Monitoring and Quality Improvement Standards for Residential Services Programs FY 2018-2019

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.
### Standard 1: Management Accountability

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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. A contract provider may hire an employee to a position that 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 demonstrates that he or she exhibits no behaviors that 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 of good moral character. The Department is aware and vigilant of its status as a criminal justice agency and its special responsibilities in dealing with the youth population, and has determined it is appropriate to establish stringent screening requirements for all DJJ and provider personnel and volunteers. Therefore, the Department utilizes Level 2 Screening Standards as required in s. 435.05, F.S.

Contracted/grant provider volunteers, mentors, and interns who assist or interact with provider youth on an intermittent basis for less than ten hours per 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 or her line of sight. (Note: Intermittent basis means the volunteer provides assistance on a non-continuous basis or at irregular intervals; visiting no more than once a quarter. Any contracted/grant provider volunteers, mentors, and interns who assist or interact with youth and have access to confidential information MUST be background screened.)

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 into another position within their organization, as long as there is no break in service.
A new background screening is required when a Department employee is hired by a provider or when a provider employee is hired by another contracted provider company.

Moving from DJJ to a contracted provider or from a contracted provider to DJJ, or from one contracted provider company to another is considered a new hire.

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 ineligible 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 file.

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 SVS module, FDLE’s ATMS result, and completed any agency personnel file review prior to hiring or utilizing a volunteer that will have contact with youth, or access to confidential youth records.

A new background screening is not required for a volunteer who has been hired by the center, 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/FBI, the 5-year rescreening/resubmission is being completed, and the volunteer is added to the Clearinghouse employee roster within 90-days of completing the screening request.

Teachers 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 programs are not required to undergo background screening by DJJ.
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 volunteer 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 program).

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 for employment by DJJ Inspector General to continue employment.

Review documentation to determine whether the Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit prior to January 31 of the current calendar year. (Review spreadsheet BSU sent.)

Reference:

- FDJJ-1800 PC, Background Screening Policy and Procedures
- F.A.C. 63E-7.016 (4) (a), Residential Services, Program Administration
- F.A.C. 63E-7.016 (12) (d), Residential Services, Program Administration
- F.S. 985.644 Departmental Contracting Powers; Personnel Standards and Screening; (1)(b) and (3)(a)
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 DJJ 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/resubmissions 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 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 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 since five years from the initial hire date of employment to determine 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 program – not employees paid by the school board).

Reference:

- FDJJ-1800 PC, Background Screening Policy and Procedures
1.03 Provision of an Abuse-Free Environment

The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

- Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.
- All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.
- Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.
- The environment is free of physical, psychological, and emotional abuse.
- A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.

— CRITICAL —

Guidelines/Requirements: “Immediately” is defined as occurring near the time of the incident or when the information is first received. Any person who knows, or has reasonable cause to suspect, a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, should report such knowledge or suspicion to the Department. This includes the regional monitor/reviewer. If the regional monitor(s) sees abuse, they are required to report it.

For purposes of this rule, 63E-7, “unhindered access” means the program shall allow youth and staff to make the decision to report allegations of abuse without obtaining permission. The program shall provide youth with timely telephone access to report allegations of abuse without intimidation or reprisal. However, if the youth requests telephone access during a scheduled structured activity, the program shall provide access as soon as the activity concludes.

This does not preclude the statutory obligation of staff to report any knowledge of child abuse or neglect.
Direct care staff shall model prosocial behaviors for youth throughout the course of each day in the program, reinforce delinquency interventions, and guide and re-direct youth toward prosocial behaviors and positive choices. Staff behavior should be respectful of others and reflect desired behaviors for youth. Staff shall not use corporal punishment, profanity, threats, or intimidation in the presence of youth. Per FDJJ 1100, “Rights of Youth in DJJ Care, Custody, or Supervision,” the Department of Juvenile Justice is committed to observing, upholding and enforcing all laws pertaining to individual rights. Department officers, staff, and contracted providers shall respect and protect each youth's rights and comply with all law relating thereto. Regional monitor(s)/reviewers shall ensure staff adhere to a Code of Conduct.

