive training in mental disorders and substance-related disorders, counseling theory and techniques, group dynamics and group therapy, treatment planning and discharge planning for one year by a mental health staff who holds a master’s degree.

Non-Licensed Substance Abuse Clinical Staff Person
- A non-licensed substance abuse clinical staff may provide substance abuse services in a center only as an employee of a Service Provider licensed under Chapter 397, F.S. or in a center licensed under Chapter 397, F.S. A non-licensed substance abuse clinical staff must work under the direct supervision of a “qualified professional” as defined in Section 397.311, F.S.
- A non-licensed substance abuse clinical staff is an employee of a service provider licensed under Chapter 397 or in a center licensed under Chapter 397, F.S., who holds, at a minimum, a bachelor’s degree from an accredited university or college with a major in psychology, social work, counseling, or related human services field. Related human services field is one in which major course work includes the study of human behavior and development, counseling and interviewing techniques, and individual, group, or family therapy.
Mental Health Clinical Staff and Substance Abuse Clinical Staff Training

- Non-licensed mental health clinicians holding a bachelor's degree with less than two years of experience must have fifty-two hours pre-service training to include sixteen hours training in their duties and responsibilities. Training must include, at a minimum, the following: basic counseling skills, basic group therapy skills, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, and typical behavior problems.

- A non-licensed mental health clinical staff who conducts Assessments of Suicide Risk (ASR) must have received twenty hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training must have included administration of, at a minimum, five ASRs or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional (LMHP) and documented on Department form MHSA 022.

- A non-licensed substance abuse clinical staff person providing substance abuse services in a center must have received training in accordance with Rule 65D-30 F.A.C.

Direct Supervision

“Direct Supervision for Mental Health Clinical Staff” means a licensed mental health professional has at least one hour a week of on-site, face-to-face interaction with non-licensed mental health clinical staff individually or in group format, for the purpose of overseeing and directing the mental health services he or she is providing in the center, as permitted by law within his or her state licensure.

- Each non-licensed mental health clinical staff must work under the direct supervision of a LMHP, and must receive a minimum of one hour a week of on-site, face-to-face direct supervision by the LMHP for the purpose of overseeing and directing the mental health services he or she is providing in the program.

“Direct Supervision for Substance Abuse Clinical Staff” means a qualified professional has at least one hourly session a week of on-site, face-to-face interaction with a non-licensed or non-certified substance abuse clinical staff who is an employee of a service provider licensed under Chapter 397, F.S., or an employee in a center licensed under Chapter 397, F.S., individually or in group format, for the purpose of overseeing and directing the substance abuse services he or she is providing in the center.

- Each non-licensed substance abuse clinical staff must work under the direct supervision of a "qualified professional," as defined in Section 397.311, which means a physician or physician assistant licensed under Chapter 458 or 459, psychologist licensed under Chapter 490, clinical social worker, mental health counselor, or marriage and family therapist licensed under Chapter 491 or an advanced registered nurse practitioner having a specialty in psychiatry licensed under part I of Chapter 464, or a person who is certified through a DCF-recognized certification process for substance abuse treatment services. The non-licensed substance abuse clinical staff must receive at least one hour a week of on-site, face-to-face direct supervision by the "qualified professional."

- Documentation of direct supervision must be recorded on Department form MHSA 019 or a form which includes all the information in Form MHSA 019.
• If any non-licensed mental health clinical staff or non-licensed substance abuse clinical staff, regardless if they are full-time, part-time, or intermittent, is on-site to provide mental health or substance abuse services at any time during the week (Sunday – Saturday), the licensed professional must provide at least one hour of direct supervision to the non-licensed staff during that week.

• The LMHP providing direct supervision is responsible for reviewing each ASR and Follow-Up ASR, Crisis Assessment and Follow-Up Crisis Assessment conducted by the non-licensed mental health clinical staff within twenty-four hours of the referral for assessment. The ASR, Follow-Up ASR, Crisis Assessment, or Follow-Up Crisis Assessment conducted by the non-licensed mental health clinical staff must be signed by the LMHP the next scheduled time he/she is on-site.

Review documentation which confirms each non-licensed clinical staff person holds the education and training specified in Rule 63N-1 and the contract.

Review clinical supervision logs to determine appropriate on-site supervision for non-licensed staff.

**Reference:**

• DJJ Rule 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services

• Pursuant to Contract Requirements
3.04 Mental Health and Substance Abuse Admission Screening [Detention Staff/Contract Provider]

The mental health and substance abuse needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.

The superintendent has established procedures for a thorough review of preliminary screenings conducted by the Office of Probation and Community Intervention.

Guidelines/Requirements: Mental health and substance abuse and suicide risk screenings in centers are accomplished through review of the youth’s Massachusetts Youth Screening Instrument, Version II (MAYSI-2) and administration of the Department’s Suicide Risk Screening Instrument (SRSI). Suicide risk screening requires a review of the MAYSI-2 – Suicide Ideation Subscale and administration of the Suicide Risk Screening Instrument (SRSI).

The superintendent is responsible for developing written facility operating procedures for the implementation of a standardized admission/intake mental health and substance abuse screening process. The policy shall address the following:

- Review of the MAYSI-2
- Review of the SRSI sections administered in the Juvenile Assessment Center or JPO Screening Unit
- Administration of the Suicide Risk Screening Instrument (SRSI) upon a youth’s admission to the center.
- Standardized process for referral of youth identified as in need of Assessment of Suicide Risk (ASR) or further mental health and/or substance abuse evaluation to the center’s mental health provider.
- The staff making the referral shall document a consultation with the DMHCA or licensed mental health professional on the MH/SA referral summary.

Massachusetts Youth Screening Instrument (MAYSI-2)

- Youth whose MAYSI-2 indicates elevated suicide risk subscales shall be placed on suicide precautions and referred for an Assessment of Suicide Risk.
- If results of the MAYSI-2 indicates the need for a Comprehensive Assessment, it will be reported to mental health clinical staff.
Suicide Risk Screening Instrument (SRSI)

- Upon intake, the Department’s SRSI form MHSA 002 must be administered by the officer, nurse, or mental health clinical staff in the Department’s Juvenile Justice Information System.
- Complete entries include a summary and recommendations in "Screening Results" sections.
- Youth with ANY positive ("YES") responses on the SRSI (Form MHSA 002) are placed on suicide precautions and a mental health referral is completed, which documents the youth's need for an ASR.

Review sample of youth records for CAT Pre-screen and SRSI.

Reference:

- DJJ Rule 63N-1.0051 and 63N-1.0052, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.05 Mental Health and Substance Abuse/Evaluation [Detention Staff/Contract Provider]

The probation and JAC intake/detention screening process ensures youth identified through preliminary screening with mental health and substance abuse issues or problems receive in-depth mental health and/or substance abuse assessment shortly after intake to the juvenile justice system.

Guidelines/Requirements: The superintendent is responsible for establishing procedures to track the receipt of Comprehensive Assessments at the center. The juvenile probation officer (JPO) is responsible for contacting the center if the Comprehensive Assessment is not received within fourteen days of the youth’s admission and providing the center with an update of the status of the assessment.

Comprehensive Assessments - Community Provider

- Youth who have elevated Community Assessment Tool (CAT) Scales are referred through the JAC or JPO conducting the intake for a Comprehensive Assessment through a community provider.
- Comprehensive Assessments by community providers are to be provided to the center within fourteen days. If not provided, the JPO is to contact the center and advise of its status.
- Comprehensive Assessments must be completed by the thirty-first day of the youth’s admission to a center, either by the community provider or the center’s mental health provider.

Comprehensive Mental Health Evaluations - Detention Provider

- If a detained youth, whose intake screening did not indicate the need for a Comprehensive Assessment, exhibits behavior indicating the need for an assessment, the detention provider shall complete a Comprehensive Mental Health Evaluation and/or Comprehensive Substance Abuse Evaluation, as set forth in Rule 63N-1, F.A.C.
- The evaluation shall be completed within thirty days of referral.
- The Comprehensive Mental Health/Substance Abuse Evaluation may consist of the SAMH in the Department’s OHS-Electronic Medical Record, or a comparable Department approved instrument.

The JPO is responsible for ensuring predisposition comprehensive evaluations for detained youth are forwarded to the center, and the superintendent or designee is responsible for ensuring procedures are in place for a thorough review of the comprehensive evaluations forwarded to the center.

Review sample of youth records for comprehensive mental health and/or substance abuse assessments/evaluations.

Reference:

- DJJ Rule 63N-1.0054, 63N-1.0055, 63N-1.0056, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.06 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]

Mental health and substance abuse treatment planning in Department facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate a youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting.

Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while in at the center, must be assigned to a mini-treatment team.

Guidelines/Requirements: Youth determined to have a serious mental disorders or substance abuse impairment and are receiving mental health and/or substance abuse treatment at the center must have an initial or individualized mental health or substance abuse treatment plan based off of findings in the Comprehensive Mental Health and/or Substance Abuse Assessment/Evaluation, or Psychiatric Evaluation/Diagnostic Interview.

Mini-Treatment Teams

- All youth determined to need mental health and/or substance abuse treatment must be assigned to a mini-treatment team.
- Mini-Treatment Teams are comprised of, at a minimum, mental health clinical staff, one staff from a different service area, the youth, and if possible, the youth's parent/guardian.

Mental Health and Substance Abuse Treatment Services

- Youth determined in need of mental health treatment must receive individual, group, or family counseling by a licensed mental health professional (LMHP) or a non-licensed mental health clinical staff working under the direct supervision of a LMHP, in accordance with the youth's Initial or Individualized Mental Health Treatment Plan.

- “Necessary and Appropriate Mental Health and Substance Abuse Treatment and Services” are mental health or substance abuse care or services which are reasonably expected to become necessary in the course of custody and care of juveniles, and which are consistent with generally acceptable professional standards of care for mental health and substance abuse services. Service frequency reflects diagnoses and treatment needs.

- Youth determined to be in need of substance abuse treatment must receive individual, group, or family counseling provided by a licensed qualified professional or a non-licensed substance abuse clinical staff who is an employee of a service provider licensed under Chapter 397, who works under the direct supervision of a qualified professional, as defined in Section 397.311 F.S., in accordance with the youth's Initial or Individualized Substance Abuse Treatment Plan.

- All youth receiving mental health treatment shall have a properly executed Authority for Evaluation and Treatment (AET) form.

- All youth receiving substance abuse treatment shall have a signed Substance Abuse Consent and Release forms (MHSA 012 and MHSA 013), or a court order for substance abuse evaluation and treatment.
Mental health treatment notes or substance abuse treatment notes shall be documented on the Department form MHSA 018, or a form which contains all of the elements of form MHSA 018.

Mental Health staff have adequate access to youth to provide treatment services

Mental Health and Substance Abuse Group Therapy

- Group therapy is limited to ten or fewer youth with mental health diagnoses for mental health treatment groups and fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups.


Review sample of youth records for documentation of AETs and Substance Abuse Consent forms.

Interview the DMHCA regarding treatment services provided at the center.

Review youth interview results.

Reference:

- DJJ Rule 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services

- Pursuant to Contract Requirements
3.07 Treatment and Discharge Planning [Contract Provider]

The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health/substance abuse treatment in the center.

All youth who receive mental health and/or substance abuse treatment while in at the center shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the center.