Review all incident reports, since the last annual compliance review, for substantiated allegations of child abuse.

Conduct both staff and youth interviews to determine if basic needs have been deprived, to include but not limited to, use of profanity by staff.

Both formal and informal interviews shall be conducted to determine if youth have been subjected to threats or intimidation by staff.

Interview a sample of youth to determine if the youth feels safe in the program and if staff are respectful to youth.

Interview a sample of staff to determine how staff and youth are able to call the Florida Abuse Hotline.

Interview the program director to determine the program’s code of conduct, what actions are taken when physical abuse, threats, or profanity is used towards youth, and to explain the program’s incident reporting process, to include incidents where youth were denied or limited access to the Florida Abuse Hotline.
Substantiated incidents of abuse shall not be factored into the rating of this indicator. Reference any outstanding or ongoing incidents, include substantiated incidents, any outstanding corrective actions, and/or changes made by the program.

Reference:

- F.S. Chapter 39, Proceedings Relating to Children
- F.S. Chapter 39.201, Mandatory Reports of Child Abuse, Abandonment, Neglect; Mandatory Reports of Death; Central Abuse Hotline
- F.A.C. 63E-7.005 (2c), Residential Services, Youth Orientation
- F.A.C. 63E-7.006(e) Access to the Florida Department of Children and Families central abuse hotline
- F.A.C. 63E-7.011 (2) (d) (2b), Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63E-7.016, Residential Services, Program Administration
- FDJJ Policy 1100, Rights of Youth in DJJ Care, Custody, or Supervision
1.04 Management Response to Allegations

Management shall be cognizant of youth and staff needs and provide direction to each on how to access the Florida Abuse Hotline. There is evidence management takes immediate action to address incidents of physical, psychological, and emotional abuse.

— CRITICAL —

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” if the program has not had any incidents of physical, psychological, or emotional abuse since the last annual compliance review.

Documentation will be reviewed to identify applicable corrective action taken by management for follow-up to allegations and/or substantiated incidents of abuse or neglect. Due to the confidential nature of such records, only approved Department staff, including, but not limited to, Monitoring and Quality Improvement staff and residential operations staff, are permitted to review personnel records. Personnel records are not to be reviewed by state or provider peers or residential program staff.

Review internal incident reports, to include disciplinary actions, to ensure management staff took immediate corrective action to address incidents of physical, psychological, and emotional abuse.

Interview the program director to determine how staff and youth are knowledgeable on contacting the Florida Abuse Hotline and Central Communications Center (CCC) and to determine how many staff had disciplinary actions due to allegations of abuse towards youth in the annual compliance review period.

Reference:

- F.A.C. 63E-7.016 (7) Program Administration, Residential Program Reporting Requirements
- F.A.C. 63H-2.003 (1) (b) (18), Residential Services, Contracted Residential Staff
- F.A.C. 63H-2.005 (2) (a) 1b, Residential Services, State Residential Staff
1.05 Incident Reporting (CCC)

Whenever a reportable incident occurs, the program 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 Central Communications Center (CCC) reports for the past six months, the regional monitor(s)/reviewer(s) may sample reports since the date of the last annual compliance review, but no more than twelve months.

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

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.

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.

Review CCC reports for the past six months to determine compliance with CCC reporting procedures.

Determine if additional incidents should have been reported to the CCC upon review of internal incidents/grievances. Interview program director to explain the program’s incident reporting process.

Reference:
- F.A.C. 63F-11, Central Communications Center
1.06 Protective Action Response (PAR) and Physical Intervention Rate

The program 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 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.

In the event mechanical restraints are used, the program shall follow preexisting PAR policy, which includes completion of a PAR Incident Report, along with the Mechanical Restraints Supervision Log, completed and filed.

Review and notate the program’s physical intervention rate.

Program 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.

A PAR report shall be completed after an incident involving the use of counter move, 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 program’s Department approved PAR Plan.

Review a sampling of PAR reports to determine if:

- A review by a PAR certified instructor/supervisory staff.
  (Note: If reviewed by both parties, they should not be the same staff, unless no PAR certified instructor/supervisor is available prior to the Facility Administrator Review.)
- A post-PAR interview was conducted with the youth by the superintendent, or designee, as soon as possible, but
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no longer than 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 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.