Guidelines/Requirements:

Initial Treatment Plans

- Initial Treatment Plans are developed on Department form MHSA 015 or on a form which contains all of the information in form MHSA 015.
- Initial Treatment Plans are to be developed within seven days of the onset of treatment, or for youth receiving psychotropic medication, within seven days of the initial diagnostic psychiatric interview.
- Initial Treatment Plans are to be signed by the mental health or substance abuse clinical staff completing form, and if completed by a non-licensed staff, by the licensed clinical supervisor, within ten days of completion. The plan is also signed by mini-treatment team members who participated in development of the plan, youth, and parent/guardian (as allowed).
- Psychiatric services, including psychotropic medication and frequency of monitoring by psychiatrist, must be included in the Initial Treatment Plan for youth receiving psychotropic medication.

Individualized Treatment Plans

- Individualized Treatment Plans are developed for youth receiving mental health and/or substance abuse treatment in the center by the thirty-first day of the youth’s admission.
- Youth in the center less than thirty days may have an Individualized Treatment Plan rather than an Initial Treatment Plan.
- Individualized plans are developed to be on Department form MHSA 016 or on a form which contains all of the information on form MHSA 016.
- Individualized Treatment Plans are signed by the mental health or substance abuse clinical staff completing the plan, and if the mental health clinical staff person is not licensed, by a licensed mental health professional for the mental health treatment plan or qualified professional, as defined in Section 397.311 for the substance abuse treatment plan, within ten days of completion. Plan is also signed by mini-treatment team members, youth, and parent/guardian (as allowed).
- Psychiatric services, including psychotropic medication and frequency of monitoring by psychiatrist, must be included for youth receiving psychotropic medication.
Individualized Treatment Plan reviews must be completed on Department form MHSA 017 or a form which contains all the information in form MHSA 017, at a minimum, every thirty days following the development of the individualized treatment plan.

If a youth is an alleged victim of a PREA event, the youth’s treatment plan will include, or be revised to include, mental health treatment services that address the youth’s needs if crisis assessment indicates a need for adjusted or additional services.

Discharge Plans

All youth who received mental health and/or substance abuse treatment while in the center shall have a discharge plan documented on Department form MHSA 011.

The discharge plan should be provided to the youth, the parent/guardian (as allowed), and JPO.

Review sample of youth records (open and closed) for documentation of treatment and discharge planning.

Review closed records to determine if discharge plans were provided to youth, parents/guardians (as allowed), and the JPO.

Reference:

- DJJ Rule 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.08 Psychiatric Services [Contract Provider]

Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.

— CRITICAL —

Guidelines/Requirements: Psychiatric services shall be provided by a psychiatrist or by a licensed and certified psychiatric advanced practice registered nurse (APRN)/advanced registered nurse practitioner (ARNP) under Chapter 464, F.S., who works under the clinical supervision of a Psychiatrist as specified in the collaborative practice protocol with the supervising psychiatrist filed with the Florida Department of Health as set forth in Rule 63N-1 F.A.C.

A “psychiatrist” is a physician licensed pursuant to Chapter 458 or 459, F.S. who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination. A psychiatrist who is board certified in Forensic Psychiatry by the American Board of Psychiatry and Neurology or the American Board of Forensic Psychiatry may provide services in Department facilities or programs but must have prior experience and training in psychiatric treatment with children or adolescents.

A psychiatrist or psychiatric APRN/ARNP providing psychiatric services in the center must comply with Rule 63N-1.0085 and Rule 63M-2.010-2.023 and 63M-2.025-2.027, F.A.C., provisions regarding psychiatric services and medication management whenever a youth is considered for, prescribed or receiving psychotropic medication.

Youth entering the center on psychotropic medication, or referred for psychiatric interview, shall receive an initial diagnostic interview within fourteen days of the youth’s admission. The initial diagnostic psychiatric interview shall include the elements specified in Rule 63N-1 F.A.C.

Youth entering the center on psychotropic medication, or those prescribed psychotropic medication subsequent to their admission, shall receive an in-depth psychiatric evaluation within thirty days of intake or referral. The psychiatric evaluation must reflect the elements specified in the Rule 63N-1, F.A.C.

The psychiatric evaluation may be documented on the Department form entitled “Clinical Psychotropic Progress Note (CPPN)” (all 3 pages) or in a form developed by the center. The form utilized (CPPN) or center form shall be clearly identified as a “Psychiatric Evaluation.”

If a documented psychiatric evaluation (within six months prior to admission) is available, an updated psychiatric evaluation may be conducted.

The CPPN, Department form HS 006, page 3, must be completed if new psychotropic medication is prescribed or there are any changes to the youth’s existing psychotropic medication.
The following information shall be documented when psychotropic medication prescribed/dispensed/administered by the psychiatrist or psychiatric ARNP:

- Identifying data;
- Diagnosis;
- Target symptoms of each medication;
- Evaluation and description of effect of prescribed medication on target symptom(s);
- Prescribed psychotropic medication, if any (name, dosage and quantity of the medication);
  1. Normal dose range;
  2. Ordered Dosage;
  3. Frequency and route of administration;
  4. Reasons for changes in medication and/or dosage shall be clearly documented by the Psychiatrist or Psychiatric APRN/ARNP.

- Side Effects (description of response to medication(s) both positive and adverse drug experiences or documentation if none present);
- Youth’s adherence to the medication regime;
- Height, weight, blood pressure, most recent serum drug levels or laboratory findings (as appropriate);
- Whether there was telephone contact with parent/guardian to discuss medication
- Signature of the Psychiatrist or Psychiatric APRN/ARNP;
- Date of signature.

The psychiatrist, psychiatric APRN/ARNP, and nursing staff shall have documentation of monitoring for Tardive Dyskinesia, as indicated by the psychiatrist.

Review the psychiatrist’s contract to determine service provision.

Review sample of youth records for documentation of psychiatric services.

Review collaborative practice protocol with psychiatric ARNP and verify a copy is maintained on-site.

Review progress notes and CPPNs to determine if youth admitted with psychotropic medication were seen within fourteen days of admission by a psychiatrist. A monthly CPPN shall be completed if youth are continued on or subsequently prescribed psychotropic medication as youth must receive medication review every thirty days.

**Reference:**

- DJJ Rule 63N-1.0085, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.09 Suicide Prevention Plan [Detention Staff]

The center follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with Rule 63N-1, Florida Administrative Code.

— CRITICAL —

Guidelines/Requirements: The center has a written plan detailing suicide prevention procedures. The plan includes the following:

▪ Identification and assessment of youth at risk of suicide
▪ Staff training (Each center must provide at least six hours of training annually on suicide prevention and implementation of suicide precautions, which includes quarterly mock suicide drills for all staff who come in contact with youth on each shift. (mental health clinical staff are exempt from this requirement.)
▪ Suicide precautions
▪ Levels of supervision
▪ Referral
▪ Communication
▪ Notification
▪ Documentation
▪ Immediate staff response
▪ Review process

Review the center’s suicide prevention plan.

Reference:

▪ DJJ Rule 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
▪ Detention Services FOP 1.08 Training; 5.03 COOP Plan/Emergency Plan; and 5.05 Drills
3.10 Suicide Prevention Services [Detention Staff/Contract Provider]

Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors or identified through assessment as a potential suicide risk.

Any youth exhibiting suicide risk behaviors must be placed on suicide precautions (precautionary observation or secure observation), and at a minimum of constant supervision.

All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR).

— CRITICAL —

Guidelines/Requirements:

- All youth on suicide precautions are placed on precautionary observation (at a minimum of constant supervision) or secure observation (one-to-one supervision).
- A Department’s Juvenile Justice Information System (JJIS) suicide alert shall be initiated for all youth placed on suicide precautions.
- Precautionary observation allows the "at risk" youth to participate in select activities with other youth in designated safe housing/observation areas in the center.
- Precautionary observation must not limit a youth's activity to an individual cell or restrict him/her to his/her sleeping room.
- The youth must remain on precautionary observation until he/she has received an Assessment of Suicide Risk (ASR) or Follow-Up ASR which indicates the precautionary observation can be discontinued.
- Youth whose behavior requires a level of observation and control beyond precautionary observation may be placed in a secure observation room.
- Documentation of a Health Status Checklist, youth search, and inspection of secure observation room are present for all youth on secure observation.
- Youth on suicide precautions whose misbehavior results in their being placed on behavioral confinement are placed on secure observation.
- Youth in secure observation receive an ASR or Follow-Up ASR prior to discontinuation of secure observation.
Review of Serious Suicide Attempts or Incidents of Self-Injurious Behavior

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide. The multidisciplinary review must include the following:

- Circumstances surrounding event
- Facility procedures relevant to the incident
- All relevant training received by involved staff
- Pertinent medical and mental health services involving the victim
- Possible precipitating factors
- Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures

Assessments of Suicide Risk (ASR) and Follow-Up Assessment of Suicide Risk

Each ASR form must document assessment of the youth in real time and not simply reference an earlier assessment.

- All youth determined to be at risk of suicide, based on intake screening, staff observations, or youth functioning shall be administered an ASR on Department form MHSA 004.
- ASR shall be completed within twenty-four hours (or immediately if the youth is in crisis).
- The ASR must be completed by a licensed staff or by an appropriately trained non-licensed staff.
- If the ASR if completed by a non-licensed mental health clinical staff, the ASR must be reviewed and signed by a licensed mental health professional in accordance with Rule 63N-1, F.A.C.
- If the ASR indicates discontinuation of suicide precautions, the youth shall not be transitioned to a lower level of supervision until the non-licensed mental health clinical staff confers with both a licensed mental health professional and the superintendent/designee.
- Licensed mental health professional must confer with superintendent/designee prior to revising supervision level.
- Documentation of the actual date/time clinician conferred with superintendent/designee and licensed mental health professional must be recorded on the ASR in the date/time sections. If the ASR is not entered into JJIS in real time, the actual date/time ASR functions were conducted must be recorded in the applicable narrative sections of the ASR entered into JJIS.

- Youth placed on precautionary observation prior to an ASR whose ASR determines the youth is not a potential suicide risk and suicide precautions may be discontinued, may be transitioned directly to standard supervision.
- Youth whose ASR indicates potential suicide risk must be maintained on suicide precautions and either one-to-one or constant supervision until Follow-Up ASR indicates suicide precautions may be discontinued. Follow-Up ASR must be recorded on Department form MHSA 005.
- When the youth's Follow-Up ASR indicates suicide precautions may be discontinued, the youth must be stepped down to close supervision prior to transition to normal routine and standard supervision.

- Youth placed in secure observation due to disciplinary confinement must receive an ASR or Follow-Up ASR prior to removal from secure observation to determine his/her level of suicide risk and whether he/she is to be maintained on suicide precautions (secure observation or precautionary observation) suicide precautions are to be discontinued and the youth stepped down to close supervision and transitioned to normal routine.

- Youth on secure observation are to receive an ASR within eight hours of placement in the room, or if placed when mental health staff are not available (evenings or night shift), the ASR shall be completed the following morning.

Review sample of youth records of youth requiring suicide prevention services, to include youth on precautionary and secure observation. Ensure suicide risk assessments and/or follow-up suicide risk assessments are completed prior to removal from precautionary or secure observation.

Review logbooks to determine if beginning and ending times are documented for youth placed on precautions.