Review the monthly summary of all PAR incidents submitted within the last six months to the Department within two weeks of the end of each month.

Interview program director to explain the program’s process for monitoring PAR incidents and use of force, to include corrective actions related to the improper use and excessive/unnecessary force.

Reference:
- F.A.C. 63H-1, Staff Training, Basic Curricula (PAR)
- Pursuant to Contract Requirements: Residential Contract to include performance expectations
1.07 Pre-Service/Certification Requirements

Residential staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.

— CRITICAL —

Guidelines/Requirements: Pre-service/certification training and examinations are documented on the Department’s Learning Management System (SkillPro). Review a sample of training records on SkillPro.

**Contracted Residential Staff:**

Staff must complete a minimum of 120 hours of pre-service training, instructor-led and web-based, completed in the areas listed in F.A.C. 63H-2.003(1b).

All contracted residential facilities/programs shall submit, in writing, a list of pre-service training to Office of Staff Development and Training including course names, descriptions, objectives, and training hours for any instructor-led training, completed in the areas listed in F.A.C. 63H-2.003(1b).

Contracted residential staff are authorized to be in the presence of youth prior to the completion of the training requirements outlined in F.A.C. 63H-2.003(1b); however, the following essential skills must be completed first:

- PAR trained (must be successfully completed within ninety days of hire)
- CPR/First Aid certified
- Professionalism and ethics, including standards of conduct
- Suicide prevention
- Emergency procedures
- Child abuse reporting
- **PREA**

Review the documentation to support the pre-service training plan was submitted and approved by the Office of Staff Development and Training.

Yes ☐  No ☐  N/A ☐  Yes ☐  No ☐  N/A ☐
Regional monitor(s)/reviewers should ask the program which staff are considered to be direct care staff and are counted for in the staff to youth ratio. (Inquire as to whether there are additional staff who may occasionally supervise youth, such as maintenance, kitchen, or other staff members.)

Review the applicable contract for any additional training requirements for the respective positions of each sample file under review.

**Reference:**

- F.A.C. 63H-2.003 Contracted Residential Staff
- F.A.C. 63H-1.009 (1), Basic Curricula (PAR), Certification
- Pursuant to Contract Requirements: Residential Provider Contract, Personnel Detail, Staffing and Training Requirements
1.08 **In-Service Training**

Residential staff 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 is completed.

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

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**Guidelines/Requirements:**

**Contracted Residential Staff:**

The following are mandatory training topics that must be completed each year by contracted residential staff (unless specific certification is good for more than one year, 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

All contracted residential facilities/programs shall submit, in writing, a list of in-service training to the Office of Staff Development and Training including course names, descriptions, objectives, and training hours for all instructor-led in-service training other than the mandatory training topics listed above.

**Supervisory Staff Training for Residential Facilities:**

As part of the twenty-four hours of in-service training required for direct care staff, supervisory staff shall complete eight hours of training in the areas of:

- Management
- Leadership
- Personal Accountability
- Employee Relations
- Communication Skills
- Fiscal
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).

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

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

Review the documentation to support the in-service training plan was submitted and approved by the Office of Staff Development and Training.

Review training records and/or the Department’s Learning Management System (SkillPro) for residential staff in subsequent years of employment to ensure training was completed as required. This sample must include supervisory staff.

Regional monitor(s)/reviewer(s) should ask the program which staff are considered to be direct-care staff and are counted for in the staff to youth ratio. (Inquire as to whether there are additional staff who may occasionally supervise youth, such as maintenance, kitchen, or other staff members.)

Review the applicable contract for any additional training requirements for the respective positions of each sample file under review. 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-2.003, Contracted Residential Staff
- F.A.C. 63H-1.012, Annual Training Requirement
- Pursuant to Contract Requirements: Residential Provider Contract, Personnel Detail, Staffing and Training Requirements
1.09 Grievance Process

Program staff shall be trained on the program’s youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility.