Review JJIS to determine if alerts are appropriately entered and to determine if JJIS alerts were removed prior to the youth being removed from precautionary observation.

Review youth and staff interview results.

Reference:

- DJJ Rule 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services

- Pursuant to Contract Requirements
3.11 Suicide Precaution Observation Logs [Detention Staff/Contract Provider]

Youth placed on suicide precautions must be maintained on one-to-one or constant supervision. The staff assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth’s behavior at intervals of no more than thirty minutes.

— CRITICAL —

Guidelines/Requirements: Suicide Precaution Observation Log (MHSA 006) must be maintained for the duration a youth is on suicide precautions.

Suicide Precaution Observation Logs document staff observations of the youth's behavior in intervals which do not exceed thirty minutes.

When "warning signs" are observed, notification of the superintendent/designee and mental health clinical staff is documented on the Suicide Precaution Observation Log.

Suicide Precaution Observation Logs are reviewed and signed by each shift supervisor.

Suicide Precaution Observation Logs are reviewed and signed by mental health clinical staff daily.

Review a sample of completed Suicide Precaution Observation Logs to determine supervision, supervisory reviews, response to warning signs, and safe housing requirements.

Reference:

- DJJ Rule 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.12 Suicide Prevention Training [Detention Staff]

All staff who work with youth must be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.

— CRITICAL —

Guidelines/Requirements: All staff who work with youth are to receive a minimum of six hours annual training on suicide prevention and implementation of suicide precautions.

Mock suicide drills are to be held each shift, no less than quarterly.

Verify staff have received the required six hours of annual suicide prevention training with the team member reviewing training records (Mental health clinical staff are exempt from this training requirement).

Review documentation of mock suicide drills.

Review staff interview results.

NOTE: Mock Drills on response to a suicide attempt or incident of serious self-inflicted injury are conducted for each shift, at a minimum, on a quarterly basis. The Department recognizes not all staff on a particular shift may be present when a mock drill is conducted. Staff members who are not present during a quarterly mock drill must have the opportunity to review each mock drill scenario and procedures in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury incident in the center. Mock suicide drills show methods for contacting other center staff, medical personnel, and emergency medical services, CPR techniques or other first aid procedures, as necessary, and include the use of items within the suicide response kit, as necessary. At least two of the four quarterly mock drills must include lifesaving measures such as CPR.

Reference:

- F.A.C. 63H-2.007, Residential Services, Detention Staff
- DJJ Rule 63N-1.0091, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.13 **Mental Health Crisis Intervention Services [Detention Staff]**

Every center must respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the facility. The program must be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others, which would require suicide precautions or emergency treatment.

— CRITICAL —

**Guidelines/Requirements:** A mental health crisis is an acute emotional or behavioral problem or psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) which is extreme and does not respond to ordinary crisis intervention and mental health expertise is needed.

Each program must have a written Crisis Intervention Plan which details crisis intervention procedures including the following:

- Notification and alert system
- Means of referral, including youth self-referral
- Communication
- Supervision
- Documentation and review

Program may develop an integrated mental health crisis intervention and emergency mental health and substance abuse services plan, as required.

Review the mental health Crisis Intervention Plan.

**Reference:**

- DJJ Rule 63N-1.010, 63N-1.0101, 63N-1.0102, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.14 Emergency Care Plan [Detention Staff]

Youth determined to be an imminent danger to themselves or others due to mental health or substance abuse emergencies occurring in center, requires emergency care to be provided in accordance with the center’s Emergency Care Plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated crisis intervention and emergency services plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.

— CRITICAL —

Guidelines/Requirements: The center’s Emergency Care Plan must include the following:

▪ Immediate staff response
▪ Notifications
▪ Communication
▪ Supervision
▪ Authorization to Transport for Emergency Mental Health or Substance Abuse Services
▪ Transport for Emergency Mental Health Evaluation and Treatment under Ch. 394 FS (Baker Act)
▪ Transport for Emergency Substance Abuse Assessment and Treatment under Ch. 397 (Marchman Act)
▪ Documentation
▪ Training
▪ Review

Review the Mental Health Emergency Services Plan.

Reference:
▪ DJJ Rule 63N-1.011 and Rule 63N-1.0112, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.15 Crisis Assessments [Contract Provider]

A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional (LMHP), or under the direct supervision of a LMHP, to determine the severity of youth's symptoms and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the superintendent or designee must be notified of the crisis situation and need for Crisis Assessment. A Crisis Assessment is to be utilized only when the youth’s crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth’s behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk (ASR) instead of a Crisis Assessment.

— CRITICAL —

Guidelines/Requirements: Youth in crisis are administered a Crisis Assessment, which includes the following:

- Reason for assessment
- Mental Status Examination and Interview
- Determination of danger to self/others (including imminence of behavior, intent of behavior, clarity of danger, lethality of behavior)
- Initial clinical impression
- Supervision recommendations
- Treatment recommendations
- Recommendations for follow-up or further evaluation
- Notification to parent/guardian of follow-up treatment

Crisis Assessments are documented on Department form MHSA 023 or a form which contain all of the information in form MHSA 023. A Crisis Assessment must be conducted by a licensed mental health professional (LMHP) or a non-licensed mental health clinical staff working under the direct supervision of a LMHP. A Crisis Assessment shall be conducted immediately or within two hours for emergencies, or within twenty-four hours, based on the needs of the youth.

A mental health alert is entered into the Department’s Juvenile Justice Information System (JJIS) when a youth has received a Crisis Assessment and has been determined to exhibit behaviors which pose a potential safety or security risk in the facility. Youth determined through assessment to pose a safety and security risk must remain on alert until follow-up mental status examination, by, or under the supervision of, a LMHP.

If a youth is an alleged victim in a PREA event, a Mental Health and Substance Abuse Referral Summary must be submitted immediately for immediate Crisis Assessment. The youth must also be offered ongoing mental health treatment services consistent with the community level of care.
Review a sample of youth Crisis Assessments (MHSA023) from the last six months (if applicable).

Review the center’s policy, crisis assessment tool, and staff training records to ensure the program is adequately prepared to conduct crisis assessments.

Review JJIS alerts associated with mental health crisis situations.

Reference:
- DJJ Rule 63N-1.0103, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
3.16 **Baker and Marchman Acts [Detention Staff/Contract Provider]**

Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.

--- CRITICAL ---

**Guidelines/Requirements:** This indicator shall be rated “Non-Applicable” if the center has not had any Baker or Marchman Acts during the annual compliance review period.

Staff must ensure youth safety and supervision pending a Baker Act or Marchman Act. Mental health and administrative staff must be notified and involved when Baker or Marchman Acts are utilized. Parents/guardians and the assigned juvenile probation officer (JPO) are to be notified when youth have an emergency situation.

Youth returning to the center from a Baker Act or Marchman Act are placed on constant supervision upon return and a mental health referral is completed indicating a Mental Status Examination (MSE) must be conducted. (NOTE: MH Alert and constant supervision for youth who were transported due to mental health crisis or SP and constant supervision for youth who were transported due to suicide risk.)

For youth who have a suicide risk alert in JJIS, discontinuation of suicide risk alert and suicide precautions must be based upon an Assessment of Suicide Risk as set forth in Rule 63N-1 (See Rule 63N-1.006, 63N-1.0093, 63N-1.0094, 63N-1.00951 and 63N-1.00952 provisions.)

For youth who have a mental health alert in JJIS, discontinuation of mental health alert and constant supervision must be based on crisis assessment as set forth in Rule 63N-1 (See Rule 63N-1.006, 63N-1.0101, 63N-1.102 and 63N-1.0103 provisions).

MSE is completed by, or under the direct supervision of, a licensed mental health professional and the youth is maintained on a minimum of constant supervision until properly transitioned to a lower level of supervision.

Youth's supervision level is not lowered until an appropriate assessment is completed and mental health staff confers with licensed supervisor and superintendent or designee.

Review a sample of records for youth requiring Baker Act/Marchman Act over the last six months. If none in the last six months, the regional monitor(s)/reviewer(s) may review for the period since the last annual compliance review.

If a Baker Act or Marchman Act occurred, review the policy to ensure the center followed the proper procedures.

**Reference:**

- DJJ Rule 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Pursuant to Contract Requirements
Standard 4: Health Services

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* The Department has identified certain key critical indicators. These indicators represent critical areas requiring immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area.
4.01 Designated Health Authority/Designee [Contract Provider]

The designated health authority (DHA) is clinically responsible for the medical care of all youth at the center.

— CRITICAL —

Guidelines/Requirements: The provider has a contract agreement with a licensed physician (MD) or osteopathic physician (DO) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The designated health authority (DHA) may delegate clinical duties only to a designee/advanced practice registered nurse (APRN)/advanced registered nurse practitioner (ARNP) or physician’s assistant (PA).

The physician’s specialty training shall be in either pediatrics, family practice, or internal medicine (with experience in adolescent health), or a demonstrated prior experience in treating the primary health care needs of adolescents.

The designee shall hold an unrestricted license to practice in Florida.

The APRN/ARNP shall have a Collaborative Practice Protocol in place, it shall state the physician who is serving as the center’s DHA, and the protocol shall be maintained on-site at the center.

When a PA is utilized, the DHA shall have a supervisory relationship with the PA.

The DHA shall be on-site at least once a week, with a week defined as the seven-day period beginning on Sunday and ending on Saturday. However, at no time will more than nine days pass between on-site visits.

During vacation or scheduled absences, coverage shall be arranged of equal licensure.

The DHA/designee is responsible for communication with center staff regarding youth medical needs, and have availability for consultation by electronic means twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care.

Review provider contract and review sign in/out logs to confirm required visits for the past six months.

Check licenses of all medical professionals providing care to youth provided by the center or on the Department of Health’s website. Review Collaborative Practice Protocol with the APRN/ARNP. The protocol is to be maintained on-site at the center.

Review the license for the APRN/ARNP (if applicable). Interview the DHA or designee to verify the role in the coordination and implementation of health services at the center to include how often the DHA is on-site.

Review applicable Detention FOPs.

If Telemedicine is used, review the provider’s Telemedicine FOP for process for sign-in and sign-out of Practitioner.

Reference:

- F.A.C. 63M-2.0031, Health Services, Office of Health Services
- Pursuant to Contract Requirements and FOPs
4.02 Facility Operating Procedures [Contract Provider]

There shall be Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.

Guidelines/Requirements: At a minimum, an annual review of all FOPs and protocols is required. It is demonstrated by the signature and date of the designated health authority (DHA), superintendent, and other representatives from relevant disciplines. Individuals from these disciplines may sign and date a cover page listing all of the FOPs, signifying they have read the FOPs and any new health-related Department Policy. FOPs, or other protocols related to psychiatric services and psychotropic medication management, may only be performed by the center’s psychiatrist or psychiatric ARNP/APRN.

Approval of medical treatment protocols or standing procedures shall be written and authorized by the DHA and may not be delegated to any other person.

Nursing staff shall review, sign, and date a cover page on which all FOPs, treatment protocols, and other procedures are listed. New policies or changes in policies made during the year shall be reviewed, signed, and dated by each nurse on the individual policy changes that occur between annual reviews.

All newly employed health care personnel shall receive a comprehensive clinical orientation to Department health care policies and procedures, given by a registered nurse (RN) or designated, licensed health care professional.

Review the center’s health-related policies, procedures, and protocols to ensure they have been reviewed and approved by the appropriate provider and outline the center’s health care services.

Review all orientation documentation for new health care staff.

Reference:

- F.A.C. 63M-2.0035, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.03 Authority for Evaluation and Treatment [Detention Staff/Contract Provider]

Each center shall ensure the completion of the Authority for Evaluation and Treatment (AET) or Limited Consent for Evaluation and Treatment authorizing specific treatment for youth in the custody of the Department.

**Guidelines/Requirements:** The original Authority for Evaluation and Treatment (AET) shall be filed in the Individual Healthcare Record (IHCR).

The AET shall be signed by the parent/guardian and witnessed by a Department representative. It is the responsibility of the Department representative obtaining the signatures to verify the form is completed with all required documentation.

In the event a parent/guardian refuses to sign the AET or if the legally assigned guardian is not a parent/guardian there shall be a court order, and the court order shall be filed in the IHCR/EMR/EHR.

The AET is valid for as long as the youth is under any type of supervision, custody, or other form of legal control by the Department; OR, for one year after it was signed by the parent/guardian, whichever comes later; OR until the youth’s eighteenth birthday.

A legible copy shall suffice. The word ‘COPY’ shall be legibly handwritten or stamped.

An AET is required prior to providing medical services (except for emergency care and routine medical/mental health intake screenings).

**When the youth’s parent/guardian cannot be located to obtain the AET:** Where a signed AET has not been obtained, and the person with the power to consent to examination or treatment cannot be contacted after diligent search, and has not expressly objected to consent, the superintendent/designee may consent to ordinary and necessary medical treatment, including immunizations, and dental examination and treatment as set forth in Section 743.0645, F.S. The assigned juvenile probation officer (JPO) shall conduct the diligent search, as set forth in the form Affidavit of Diligent Effort (HS 056, January 2012). The assigned JPO shall complete the Affidavit of Diligent Effort and provide for attachment to the youth’s Limited Consent for Evaluation and Treatment (HS 057, December 2013). The superintendent/designee providing the consent for the youth shall sign the Limited Consent for Evaluation and Treatment.
When the youth is in the Department of Children and Families (DCF) system: Where the youth is in the dependency system and is served by DCF, the following process applies:

- Where the youth has not been removed from the parent/guardian’s home, the JPO shall obtain the parent/guardian’s consent to ordinary medical treatment by executing an AET.

- Where parental rights have not been terminated and the youth is in out-of-home care, such as a foster home, group home, or unlicensed caregiver, the JPO shall contact DCF or its contracted service provider to locate the parent/guardian to consent to ordinary medical treatment by executing the AET.

- Parental consent is not required where the court order placing the youth in out-of-home care specifically gives authority to consent to ordinary medical treatment to DCF or the out-of-home caregiver may consent to ordinary medical treatment by executing the Limited Consent for Evaluation and Treatment (HS 057, December 2013).

- Where parental rights have been terminated and the youth is in custody of DCF, contracted service provider or DCF may consent to ordinary medical treatment by executing the Limited Consent for Evaluation and Treatment (HS 057, December 2013).

(*NOTE: The Limited Consent does not provide consent for the continuance of psychotropic medications the youth is currently taking. In cases where psychotropic medications must be continued, a court order is required or the DCF form 5339 signed by the legal guardian and consent is provided.)

Review the IHCR for appropriate AET/Court Order/Limited Consent

Reference:

- F.A.C. 63M-2.0051, Health Services, Office of Health Services

- Pursuant to Contract Requirements & FOPs
4.04 Parental Notification/Consent [Contract Provider]

The center shall inform the parent/guardian of significant changes in the youth’s condition and obtain consent when new medications and treatments are prescribed.

Guidelines/Requirements: Appropriate OHS consent/notification forms shall be utilized a practitioner has ordered medication treatment or medication changes.

For new medication, verbal attempts/contacts/consents shall be documented in the chronological progress notes in the Individual Healthcare Record (IHCR) by the staff attempting and/or contacting the parent/guardian or on the 3rd page of the CPPN respectfully.

A staff member should witness all telephone call attempts and conversations. If additional staff member is unavailable to witness call attempts, then the center shall have an internal process by which the attempts are verified.

Any verbal notification (in person or by phone) shall be followed up with a written Parental Notification/Consent if required, return and signed by the parent/guardian. This written notification/consent shall be documented on forms HS 020 and HS 021 or the Acknowledgement of Receipt of the CPPN when documented on the CPPN.

If a youth reaches eighteen years of age while in the program and is not incapacitated or is otherwise emancipated, the youth is responsible for authorizing his/her health care and authorizing release of his/her healthcare records.

Whenever a new psychotropic medication is prescribed, is discontinued, or the drug dosage is significantly changed, parental/guardian verbal consent for psychotropic medication is documented through form HS 006 CPPN on page 3 or a form containing all the information required in HS 006 at page 3. Written consent is documented on the Acknowledgment of Receipt of CPPN Form (HS 001).

Youth in the custody of DCF must follow DCF rule 65C to obtain consent prior to administering newly prescribed psychotropic medications or changes to psychotropic medications. This is accomplished through completion of the DCF form 5339 and a court order.

Once consent is requested and obtained, the vaccination/immunizations should be provided.

If a parent/guardian claims exemption and does not consent to vaccinations for religious reasons, they shall complete the “Religious Exemption from Immunization” form provided by the County Health Department, have it signed and authorized there, and then submit this to the center. Copies of the exemption shall be filed in the youth’s IHCR.

If a parent/guardian does not consent to a vaccination for medical reasons, then a signed letter shall be provided to the center by the youth’s physician or DOH exemption form indicating the reason for the exemption. Copies shall be filed in the youth’s IHCR.

Review progress notes to confirm parent/guardian consent when obtained verbally. Entry should include a witness for all psychotropic medications. A written notification shall also be sent using the required CPPN Parental Notification form.

Review immunizations in each sampled youth’s IHCR along with any exemption forms, when applicable.
Review parental notifications for the following events/circumstances:

- Over-the-counter (OTC) medications not covered by the AET
- Vaccinations/Immunizations not consented for on the AET
- Significant changes to existing medication (excluding psychotropic medications)
- Discontinuation of medication prescribed prior to youth entering custody of the Department
- Changes in youths’ medical condition/medication for youth with chronic conditions
- Off-site emergency care, notification made by telephone and, subsequently, in writing
- Hospitalizations, surgeries/invasive procedures, non-routine dental procedures
- Whenever a youth is taken off-site for medical treatment

Additional records may need to be reviewed

Reference:

- F.A.C. 63M-2, Health Services, Office of Health Services
- F.A.C. 63N-1, Mental Health, Office of Health Services
- Rule 63D-3.046, F.A.C.
- Pursuant to Contract Requirements and FOPs
4.05 Healthcare Admission Screening & Rescreening Form (Medical and Mental Health Screening Form) (Screening Entered into JJIS) [Contract Provider]

Youth are screened upon admission for healthcare concerns which may need a referral for further assessment by healthcare staff.

Guidelines/Requirements: Medical and Mental Health Screening Form is to be completed on date of admission. A healthcare admission rescreening is to be completed each time the physical custody of the youth changes with subsequent return or readmission to the center.

All female youth who are sexually active, those identifying their menstrual cycle as more than two weeks late, or those who request testing, shall receive a qualitative urine pregnancy screening test, with the youth’s verbal consent, at the time of admission.

Screenings shall be completed by an RN, LPN, direct care staff, or MD/APRN/ARNP.

If completed by a direct care staff, the screening shall be reviewed with the youth by a LPN or higher within twenty-four hours. If completed by a direct care staff, the screening shall be reviewed with the youth by a licensed medical staff within twenty-four hours.

Review superintendent interview results.

Review the youth Face Sheet in the Department’s Juvenile Justice Information System (JJIS) for any changes in custody.

Review youth records for new Medical/Mental Health Screening form (DJJ/DCF 001) or Facility Entry Physical Health Screening form (HS 010) for change in physical custody.

Additional records may need to be reviewed.

Review Chronological Progress notes/IHCR for consent for pregnancy screening and, if applicable, results for all sexually active youth.

Reference:
- DJJ Rule 63M-2.0041, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
- DJJ Rule 63G-2 Secure Detention Services
4.06 Youth Orientation to Healthcare Services/Health Education [Contract Provider]

All youth are to be oriented to the general process of healthcare delivery services at the center.

Guidelines/Requirements: Youth receive a general healthcare orientation within twenty-four hours of admission to the center.

Examples of topics to be covered include:

- Access to Medical
- Sick Call (use, how to access)
- What constitutes an "emergency" and who to notify
- Medication process and side effect monitoring
- The right to refuse care and how it is documented
- What to do in the case of a sexual assault or attempted sexual assault
- The non-disciplinary role of the healthcare providers

Review the orientation packet for each youth sampled. The youth are not required to sign orientation sheets and the center may utilize an education/orientation binder to ensure all topics are reviewed with youth.

Review FOP/contract for additional routine Health Education Topics.

Review sample of youth records to verify required orientation topics were provided. Review the Health Education form (HS 013) for topics reviewed.

Reference:

- F.A.C. 63M-2.0046, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.07 Designated Health Authority/Designee Admission Notification [Contract Provider]

The DHA or designee is notified when youth admitted require emergency care or routine notification in accordance with Department requirements.

Guidelines/Requirements: Referrals to the center’s physician, PA, or APRN/ARNP shall be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission.

The designated health authority (DHA) or designee shall be notified immediately when a youth admitted requires emergency care. The LPN or RN may first conduct a preliminary triage examination before contacting EMS and the DHA, PA, or APRN/ARNP. The DHA or designee must be notified of all youth admitted with a medical condition. This notification may be by telephone or verbally.

The notification shall be documented in the youth’s Individual Healthcare Record (IHCR)/Electronic Medical Record (EMR)/Electronic Health Record (EHR).

Review Facility Operating Procedures for appropriate timeframes for notification.

Review chronological progress notes in the EMR/IHCR and the Chronic Condition Log for documentation showing the correlation and verification of this requirement.

Reference:

- F.A.C. 63M-2.0043, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.08 Health-Related History [Contract Provider]

The standard Department Health-Related History (HRH) form shall be completed for all youth admitted into the physical custody the center.

Guidelines/Requirements: The HRH form shall be updated/completed within seven days of admission.

The HRH shall be conducted and signed as completed by a licensed nurse or practitioner.

The designated health authority (DHA) or designee shall document he/she has reviewed the HRH form. This can be accomplished by the check box on the Comprehensive Physical Assessment indicating the HRH form was reviewed and/or by documentation on the focused note: the admission documents/HRH were reviewed.

The completion or revision of the HRH form shall be conducted and dated prior to, or at the same time as, the Comprehensive Physical Assessment.

The most recent Department form should be used.

Review HRH forms for signatures and dates for the most current admission.

The HRH is not required to be updated when transfer occurs between centers and one has already been completed for this admission.

Reference:

- F.A.C. 63M-2.0047, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.09 Comprehensive Physical Assessment/TB Screening [Contract Provider]

The Comprehensive Physical Assessment (CPA) form shall be completed for all youth admitted into the physical custody of the center.

Guidelines/Requirements: CPA is to be completed within seven calendar days of admission.