Completed grievances shall be maintained by the program for a minimum of twelve months.

Guidelines/Requirements: Review a sample of pre-service staff training records to determine if they have received the required training on the program’s grievance process and procedures.

A residential commitment program shall establish written procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances in the program related to the violation or denial of basic rights. These procedures shall establish each youth’s right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected.

The procedures shall address each of the following phases of the youth grievance process, specifying timeframes promoting timely feedback to youth and rectification of situations or conditions when grievances are determined to be valid or justified.

- Informal phase wherein the youth attempts to resolve the complaint or condition with staff on duty at the time of the grieved situation (i.e. speak out(s), “Chatty Kathys” forms, or suggestion box).
- Formal phase wherein the youth submits a written grievance requiring a written response from a supervisory staff person.
- Appeal phase wherein the youth may appeal the outcome of the formal phase to the program director or designee.

Interview staff to gauge their understanding of the program’s grievance process.

Conduct interview with the program director to explain the program’s grievance process.
Conduct and review youth and staff interviews to determine their understanding and rating of the program’s grievance process.

The program shall maintain documentation on each youth grievance and its outcome for at least one year.

Staff shall ensure any youth requesting to file a grievance be given the proper forms, assistance, and instructions on the preparation and submission of the grievance.

Review a random sample of grievance documentation for the past six months for youth participation, supervisory oversight, and final outcome.

Review youth interviews to determine if youth are able to request assistance in completing a grievance form.

Reference:

- F.A.C. 63E-7.006 (7), Residential Services, Quality of Life and Youth Grievance Process
- F.A.C. 63E-7.005 (2) (i), Residential Services, Youth Orientation
1.10 Delinquency Interventions and Facilitator Training

The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.

Guidelines/Requirements: For each youth in its care, the program implements a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, as defined by Florida Administrative Code, addressing a priority need identified for that youth.

Education and work experience are considered by the director of programming when determining staff delivery of delinquency intervention services.

Review the program’s intervention or strategy to determine if it is evidence-based.

Yes ☐ No ☐ N/A ☐

Review the program’s activity schedule to determine if the program is providing structured, planned programming or activities at least sixty percent of the youth’s awake hours.

Yes ☐ No ☐ N/A ☐

Review a sample of performance plans to determine if delinquency intervention services are provided based on the common characteristics of the youth.

Yes ☐ No ☐ N/A ☐

Review a sample of staff training records to determine if staff were trained on the evidence-based strategy or model.

Yes ☐ No ☐ N/A ☐

Review the providers contractually required service(s) and identified personnel to be trained.

Yes ☐ No ☐ N/A ☐

Review group sign-in sheets to determine if the groups are being delivered as designed.

Yes ☐ No ☐ N/A ☐
Conduct interview with program director to determine what intervention model or strategy that is an evidence-based, promising practice, or a practice with demonstrated effectiveness has been implemented to address the priority needs of each youth and to determine how a staff member’s education and work experience are considered when determining which staff would deliver life skills training or groups.

Conduct interview with program director to determine how youth are matched to staff/counselors/case managers and intervention groups.

Review personnel records to verify appropriate education and work experience.

Review the table in the program’s contract to validate practice.

Reference:

- F.A.C. 63E-7.011 (2) (a,c), Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63E-7.002 Evidenced-based Delinquency Intervention
- Pursuant to Contract Requirements: Delinquency Intervention Services Table
1.11 Life Skills Training Provided to Youth

The program shall provide interventions or instruction focusing on developing life and social skill competencies in youth.

**Guidelines/Requirements:** Life skills are those skills helping youth to function more responsibly and successfully in everyday life situations, including social skills specifically addressing interpersonal relationships.

The program shall provide life and social skills intervention services addressing, at a minimum, identification and avoidance of high-risk situations that could endanger self or others, communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, to include problem solving and decision making.

**Note:** The Department’s Impact of Crime (IOC) is not recognized as a life skills curriculum.

- Review the program activity schedule to ensure life skills education/training/groups are being provided.

  - Yes ☐ No ☐ N/A ☐

- Review the program’s process to determine how these services are provided and by what discipline within the program. Review the provider’s contractually required service(s).