TB screening shall be completed within seventy-two hours of admission if one is not documented in the youth’s Individual Healthcare Record (IHCR) within the past year.

A current CPA at the time of admission for medical grade “1” is two years from the initial date of the CPA; for grades “2-5” is one year from the initial date of the CPA.

The CPA shall be completed only by a MD, DO, ARNP, or PA.

The youth’s Medical Grade is required documentation on the CPA.

A CPA completed prior to the youth’s current admission may be used as follows, but may not be altered:

- A current CPA with no changes in the youth’s medical condition
- The current CPA shall be reviewed as the youth is examined and signed off as reviewed by the physician, PA, or ARNP
- A focused evaluation should be present with each readmission where a new CPA is not initiated, and a current CPA is used

Gynecological examinations (for sexually active females) All pelvic exams shall only occur with the female youth’s full verbal consent.

All fields on the CPA shall be completed by the examining practitioner, as required for all new CPAs: (Body Mass Index (BMI), visual acuity field, Tanner stage, scalp/ head, cardiovascular, medical grade, the most recent Tuberculosis Skin Test (TST), etc.). Any youth with symptoms suggestive of active TB shall not be placed in the general population until medically cleared by the designated health authority (DHA) or designee, PA, or APRN/ARNP. TB refusal may result in the completion of a chest x-ray, and may not need repeating more frequently than every five years unless a youth reports an exposure to someone with active TB.

Review facility operating procedures for appropriate documentation when any part of the exam is not conducted and/or is refused by the youth.

A refusal form shall be completed or documentation when deferred by practitioner after review of the HRH form shall be documented for any part of the exam that is not performed. Review the CPAs of all youth sampled.

Review of Youth Refusal Forms

Review Chronological Progress notes for Focused Evaluations.

Review the Department’s Problem List to determine if it was updated, as required.

Review the Medical and Mental Health Screening, the CPA, and/or Infectious and Communicable Disease (ICD) form for documentation of a completed TST results/Chest x-ray results.

Chest x-ray results may also be found in the radiology test section of the IHCR and EMR/EHR.
Reference:

- F.A.C. 63M-2.0048, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.10 Sexually Transmitted Infection/HIV Screening [Contract Provider]

The center shall ensure all youth are evaluated and treated (if indicated) for sexually transmitted infections (STIs) and HIV risk factors.

Guidelines/Requirements: All sexually active youth shall be clinically screened and evaluated for STIs. HIV test results shall be filed in a confidential manner consistent with FS 381.004.

The MD/DO/PA/APRN/ARNP shall review the STD screening tool and provide orders for specific testing (if indicated).

Youth have the right to request or decline HIV testing. It shall be offered to each youth with or without risk factors identified.

The results of tests shall be noted on the youth’s Infectious and Communicable Disease (ICD) form and located in the Individual Health Care Record (IHCR).

Rescreening should be conducted if the sexually active youth has been out of the Department’s physical custody, and/or symptoms are present.

Referrals/testing should be documented on the STI and in the practitioner’s order. In addition, it may also be found in the chronological progress notes. The ICD forms for each applicable youth shall be reviewed for documented STI results. STI results shall also be filed in the lab section of the IHCR.

A certified HIV counselor shall conduct the testing. It may also be conducted by a practitioner. Re-testing shall be at the discretion of the HIV counselor/practitioner.

If testing is completed on-site, documented consent from the youth shall be obtained and stored in the youth’s IHCR/EMR. If testing is completed by outside provider, a copy of the consent will be acceptable and filed in the youth’s IHCR/EMR.

Documentation of pre/post-test counseling shall be documented on the Individual Health Education Record (HS013) and may also be found in the chronological progress notes (but not the test results).

The youth’s HIV status should never be included on the program’s internal alert system or listed on the Department’s Problem List.

Pursuant to Chapter 381 F.S., HIV test results can be disclosed only to the youth and to the following entities:

- The youth’s legally authorized representative
- Health care providers during consultation, diagnosis or treatment of the individual
- The Department of Health for purposes of reporting and control of spread of disease
- Health facility staff committees conducting program monitoring, evaluation, and service reviews
- Medical personnel who have been subject to a significant exposure
- Health care center personnel or agents for the health care provider who have a need to know during patient care activities or administrative operations
For release of information to any other individuals, the youth must sign a consent/release form stating those individuals to whom this information should be released to.

Review youth interview results to determine if youth believe they can request HIV testing.

Additional healthcare records may be reviewed to ensure sample size is met

Review the Health-Related History (HRH) and STI forms for documentation of screenings and re-screening’s, when applicable, for each youth record reviewed.

If HIV results are maintained in a sealed envelope and proof of review by a practitioner is documented on the envelope, it is not recommended for reviewers to unseal the envelope.

Reference:

- F.A.C. 63M-2.0041 & 63M-2.0052, Health Services, Office of Health Services
- F.S. 381.004, HIV Testing
- Pursuant to Contract Requirements & FOPs
4.11 Sick Call Process [Detention Staff/Contract Provider]

All youth in the center shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. The center shall respond appropriately, in a timely manner, and document all sick call encounters as required by the Department. All youth in restricted housing/confinement shall have timely access to medical care, as required by Rule.

Guidelines/Requirements: There shall be regularly scheduled hours in each center for a youth to be evaluated by a licensed nurse. Only a licensed nurse shall conduct sick call. If LPN conducts sick call, it shall be reviewed daily, either telephonically or in person, with the MD, DO, PA, APRN/ARNP, or RN. Youth in restricted housing of any kind (e.g., confinement, seclusion, room restriction, and/or secure observation) are questioned daily for sick call/health complaints and documented in the Individual Healthcare Record (IHCR)/Electronic Medical Record (EMR).

When there is not a licensed nurse on-site, the program shall have a procedure whereby the shift supervisor shall review all sick call requests as soon as possible, and within four hours after the request is submitted.

All centers shall utilize the Facility Management System (FMS) to allow staff to enter the sick call requests generated by the youth. This entry shall then generate a notice to the nurse for timely review. Every center shall have a backup procedure for notification to the nurse in situations where the computerized system is unavailable.

Sick call forms (EMR located in the Department’s Juvenile Justice Information System) or progress notes shall be documented in accordance with Rule 63M-2 (e.g., vital signs, treatment, education, follow-up plans).

Sick calls are automated fill form once seen by clinical staff, but the most recent Sick Call Index should be found in the hard copy of the IHCR.

The completed Sick Call Request form is to be filed within the progress notes in the youth’s Individual Health Care Record in reverse chronological order and maintained in the EMR/EHR...

Youth presenting with similar sick call complaints three or more times within a two-week period require a referral to the MD, DO, PA, or APRN/ARNP.

Youth complaints of severe pain with which staff (nursing or non-healthcare) is unfamiliar shall be treated as emergencies and an immediate referral made to the licensed healthcare professional.

Sick call shall be conducted daily, or as pursuant to contract requirements, whichever is greater.

Review sick call request forms from the EMR/IHCRs sampled. Look for referrals when required and/or documented follow-up when needed for youth in severe pain.

Review each youth’s corresponding Sick Call Index, referral log, or JJIS generated sick call referral log and corresponding sick call form.

If the center has not had any instances of restricted housing, review the center’s policy. Confer with annual compliance review team member assigned to Standard 5.

When possible, observe this practice with the youth’s permission to ensure confidentiality is maintained.

Review staff and youth interview results.
Reference:

- F.A.C. 63M-2.002 & 63M-2.006, F.A.C., Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.12 Episodic/First Aid & Emergency Care

The center shall have a comprehensive process for the provision of episodic care and first aid care.

Guidelines/Requirements: Every center shall provide episodic care to include basic first aid procedures and interventions.

Emergency medical and dental care shall be available, including EMS services, twenty-four hours a day. All healthcare and non-healthcare staff shall know they have the right and responsibility to immediately call 9-1-1 at any time a youth’s condition appears compromised.

Emergency medical and dental care shall be available, including EMS services, twenty-four hours a day.

All non-healthcare staff who have direct contact with youth shall maintain current certifications in first aid and basic cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED) training.

If a youth requires the use of an epinephrine auto injector, all healthcare and direct care staff (at the supervisory level) shall be appropriately trained on the administration of the epinephrine auto injector and shall administer the epinephrine auto injector, when indicated.

An appropriately trained/RN can train other healthcare staff and non-healthcare staff on the use of the epinephrine auto injector.

All licensed healthcare staff shall maintain, at a minimum, current certification in CPR (with AED training, as applicable).

The AED, shall be placed in a secured area easily accessible to staff.

**The battery shall be maintained by the maintenance provider only.

Emergency drills are held on each shift and are conducted at least quarterly. CPR/AED demonstration must be practiced on a regular basis.

A list of emergency telephone numbers and cell phone numbers, including the number of the statewide Poison Control Center, shall be posted and accessible to all staff, on all shifts. This list should not be in a location accessible to youth.

Non-healthcare staff episodic care shall be documented on Department form, Report of On-Site Care by Non-Healthcare Staff.

Episodic care provided by a non-licensed staff must have a follow-up evaluation by a licensed health care professional the next time this person is on-site, or sooner, if warranted.

Episodic care by licensed staff requires documentation in the EMR Episodic Care Progress Note, and must contain all elements of a SOAP note.

There shall be an on-site tracking log for episodic care.

First aid kits (inclusive of transportation vehicles) are in designated areas and the DHA approves contents. They are monitored monthly and replenished as needed. The center should have a process where vehicle first aid kits are maintained to prevent breakdown of contents. Documentation of routine replenishment will be necessary for items that deteriorate when exposed to heat. (Examples include, but are not limited to, liquids, gloves, and CPR masks).
Review a sample of first aid kits for expired and approved contents.

Emergency drills are held on each shift and documented at least quarterly. CPR/AED demonstration must be practiced at least annually.

Suicide and medical drills may be combined.

Review Episodic Care Log for past six months and compare with all on/off-site events from Individual Healthcare Records (IHCRs)/Electronic Medical Record (EMR) sampled.

Review progress notes and non-healthcare staff forms for each on/off-site event.

Review any documented drills related to above guidelines.

Additional records may need to be reviewed for this indicator if selected records do not include episodic/emergency care.

**The Department has procedures established for AEDs to be monitored by an outside provider. Review documentation of the last time the AED was serviced.**

**Reference:**

- F.A.C. 63M-2.009, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.13 Off-Site Care/Referrals [Contract Provider]

The center shall provide for timely referrals and coordination of medical services to an off-site healthcare provider (emergent and non-emergent), and document such services, as required by the Department.

Guidelines/Requirements: For all youth who require routine off-site medical or off-site emergency care, the Summary of Off-Site Care form shall be utilized and filed in the Individual Healthcare Record (IHCR).

If applicable, discharge and other documents are filed in IHCR.

The designated health authority (DHA)/designee has documented the review of all off-site care findings, instructions, and information. The provider shall ensure actual dictation and documents are requested from the outside provider.

All follow-up testing, referrals, and appointments require documentation indicating the youth received appropriate, and timely follow-up care, as needed.

Review all Summary of Off-Site Care forms, returning off-site orders, and progress notes for all events in each youth’s IHCR sampled.

Additional records may need to be reviewed for this indicator.

Reference:

- F.A.C. 63M-2.008 & 63M-2.063, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.14 Chronic Conditions/Periodic Evaluations [Contract Provider]

The center shall ensure youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up.