  - Yes ☐ No ☐ N/A ☐

- Review staff training records to ensure they have been trained to deliver the curriculum/service.

  - Yes ☐ No ☐ N/A ☐

- Review sample of youth records (treatment plans and performance plans) to determine if they youth are receiving services as outlined.

  - Yes ☐ No ☐ N/A ☐

- Reviewer/regional monitor(s) shall review group sign-in sheets to determine if the curriculum is being delivered as designed.

  - Yes ☐ No ☐ N/A ☐
Conduct program director and youth interviews to determine if youth are participating in groups, what new skills youth have learned in the groups, and if youth are provided an opportunity to practice the skills.

Reference:

- F.A.C. 63E-7.011(2) (d) (2,a), Residential Services, Delinquency Intervention and Treatment Services
- Pursuant to Contract Requirements: Delinquency Interventions/Life Skills Education/Training for Youth

Yes ☐ No ☐ N/A ☐
1.12 Restorative Justice Awareness for Youth

The program shall provide activities or instruction intended to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability for youths’ criminal actions and harm to others.

Guidelines/Requirements: These activities or instruction shall be planned or designed to:

- Assist youth to accept responsibility for harm they have caused by their past criminal actions, challenging them to recognize and modify their irresponsible thinking, such as denying, minimizing, rationalizing, and blaming victims;

- Teach youth about the impact of crime on victims, their families, and their communities;

- Expose youth to victims’ perspectives through victim speakers, in person or on videotape or audiotape, or through victim impact statements, and engage youth in follow-up activities to process their reactions to each victim’s accounting of how crime affected his or her life; and

- Provide opportunities for youth to plan and participate in reparation activities intended to restore victims and communities, such as restitution activities and community service projects.

Review training records of personnel conducting restorative justice awareness groups and activities.

Review a sample of youth case management records to determine if the program is providing activities and/or instruction intended to increase each youth’s accountability for criminal actions and harm to others.

Review the program’s activity schedule to determine when the restorative justice awareness groups and activities are provided. Review the providers contractually required service(s).
Observe youth participating in restorative justice awareness groups and activities.

Review group sign-in sheets to determine if the curriculum is being delivered as designed.

Conduct interview with program director to determine when and what types of restorative justice awareness groups or activities are provided for youth. How are youth exposed to the victim’s perspective through victim speakers? Are youth permitted to participate in reparation activities intended to restore victims and communities?

Reference:

- F.A.C. 63E-7.011 (2) 3 a-d, Residential Services, Delinquency Intervention and Treatment Services
- Pursuant to Contract Requirements: Delinquency Intervention Services
1.13 Gender-Specific Programming

The program provides delinquency intervention and gender-specific treatment services.

Guidelines/Requirements: The program designs its services and service delivery system based on the common characteristics of its primary target population, including age, gender, and special needs, and their impact on youth responsivity to intervention or treatment.

The program demonstrates a program model or component addressing the needs of a targeted gender group. Health and hygiene, the physical environment, life and social skills training, and recreation and leisure activities are key components in providing a gender-specific program.

Review the program’s activity schedule to determine gender-specific programming is provided. Review the providers contractually required service(s) for gender specific programming.

Conduct interview with program director to determine what does the program do to address the needs of their targeted gender group.

Review the curriculum or material used to instruct youth on gender-specific issues.

**Review group sign-in sheets or other documentation to determine if the curriculum is being delivered as outlined in the program’s group/activity schedule.**

Reference:
- F.A.C. 63E-7.011, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63E-7.006 (3), Residential Services, Quality of Life and Youth Grievance Process
- F.S. 985.02 (1) (h) Legislative Intent for the Juvenile Justice System, General Protections for Children
- Pursuant to Contract Requirements: Gender Specific Programming
1.14 Internal Alerts System and Alerts (JJIS)

The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth’s alert status.

When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.

— CRITICAL —

Guidelines/Requirements: Any direct care, supervisory, or clinical staff may place a youth on alert status if he or she meets the criteria for inclusion in the program’s alert system. A “Suicide Risk Alert” shall be entered when a youth is identified during screening or evaluation as a potential suicide risk. A “Mental Health Alert” shall be entered when a youth is identified as having a mental disorder or acute emotional distress which may pose a security or safety risk. Only the following may recommend downgrading or discontinuing a youth’s alert status:

1. A licensed mental health professional or mental health clinical staff person, for suicide risks or other mental health alerts;
2. A medical staff person, for medical alerts, upon verification the health condition or situation no longer exists; or
3. The program director, assistant program director, or on-site supervisor, for security alerts.

Review the program’s written policy and procedure to determine how alerts are identified, documented, updated, and communicated to employees.

Yes ☐  No ☐  N/A ☐
Program alerts need to be consistent with the alerts which are entered in the Juvenile Justice Information System (JJIS). Review JJIS program alerts of identified youth. Document any discrepancies.

Check with team members reviewing case management, medical, mental health, and safety and security for youths’ identified alert risks. Verify those youth were placed on the alert system, as specified in the program’s written procedures.

Verify youth were removed or downgraded from alert status by appropriate staff. Review logbooks for updates to alerts.

Interview the program director and staff to explain the program’s internal alert system and how and when does management review the alerts.

If the youth has an alert in JJIS, it must be reflected in the Internal Alert System. Any inconsistencies need to be documented and resolved. We do not take this to mean if a youth has an internal alert for something not captured in JJIS the program can't utilize it in their internal alert system.

Any direct care, supervisory, or clinical staff may place a youth on alert status if he or she meets the criteria for inclusion in the program’s alert system. A “Suicide Risk Alert” shall be entered when a youth is identified during screening or evaluation as a potential suicide risk. A “Mental Health Alert” shall be entered when a youth is identified having a mental disorder or acute emotional distress which may pose a security or safety risk. A “Suspected Gang Affiliation Alert” shall be entered when a youth exhibits any indication of formal criminal gang activity, either observed or reported.

Suicide Risk is automatically populated by the Massachusetts Youth Screening Instrument (MAYSI) and Suicide Risk Screening Instrument (SRSI) in the Department’s Juvenile Justice Information System JJIS. The Positive Achievement Change Tool (PACT) does not automate a suicide risk alert based on risk factors and staff must complete and document manually. Gang Associates and Gang Members must be verified by Law Enforcement. Mental Health Alerts need verification from Mental Health Staff.
Review JJIS Alert List for any issues affecting classification. *(Note: If an open alert should have already been closed, please note what/any steps were taken to ensure the list is up-to-date).*

Interview the program director to explain who is responsible for updating JJIS, and how and when does management review the alerts.

**Reference:**

- F.A.C. 63E-7.004 (9), Residential Services, Youth Intake
- F.A.C. 63E-7.013, Residential Services, Safety and Security
- F.A.C. 63M-2.0045 Medical Alert System
- F.A.C. 63N-1.006 Suicide Risk Alerts & Mental Health Alerts
- F.A.C. 63E-7.016 (15) (a), Residential Services, Program Administration
- F.A.C. 63E-7 Operations of Residential Programs
1.15 Youth Records (Healthcare and Management)

The program maintains an official case record, labeled “Confidential,” for each youth, which consists of two separate records:

- An individual healthcare record
- An individual management record.

Guidelines/Requirements:

1. An individual healthcare record containing the youth’s medical, mental health, and substance abuse related information; and
2. Individual management records are organized in the following separate sections:
   a. Legal information;
   b. Demographic and chronological information;
   c. Correspondence;
   d. Case management and treatment team activities; and
   e. Miscellaneous.

The program clearly labels each individual management record and individual healthcare record as “Confidential.” All official youth case records are secured in a locked file cabinet or a locked room. The program clearly identifies any file cabinet used to store official youth case records as “Confidential.” The program complies with the records and confidential information provisions pursuant to F.S. 985.04.

Programs have an option to maintain a temporary mental health and substance abuse file (“Active Mental Health/Substance Abuse Treatment File”) during a youth’s ongoing mental health or substance abuse treatment, as required.
Standard 1.