Guidelines/Requirements: All youth with these conditions shall have periodic evaluations:

- Chronic condition
- Communicable disease
- Taking prescribed medications on an on-going basis (at least three consecutive months)
- Medical Grade 2-5
- Pregnant
- Morbidly Obese (BMI greater than 30)

All periodic evaluations are to be conducted no less than once every three months for medical conditions and prior to the change of psychotropic medications, and no less than every thirty days when prescribed.

Periodic evaluations shall be conducted prior to renewal of a prescription medication.

Review each youth’s Medical/Mental Health Screening form, HRH, CPA, and the center’s chronic condition roster to determine if the youth is applicable for this requirement.

Review progress notes for documentation of each completed periodic evaluation.

Review records for youth on the chronic conditions list who have been in the center long enough for a periodic evaluation.

Reference:

- F.A.C. 63M-2.008, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOP
4.15 Medication Management

Medication shall be received, stored, inventoried and provided in a safe and effective manner which shall be demonstrated by observation, review of documentation of procedures and processes.

Guidelines/Requirements: Only medications from a licensed pharmacy with a current, patient-specific label intact on the original medication container may be accepted into the center. All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.

The designated health authority (DHA)/physician designee, and (when applicable) the psychiatrist shall be contacted to obtain the order to resume the specified medications youth is prescribed prior to admission.

Documentation of prescription verification shall occur in the chronological progress notes in the Individual Healthcare Record/EMR or utilizing the Prescription Medication Verification checklist (HS 025).

All youth in restricted housing shall receive all prescribed medications, as ordered and on time.

Over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form shall be administered according to approved protocols or Practitioner’s Order, unless the parent/guardian has prohibited the administration of OTC medications.

The standard Department Medication Administration Record (MAR) (HS 019)/Electronic Medical Record (EMR), shall be used to document all medication and treatment. The MAR shall clearly indicate medication start and stop dates.

Staff shall initial each administered medication entry (also required for youth to initial when non-healthcare staff provide medications).

There shall be no undocumented explanation for a lapse or errors in medication administration.

At a minimum, the nursing staff shall document weekly side effect monitoring on the MAR and daily when provided by non-licensed staff.

Trained non-healthcare staff may assist in the delivery of medications, only when licensed staff are not on site.

The Six Rights of Medication Delivery/administration shall be maintained by both licensed and non-licensed staff. (Right youth, right med, right dose, right route, right time and right documentation).

Refusals are clearly documented on the MAR and Refusal Form, when applicable.

There shall be no standing orders for psychotropic medications.

There shall be no emergency treatment orders for psychotropic medication.

There shall be no PRN orders for psychotropic medications.

Review the Medical/Mental Health Screening and admission progress notes to confirm if youth was admitted on medication with subsequent verification. Review progress notes for notification to the DHA and verify with parent/guardian when applicable.

Review each applicable sampled youth’s MAR, for the above requirements.
Review progress notes and practitioner order section to determine if medication was continued, changed, or discontinued. Compare orders to the MAR.

Review that refusals are clearly documented on the MAR.

Observe at least one medication pass, when possible.

Review staff and youth interview results.

**Reference:**

- F.A.C. 63M-2022 through 63M-2.037, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.16 **Medication/Sharps Inventory and Storage Process [Contract Provider]**

Any medical equipment classified as and stock medicaitions shall be secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed of or when the medication is utilized.

**Guidelines/Requirements:** Any medical equipment classified as sharps (e.g., syringes, needles, scissors, and suture removal kits) shall be secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed. All controlled substances shall have a perpetual inventory and stored separately from other medications.

All medications shall be identified and secured in the locked area designated for storage of medications. Different medication forms (e.g., injectable, topicals, drops, liquids) shall be separated.

Controlled substances shall be maintained behind two locks with two separate key access.

Each center shall have a process for the destruction and disposal or return of expired or discontinued medications.

A perpetual and a weekly inventory of all sharps and stock OTC medications shall be conducted.

Pursuant to Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances shall be documented on the youth’s individualized Controlled Medication Inventory Record.

A third shift to first shift count of controlled medications is required prior to medical staff beginning medication pass. Strict control and accountability of the running balance for each controlled substance shall be maintained.

Supervisory level, non-health care staff trained in the delivery and oversight of medication self-administration may perform these duties. This may only occur when nursing staff are not on-site.

The number of pills, tablets, or dosages remaining after each administered dosage shall be documented on the youth’s Individualized Controlled Medication Inventory Record received with the medicine from the pharmacy or the Department form.

Reporting criteria and procedures for inventory discrepancies shall be in place.

Randomly select inventory for three different sharps, and three OTC medications, and at least two controlled substances (when currently prescribed) document and observe a count completed by the nurse. Verify if count matches ending inventory numbers.

Observe area designated to store youth medication, including separate storage of controlled substances.

Review policy and corresponding documentation, when applicable, for disposal of medication.

**Reference:**

- F.A.C. 63M-2022 through 63M-2.037, Health Services, Office of Health Services
- Pursuant to Contract Requirements & FOPs
4.17 Infection Control – Exposure Control & Education [Contract Provider]

The center shall have implemented infection control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention guidelines. The comprehensive education plan shall include pre-service and in-service training for all staff. Education for youth infection control shall also be provided at the time of intake and subsequently when the need is identified.

Guidelines/Requirements: The following categories of diseases shall be addressed, along with training related to each center’s specific exposure control plan at the time of hiring, and annually thereafter for all staff:

- Common, infectious diseases of childhood (e.g., measles, mumps, and chickenpox)
- Self-limiting, episodic contagious illnesses (e.g., the common cold)
- Viral or bacterial infectious diseases (e.g., viral or bacterial meningitis)
- Tuberculosis
- Hepatitis A, B, and C and HIV infectious diseases caused by blood-borne pathogens
- Other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly
- Outbreaks of pediculosis (lice) and/or scabies
- Methicillin-Resistant Staphylococcus Aureus (MRSA) and other emerging antibiotic-resistant micro-organisms
- Food-borne illnesses such as those cause by E. Coli
- Bio-terrorist agents (e.g., Anthrax, Small Pox)
- Chemical exposures in the workplace

All youth shall receive infection control training within seven days of admission into the center. There shall be documentation the Standard Universal Precautions are followed by all staff. Hepatitis B immunizations shall be provided to staff, if consented to in writing by staff member.

A comprehensive process for needle stick post-exposure evaluation shall be in place. The superintendent/designee shall establish a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure. All records shall be maintained confidentially for a ten-year period.

Specified infectious diseases outbreaks (10% of population or more) should be reported by the Department within the required time frame in accordance with the Department of Health requirements.

Any incident involving contagious disease requiring the quarantine or hospitalization of at least ten percent of the total population of youth or staff within a center shall be reported to the Central Communications Center (CCC) within two hours.
Training shall be documented, and records retained in the youth Individual Healthcare Record (IHCR) on the Health Education Record (HER) form (HS 013), to include the prevention of blood borne pathogens and prevention of communicable diseases. Staff training shall be documented in the staff personnel record.

Review staff training records or confirm with the annual compliance review team member looking at the training indicators.

Review IHCR/HER (HS 013) for each youth sampled to confirm documentation of required education of hand washing/infection control.

Determine if there were any instances in which the local county health department, Centers for Disease Control and Prevention, and/or CCC should have been notified of an infectious disease and ensure such instances were reported as required. This can be accomplished by review of CCCs and interview with staff.

Reference:
- F.A.C. 63M-2.050-051 & 63M-2.053-055, Health Services, Office of Health Services
- F.A.C. 63F-11
- F.A.C. 64D-3 Control of Communicable Diseases and Conditions which may Significantly Affect Public Health
- Pursuant to Contract Requirements & FOPs
4.18 **Prenatal Care/Education [Contract Provider]**

The center shall provide **access to prenatal care for all pregnant youth. Health education shall be provided to both youth and staff.**

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**Guidelines/Requirements:** Prenatal care shall begin immediately upon determination the youth is pregnant and continue until discharge/transfer and through the postpartum. A licensed nurse shall provide in-service education on girls’ healthcare annually to all non-healthcare staff. Education shall include training on monitoring and observation, for emergency needs of the pregnant youth.

The designated health authority (DHA) designee, PA, or APRN/ARNP shall provide a routine, focused medical evaluation of the youth’s pregnancy every thirty days or sooner if ordered.

The center shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth as ordered by the practitioner.

Youth shall be placed on alert for vital nutrition and health awareness for staff.

The licensed professional healthcare staff shall provide routine daily monitoring and observation for indications of pregnancy complications.

Pregnant youth shall not sleep on upper bunk beds due to falling hazards.

Each pregnant youth shall receive education on the following topics: alcohol and drug usage, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, postpartum care, basic baby care (feeding, diapering, bathing), child/infant development, and parenting skills.

There is a documented plan of care through post-birth to include psychological and physical care.

Review the EMR/Individual Healthcare Record (IHCR) of sampled youth. Closed IHCR may be used if none of the youth sampled are applicable going back six months.

Review related education packets specific for pregnant youth.

Review youth interviews to determine if the youth has received prenatal, obstetrical, or gynecological services when needed.

Review staff training records for related education topics including observation and monitoring of emergency needs/symptoms of possible miscarriage.

**Reference:**

- DJJ Rule 63M-2.010, Health Services, Office of Health Services
- Pursuant to Contract Requirements
# Standard 5: Safety and Security

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* The Department has identified certain key critical indicators. These indicators represent critical areas requiring immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area.
5.01 **Active Supervision of Youth**

Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another.

Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).

Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.

When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.

Master control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by master control.

Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.

--- CRITICAL —

**Guidelines/Requirements:** Adequate staffing of a center is essential to ensure the safety and security of the center and the center’s mission, goals, and outcomes can be achieved.

Observe staff during daily activities such as school, recreation, meals, breaks, and line movements to ensure staff are actively supervising youth.

Review the logbook to ensure resident counts are conducted.

Determine if there is a method of tracking the daily census such as a log, census sheet, grease board, or an electronic method of tracking, such as a computer program.

Conduct staff interviews to determine the methods by which counts are reconciled.

Observations for this indicator are to be made each day of the review. A rating should not be assigned until the final day.

Review staff interview results.

**Reference:**
- Detention Services FOP 3.11, Room Checks/Supervision Levels,
- Detention Services FOP 5.07, Officer Safety
- Detention Services FOP 5.08, Head Counts
5.02 Ten-Minute Checks

Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction.

Staff conduct observations in a manner ensuring the safety and security of each youth and documents each check in real time, manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; preprinted times are not acceptable.

There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.

If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth’s body, the officer shall, with the assistance of another officer, open the door to verify the youth’s presence.

— CRITICAL —

Guidelines/Requirements: The safety and security of youth must be provided while they are in sleeping rooms. Centers should have room check sheets or documentation of electronic checks where the times of room checks are documented and initialed by staff conducting the check. Preprinted times shall not be on the form. Ten-minute checks must be conducted whenever youth are in their sleeping rooms, unless circumstances, as required, dictate five-minute checks be made.

Review ten-minute check documentation (paper and/or electronic) to ensure the checks are being conducted within the required frequency.

Observe the staff conducting the ten-minute checks.

Review a sample of video on various days, times, and shifts to determine compliance.

Review ten-minute check sheets to ensure the actual times are being noted and the staff conducting the checks is identified on the check sheet.