Management Accountability

Review a sample of individual case management records to determine if the program practice is in compliance with the file tab requirements.

Reference:

- F.A.C. 63E-7.016 (15), Residential Services, Program Administration
- F.A.C. 63M-2.061 Record Documentation, Development and Maintenance
- F.A.C. 63N-1.0041 Individual Healthcare Record
1.16 Youth Input

The program has a formal process to promote constructive input by youth.

Guidelines/Requirements: Locate documentation of program efforts to solicit input from youth, through avenues such as a youth advisory council, giving them experience in identifying systemic issues impacting their residential community and making recommendations for resolution to improve conditions and enhance the quality of life for staff and youth in the program.

Conduct youth interviews to ensure youth are provided the opportunity to provide input into programming.

Conduct interview with program director to explain the formal process utilized to solicit input from youth regarding systemic issues impacting the residential community. How are youth able to make recommendations for resolution to improve conditions and enhance the quality of life for staff and youth in the program and what systems are in place for youth to provide constructive input into program operations?

Review documentation supporting youth input into programmatic activities (interviews, youth advisory board minutes, suggestion forms, etc.).

Reference:

- F.A.C. 63E-7.011 (1) (d), Residential Services, Delinquency Intervention and Treatment Services
1.17 **Advisory Board**

The program has a community support group or advisory board meeting at least quarterly. The program director solicits active involvement of interested community partners.

**Guidelines/Requirements:** Review documentation the program has a community support group or advisory board meeting at least quarterly.

Review documentation the program director solicits active involvement of interested community partners, including representatives from law enforcement, the judiciary, the school board or district, the business community, and the faith community.

Review documentation the program director recruits a victim, victim advocate, or other victim services community representative, and a parent/guardian whose child was previously, rather than currently, involved in the juvenile justice system.

Interview the program director to explain the community advisory board membership, including meeting times, and their overall involvement with the program.

Interview a board member to determine the level of involvement in program activities.

**Reference:**

- F.A.C. 63E-7.016 (12) (a), Residential Services, Program Administration
1.18 Program Planning

The program uses data to inform their planning process and to ensure provisions for staffing.

Guidelines/Requirements: The program includes information obtained from youth and parent/guardian surveys, as well as reports published annually by the Department, in its program planning.

The program director ensures provisions for staffing, including, at a minimum:

- A system of communication to keep staff informed and give them opportunities to provide input and feedback pertaining to operation of the program; and
- Staff retention planning including steps to minimize turnover and improve employee morale.

Review the program's policies and procedures to determine the program’s system of staff communication, opportunities for providing input, and feedback on the program’s operations.

Ask the program for documentation of actual practice taken to minimize staff turnover.

Ask the program if surveys are conducted with youth and parents/guardians; if so, how does the program incorporate this feedback for planning purposes. Review any supporting documentation.

Interview direct care staff asking how information is communicated to them about the program’s outcome measures and surveys results (youth, parents/guardians, and employees). Ask how often they have employee meetings. Ask about their ability to provide input and feedback into facility operations.

Review minutes and agendas from employee meetings. Document the frequency and attendance (for example, the management team meets weekly and all employee meetings are held monthly).
Interview program director to determine what internal performance tracking systems/dashboards and outcome data are being used by the program and/or provider and how this information is used for program planning and assessment purposes. **Note:** This could vary by contract and should be identified by monitoring staff prior to the annual compliance review.

Interview a sample of staff to determine how effective the communication is among the staff in the program.

Review staff interviews to determine staff’s view of the overall working conditions in this program, whether staff are briefed on the CAR reports, annual compliance reports, and youth and parent/guardian survey results.

**Reference:**

- F.A.C. 63E-7.016 (13), Residential Programs, Program Administration
- F.A.C. 63E-7.016 (4) (b), Residential Programs, Program Administration
- F.A.C. 63E-7.016 (4) (g), Residential Programs, Program Administration
1.19 Staff Performance

The program ensures a system for evaluating staff, at least annually, based on established performance standards.

Guidelines/Requirements: Review the program's policies and procedures to determine the program’s system for evaluating staff, performance standards, and frequency of evaluations.