Review staff interview results.

Reference:

- Detention Services FOP 3.11, Room Checks/Supervision Levels
5.03 Census, Counts, and Tracking

Officers must know the exact number and location of all youth under their supervision at all times. Census counts of youth shall be taken, called into master control, and documented, at a minimum:

- At the beginning and end of each shift
- Following any emergency to include power outages, evacuation due to emergency drills, and any code called outside the secure walls. In the event a code is called in any location outside the main walls of a facility, it is critical all youth counts are reconciled prior to the movement of any group of youth.
- Prior to and following routine group movement
- Any time a population change occurs
- Randomly, at least once on each shift

Staff should not include youth in the count who are not physically present with the staff person at the time of the count (e.g., court, clinic, confinement).

Guidelines/Requirements: The primary function of a juvenile justice detention officer is to supervise youth in order to maintain a safe, secure, and humane environment. Therefore, it is critical officers know the exact number and location of all youth under their supervision at all times.

Review program logbooks (master control and modules) to determine if headcounts, youth movement, and daily census are documented at the beginning and end of each shift, as required, and emergency counts have been documented in the master control logbook.

Observe counts being conducted.

Review staff interview results.

Reference:
- Detention Services FOP 5.08, Head Counts
5.04 Logbook Maintenance

The center maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Each logbook is a bound book with numbered pages. If electronic logbook software is used by the center, it is password-protected and configured to prevent entries from being deleted or altered after they are saved.

At a minimum, each logbook entry includes the date and time of the event, the names of staff and youth involved, a brief description of the event, the initials of the person making the entry, and the date and time of the entry. Logbook entries are made in black or blue ink, with no erasures or whiteout areas. No logbook entries are obliterated or removed; errors are struck through with a single line and initialed by the person correcting the error.

Log entries regarding medical, special needs, and mental health alerts, or other issues impacting facility safety and security shall be highlighted.

Guidelines/Requirements: The logbook is the permanent record of the life of the center, which may be either electronic or hard copy. Very often, entries in it have been useful as documentation in legal proceedings. The permanent log should be bound, with sequential pages. Entries must be made in ink with no erasures or whiteout areas and initialed by the staff making the entry. Logbook pages shall not be removed.

At a minimum, the master control logbook shall document the following:

- Emergency situations including contacts to the Florida Abuse Hotline and the Central Communications Center (CCC)
- Incidents
- All drills
- Receipt of medical and mental health alerts
- Population counts at the beginning and end of each shift
- Population counts throughout the shift as the count changes
- Population counts following emergency situations
- Youth group movement
- Admissions and releases
- Presence of law enforcement who are not employees of a secure detention center.
- Name(s) of youth placed in confinement, along with the time confinement was initiated and the time confinement was ended
- Name(s) of youth placed on precautionary/secure observation, along with the time precautionary/secure observation was initiated and the time ended.

Review sample of all type logbooks for the last six months.

Reference:
- Detention Services FOP 1.13, Log Books
5.05 Logbook Reviews

The superintendent or designee reviews all logbooks on a weekly basis.

The juvenile justice detention officer supervisor (JJDOS) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.

The JJDOS reviews logbooks maintained in each living area daily.

The JJDO(s) and/or the lead officer reviews the logbook maintained in his/her assigned living area when he/she accepts responsibility for the living area at shift change.

Guidelines/Requirements: Detention staff must review logbooks to ensure they are aware of alerts, security risks, and other pertinent issues. Supervisors or designee must review logbooks to ensure entries are complete and accurate.

Review the center’s logbooks for documentation of supervisory and juvenile justice detention officer (JJDO) and/or the lead officer reviews during the past six months.

Review the logbooks for the documentation of the superintendent or designee weekly reviews during the past six months.

Reference:
- Detention Services FOP 1.13, Log Books
5.06 Key Control

Each center is responsible for maintaining inventory and control of all facility keys.

All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.

Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the superintendent. These keys shall be notched or otherwise identifiable by touch.

The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.

A key inventory shall be maintained by the superintendent or designee at all times. The inventory shall account for all key rings by:

- The ring number (e.g., Ring # 1, Ring # 2)
- The number of keys on each ring
- The capability of each key
- To whom (or where) each key ring is issued

Inactive key rings shall be included on the master inventory and shall be maintained in a secure key box accessible to the shift supervisor. An inventory is to be conducted on each shift.

Emergency key rings shall be included as part of the facility key inventory.

The issuance of the key(s) and key ring numbers shall be documented on each shift report.

All staff who are issued keys shall:

- Receive key control training prior to receiving facility keys
- Be responsible for the security of those keys and be able to account for those keys at all times during their work schedule
- Carry issued keys on their person at all times
- Not allow youth to handle facility keys
- Not remove the keys from the facility or the facility grounds without authorization from the superintendent
- In the event staff mistakenly leaves the facility with keys and key ring, staff shall contact the shift supervisor immediately and shall be required to return the ring to the facility within two hours of being notified
- Shall immediately, upon first knowledge, report lost key rings to the supervisor on duty. This shall be done in a manner in which a youth would not overhear.

Personal keys/key rings belonging to employees or anyone entering the secure area shall be secured prior to entering the secure area.
**Guidelines/Requirements:** The usage, storage, and general security of any facility key is paramount to the security of the facility. Facility operating procedures shall outline a system of key control addressing assignment, tracking, storage, and disposal or replacement of lost or damaged keys, including keys to the program vehicles.

Review center policy on key control.

Observe the distribution and collection of keys.

Interview master control or supervisory personnel to determine the process for restricting usage of keys such as medical, youth and staff records, and youth property locker keys.

Review the key inventory to determine if the keys rings on the inventory match the actual key rings in use.

Observe the key storage area and determine the level of security.

Determine the procedures for addressing missing or lost keys and reporting and replacement of damaged keys.

Observe a sampling of key rings and compare to the inventory and key log.

Observe the process for securing staff’s personal keys before they enter the secure area.

Review staff interview results.

**Reference:**

- Detention Services FOP 5.12, Key Control
5.07 Vehicles and Maintenance

The center ensures any vehicle used by the center to transport youth is properly maintained, as well as maintains documentation on the use and maintenance of each vehicle. Youth and staff are not permitted to use tobacco products. Center vehicles are locked when not in use.

Guidelines/Requirements: Each vehicle is inspected prior to use. If any item is found or suspected to be out of compliance, and no other vehicle is available, staff must obtain the approval of the transportation coordinator or shift supervisor prior to use.

Vehicle searches are conducted before and after the transportation of any youth. Staff inspects the inside of vehicle prior to each transport to ensure the vehicle is safe and no contraband is present.

Maintenance Staff:
- Conduct a weekly visual check of all the transport vehicles that includes: water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness
- Conduct a monthly vehicle check of all the transport vehicles that includes: tires (including spare), battery (test), windshield and wipers, windows, mirrors, and damage (to include all scratches and/or dents).
- After the transport vehicles are searched, they must be observed or locked to prevent the introduction of contraband, prior to being loaded.
- Maintain a copy of the current transportation procedures are in each vehicle.
- The inspection must be documented on the mandatory inspection form and a copy of the form must be maintained by the maintenance staff.

Transport Staff - Prior to each transport, the two-staff assigned must:
- Inspect the vehicle for contraband, making sure the caged area of the vehicle is physically checked for objects and/or contraband.
- Ensure the vehicle has sufficient gasoline to reach the destination.
- Verify that seatbelts are securely anchored.
- Test that the security screen is secure.
- Confirm that the vehicle folder contains the vehicle logs, vehicle and mechanical restraint keys, gas credit card and vehicle registration.
- Ensure that a cell phone is assigned to the vehicle and that it is charged and turned on prior to departure.
- The inspection must be documented in the vehicle log book.

Transport Staff - After each transport, the two-staff assigned must:
- Ensure the vehicles are searched for contraband and remaining youth.
- Ensure the vehicles are locked to prevent the introduction of contraband.
The intent of this indicator is to ensure the safety of staff and youth while occupants of motor vehicles.

Review invoices from automotive shop to determine if each vehicle has received an annual safety inspection and any deficiencies were corrected.

Observe each vehicle used to transport youth and determine if it is equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit.

Observe a transport, if possible, to ensure youth and staff wear seatbelts. If unable to observe a transport, interview transportation staff and youth for their understanding of seatbelt usage.

Check the security of vehicles while not in use.

**Reference:**

- Detention Services FOP 4.03, Operation of DJJ Vehicles
- Detention Services FOP 4.04, Preventive Maintenance
- Detention Services FOP 4.06, Transportation Procedures
5.08 Tool Inventory and Management

The center ensures all tools and equipment related to maintenance and kitchen areas are properly maintained, stored, and inventoried.

Guidelines/Requirements: Inspections of tool control areas are conducted monthly, and the results of these inspections are submitted to the superintendent or designee.

Tools are stored in a locked area when not in use. Kitchen storage areas, including cabinets and drawers, are also secured when not in use. Kitchen knives and other hazardous kitchen sharps are stored in a locked cabinet, drawer, or toolbox containing an inventory list. When a replacement tool and/or item is received, staff responsible for that area properly dispose of the old and/or damaged item. Broken or defective tools are removed for repair or replacement. Tool replacement is noted in writing and verified by the superintendent or designee. Immediately following repairs, tools are returned to the appropriate storage area and properly secured.

The center maintains a perpetual inventory of all tools, and the superintendent or designee reviews maintenance tool inventories monthly. Kitchen staff conducts an itemized inventory of all equipment, including kitchen knives and other hazardous kitchen implements, upon reporting for duty. All equipment is accounted for prior to the departure of the kitchen staff. Discrepancies are immediately reported to the juvenile justice detention officer (JJDO) supervisor and the superintendent or designee.

Staff positively identify repair service personnel before allowing entry into secure areas of the facility. Service vendors are accompanied by designated center staff at all time when in the secure area of a center.

When items are reported lost, or there is reasonable suspicion a youth may be in possession of a missing item, the shift supervisor initiates a search of affected areas. When repairs are completed, or work has ceased for the day, the shift supervisor ensures working areas are thoroughly cleaned and inspected for contraband before allowing youth access.

Tools and equipment that can be used to cause death or serious injury must have strict control.

Review the center’s policy on maintenance and kitchen tools.

Inspect the tool room and kitchen to determine the level of security when tools are not in use. Inspect maintenance tools to ensure they are marked with an ID code identifying the tool as Department property.

Review the inventories used to document issuance and return of tools. Determine if there are any tools for both maintenance and kitchen tools on the inventories missing from the center. Determine whether there are any tools at the center not listed on the inventory.

Interview staff to determine practice for missing or damaged tools.

Reference:
- Detention Services FOP 5.15, Tool and Sensitive Item Control
5.09 Youth Access & Use of Tools, Cleaning Items

Youth are forbidden to use or access any tools, including kitchen or medical equipment. Youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision.

— CRITICAL —

Guidelines/Requirements: Mod cleanliness may be accomplished by youth assigned to the mod, if youth are under the direct supervision of the staff. Review interview responses to determine whether youth use inappropriate tools or cleaning items. Review staff interview results. Observe youth using cleaning tools, if possible.

Reference:

- Detention Services FOP 5.15, Tool and Sensitive Item Control
5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items

The superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items.

All flammable, toxic, caustic, and poisonous items shall be inventoried and secured when not in use. The use of hazardous material shall be consistent with the manufacturers’ instruction and all safety precautions shall be followed.

All flammable, toxic, caustic, and poisonous items shall have the Material Safety Data Sheets (MSDS) on hand in the facility. Toxic or caustic materials shall not be allowed to enter into the facility unless an MSDS is on file in an MSDS logbook and posted near items. A master copy of the MSDS logbook shall be maintained in an accessible binder for all personnel to review at all times.

No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.

Guidelines/Requirements: A flammable material is defined as liquids with a flash point below 100 degrees Fahrenheit.

Toxic materials are defined as substances, through chemical reaction or mixture, can produce possible injury or harm to the body by entering through the skin, digestive tract, or respiratory tract (e.g., zinc chromed paint, ammonia, chlorine, antifreeze, herbicides, pesticides).

Caustic materials are defined as substances that can destroy or eat away by chemical reaction (e.g., lye, caustic soda, sulfuric acid).

All flammable, toxic, caustic, and poisonous items must be stored in secure areas inaccessible to youth. Substances that do not contain one or more of the above properties but are labeled “Keep out of the reach of children” or “May be harmful if swallowed,” may not be considered to meet the above definitions, but should be kept under strict control.

Review the center’s safety plan.

Compare the inventory to actual items on-site.

Compare the MSDS to the flammable, toxic, caustic, and poisonous materials and items and determine if there is an SDS for all materials.

Reference:
- Detention Services FOP 5.14, Toxic Materials
- F.A.C. 63G-2.016, Maintenance
5.11 Access to all Flammable, Toxic, Caustic, and Poisonous Items

Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.

Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person’s bio hazardous material, bodily fluids, or human waste.

— CRITICAL —

Guidelines/Requirements: A flammable material is defined as liquids with a flash point below 100 degrees Fahrenheit. Toxic materials is defined as substances, through chemical reaction or mixture, can produce possible injury or harm to the body by entering through the skin, digestive tract, or respiratory tract (e.g., zinc chromed paint, ammonia, chlorine, antifreeze, herbicides, pesticides).

Caustic materials are defined as substances that can destroy or eat away by chemical reaction (e.g., lye, caustic soda, sulfuric acid).

All flammable, toxic, caustic, and poisonous materials must be stored in secure areas inaccessible to youth. Substances that do not contain one or more of the above properties but are labeled “Keep out of the reach of children” or “May be harmful if swallowed,” may not be considered to meet the above definitions but should be kept under strict control.

Review youth interview responses to determine youth access to toxic items.

Interview staff to determine youth’s access to toxic items.

Reference:
- Detention Services FOP 5.14, Toxic Materials
5.12 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items

The maintenance mechanic or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste shall be responsible for disposing of hazardous items and toxic materials in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 (amended 1-1-2004).

Guidelines/Requirements: A flammable material is defined as liquids with a flash point below 100 degrees Fahrenheit. Toxic materials are defined as substances, through chemical reaction or mixture, can produce possible injury or harm to the body by entering through the skin, digestive tract, or respiratory tract (e.g., zinc chromed paint, ammonia, chlorine, antifreeze, herbicides, pesticides).

Caustic materials are defined as substances that can destroy or eat away by chemical reaction (e.g., lye, caustic soda, sulfuric acid).

All flammable, toxic, caustic, and poisonous materials must be stored in secure areas inaccessible to youth. Substances that do not contain one or more of the above properties but are labeled “Keep out of the reach of children” or “May be harmful if swallowed,” may not be considered to meet the above definitions, but should be kept under strict control.

The disposal of all hazardous waste shall be by one of the following methods:

- Compaction
- Evaporation
- Flushed
- Incineration
- Bio-hazardous Waste Contractor

Hazardous liquid waste shall be disposed of in accordance with the manufacturers’ materials safety data sheet. Designated containers for hazardous liquid waste shall be kept in the hazardous materials storage area.

Liquid waste not resulting from work details (e.g., dirty mop water, unused beverages) shall be disposed of in the plumbing area of each housing unit that has a drain. Liquid waste resulting from work details shall be disposed of in sinks located in mop storage areas.

Kitchen liquid waste, except for grease, shall be disposed of in the kitchen drain. Grease shall be placed in a separate container for disposal.

Should a chemical spill occur, the following actions are to be taken:

- Upon becoming aware of a chemical spill, staff shall notify Master Control of the location.
- The shift supervisor/Master Control shall direct the shut-down of all air handlers and ventilation systems and close all windows and doors at the direction of the on-scene supervisor or superintendent.
- Assistance from outside the facility shall be contacted, as necessary, consistent with emergency procedures.

Review the center’s FOP on the disposal of flammable, toxic, caustic, and poisonous items.

Interview maintenance personnel or applicable administrative personnel to determine if flammable, toxic, caustic, and poisonous items and materials are disposed of appropriately.
Reference:

- Detention Services FOP 5.14, Toxic Materials
5.13 Confinement Under Twenty-Four Hours

Staff shall use behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth’s sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self.

Guidelines/Requirements: Confinement is used as an immediate, short term response strategy for staff to use during volatile situations in which a youth’s sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. There are conditions that must be maintained relating to both rooms used for confinement and the supervision of youth in confinement.

- Confinement room windows and cameras shall be free of obstructions.
- Any room possessing potential safety hazards shall not be used for confinement.
- Rooms used for confinement shall be searched and items impacting the safety and security to an individual youth shall be removed prior to the placement of any youth. If a youth is combative and the room search prior to confinement will further escalate the situation or create safety issues for the youth or officer(s), the search may be conducted after placement.

Youth in confinement shall be afforded living conditions approximating those available to the general population. This includes, but is not limited to: education, showers, meals, clothing, large muscle exercise, bedding (during sleeping hours only), and hygiene items, as needed and as security permits. Youth shall not have contact with the general population while participating in these activities.

Superintendents shall develop procedures for the placement of youth in confinement including the following:

- Verification of the level of supervision required, including the documentation of visual observation. Youth assessed to be at risk of suicide are provided constant sight and sound supervision.
- The Incident Report (to include the Confinement Report) shall be completed in the FMS or manually and submitted within one hour of the youth’s confinement to the juvenile justice detention officer supervisor (JJDOS) by the officer making the placement. The Incident/Confinement Report shall include a description of the incident and efforts made by staff to control the youth’s behavior.
- The Confinement Report shall be reviewed by the JJDOS within two hours of the confinement to ensure the fair and appropriate use of confinement. The JJDOS shall determine the appropriateness of the confinement placement. If the JJDOS determines the placement to be inappropriate, the youth shall immediately be released to the general population. The JJDOS shall also review the youth’s file to assess any special needs the youth may have that would merit alternatives to room confinement.
- The JJDOS, following the review of the confinement report, shall evaluate and document the youth’s status, at a minimum, every three hours to determine if the continued confinement of the youth is required. Observed youth behavior and/or conversation with the youth shall be documented on the confinement report as evidence for the need to continue or to terminate confinement.
The superintendent or designee shall review the report within forty-eight hours of the end of the confinement, excluding weekends and holidays.

The length of time a youth may be placed in confinement is dictated by a number of factors including:

- Severity of the rule violation
- Past disciplinary history
- Behavior while in confinement

Any of these factors documenting the need for continued confinement must be stated clearly in the confinement report.

The superintendent or designee may continue a youth’s time in confinement for up to twenty-four hours.

The JJDOs shall document the continued need for confinement every three hours.

Confinements shall be communicated to school personnel for appropriate record keeping and tracking of school assignments.

On occasion, youth may be placed in confinement in their sleeping room, rather than further escalating a situation by attempting to move the youth to a designated confinement room.

Review confinements on FMS to determine compliance with requirements.

Review staff interview results

Reference:

- Detention Services FOP 3.03, Confinements
5.14 Confinement Over Twenty-Four Hours

Confinement beyond twenty-four hours must be approved by the superintendent or designee.

The superintendent shall approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Reasons for extended confinement must be clearly documented on the confinement report.

The JJDO(s) shall continue to evaluate and document the youth’s status every three hours. Current youth behavior and/or conversation with the youth shall be documented on the confinement report as evidence for the need to continue or terminate confinement.

If it is necessary to extend the confinement beyond twenty-four hours, permission is needed from the regional director or designee. The regional director will notify the Assistant Secretary. This must be done every twenty-four hours.

The length of confinement shall not exceed three days unless the release of the youth into the general population would jeopardize the safety and security of the facility as documented by the superintendent. No youth shall be held in confinement beyond three days without a confinement hearing, conducted by an employee of the Department who holds a management or supervisory position.

Guidelines/Requirements: Review confinements on FMS to determine compliance with requirements.

A mental health professional shall review the status of any youth in Confinement every twenty-four hours.

Reference:
- Detention Services FOP 3.03, Confinements
5.15 Continuity of Operations Planning (COOP) Drills

COOP drills shall be conducted and documented, at minimum, twice a year, with one drill being completed prior to the hurricane season, which begins June 1st.

**Guidelines/Requirements:** Each center shall have a planned and comprehensive approach to effectively manage emergencies and disaster events, including those requiring the center to relocate its youth and staff while maintaining operations, safety, and security. The center must be prepared to initiate its procedures with very little notice.

The total number of drills must be, at a minimum, two per year. At least one drill shall be conducted prior to the start of hurricane season. This drill does not have to be a hurricane scenario-type drill.

Review the documentation provided to determine number of COOP drills, scenarios, and any resulting critique or corrective action.

Review logbooks for documentation.

Review staff interview results.

Actual events may be acceptable as a mock drill providing the event meets the requirements of a drill with critique and follow-up correction action.

**Reference:**

- DJJ Rule 63N-1 page 28, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- Detention Services FOP 5.03, COOP Plan/Emergency Plan
5.16 Escape Drills

The center shall develop, implement, and maintain an escape prevention plan incorporating the Department’s established policies and procedure regarding escapes.

The center shall conduct and document quarterly mock escape drills.

Guidelines/Requirements: All staff should have a clear understanding of the Department’s and the center’s policy on escapes and be prepared to respond quickly and appropriately. Appropriate levels of supervision, staff vigilance, and proper building maintenance are all-important considerations.

Review the center’s escape prevention plan to ensure all required elements are included.

Review the logbook to verify the escape drill documentation.

Review training to ensure all staff are trained in escape prevention annually.

Actual events may be acceptable as a mock drill providing the event meets the requirements of a drill with critique and follow-up correction action.

Review staff interview results.

Reference:

- Detention Services FOP 5.05, Drills
- Detention Services FOP 5.10, Escape and Escape Prevention
5.17 **Fire Drills**

Management has implemented a disaster preparedness plan and fire prevention plan. Monthly fire drills (with procedures being approved by local fire officials) are documented and conducted under varied conditions and on each shift.

**Guidelines/Requirements:** Each center shall have a fire evacuation and prevention plan. The center must be prepared to initiate the associated procedures with minimal notice.

Review fire drill documentation and the logbook to verify documentation of fire drills. (Drills should be conducted monthly, facility wide, on each shift.) It is the expectation all center staff who are assigned to the shift and/or present when the drill occurs participate in the drill.

Review staff and youth interview results.

**Reference:**
- Detention Services FOP 5.03, COOP Plan/Emergency Plan
- Detention Services FOP 5.05, Drills