Review position descriptions for each staff member specifying required qualifications, job functions or duties, and performance standards. Staff’s implementation of the program’s behavior management system, and delivery of delinquency intervention services are to be identified as job functions for applicable staff.

Review a sample of performance evaluations to ensure they are completed as outlined in policy, at least annually.

Regional monitor(s)/reviewers should review the residential provider’s contract to ensure all specific contractually required positions are being maintained and performed as outlined in the contract, obtain copies (if applicable).

Interview the program director to determine the program’s annual evaluation process for each staff position.

Reference:

- F.A.C. 63E-7.016 (4) (f), Residential Services, Program Administration
- Pursuant to Contract Requirements
Standard 2: Assessment and Performance Plan

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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 Initial Contacts to Parent/Guardian and Court Notification

The program notifies the youth’s parent/guardian by telephone within twenty-four hours of the youth’s admission, and by written notification within forty-eight hours of admission, and notify the youth’s committing court, assigned juvenile probation officer (JPO) and post residential services counselor (if applicable) in writing within five working days of any admission.

Guidelines/Requirements: Initial contact to parent/guardian by telephone and in writing is mandatory to ensure they are notified of the arrival of their youth at the pre-determined location.

Review a sample of youth case management records to determine if the initial contact to the parent/guardian by telephone and in writing were conducted within the required time frame.

Review a sample of the youth case management record to ensure the committing court, JPO, and post residential services counselor was notified within five working days of any admission.

Reference:

- F.A.C. 63E-7.003 (7) (b-c), Residential Services, Youth Admission
2.02 Youth Orientation

The program shall provide each youth an orientation to the program rules, expectations, goals of the program, and services applicable to youth, to begin within the day of, or prior to, the youth’s admission.

Guidelines/Requirements: A residential commitment program shall provide orientation to each youth by explaining and discussing the following:

Services available;

- Daily schedule conspicuously posted to allow easy access for youth;
- Expectations and responsibilities of youth;
- Written behavioral management system conspicuously posted and provided in a resident handbook to allow easy access for youth, including rules governing conduct and positive and negative consequences for behavior;
- Availability of and access to medical and mental health services;
- Access to the Florida Abuse Hotline addressed in Chapter 39, F.S., or if the youth is eighteen years or older, the Central Communications Center (CCC) serving as the Department’s incident reporting hotline;
- Items considered contraband, including illegal contraband and prohibited items, possession of which may result in the youth being prosecuted;
- Performance planning process involving the development of goals for each youth to achieve;
- Dress code and hygiene practices;
- Procedures on visitation, mail, and use of the telephone;
- Anticipated length of stay in the program and expectations for release from the program, including the youth’s successful completion of individual performance plan goals, the program’s recommendation to the court for release based on the youth’s performance in the program, and the court’s decision to release;
- Community access;
- Grievance procedures;
- Emergency procedures, including procedures for fire drills and building evacuation;
- Physical design of the facility, including those areas that are and are not accessible to youth; and
- Assignment to a living unit and room, treatment team and, if applicable, a staff advisor or youth group.

Yes ☐ No ☐ N/A ☐
Regional monitor(s)/reviewer(s) shall observe a youth admission, if possible.

Review a sample of youth case management records and if applicable the facility logbook(s) to validate practice.

Review youth interview results to determine if orientation began on the day of, or prior to, the youth’s admission.

**Reference:**

- F.A.C. 63E-7.005 (2) (a-m), Residential Services, Youth Orientation

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2.03 Written Consent of Youth Eighteen Years or Older

The program obtains written consent of any youth eighteen years of age or older, unless the youth is incapacitated and has a court-appointed guardian, before providing or discussing with the parent/guardian any information related to the youth’s physical or mental health screening, assessment, or treatment.

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” if the program has not had any youth eighteen years or older since the last annual compliance review.

Locate documentation indicating signed consent for youth in the program who are eighteen years of age or older.

Review the Department’s Juvenile Justice Information System (JJIS) to determine if the program has any youth eighteen years or older since the last annual compliance review.

Review a sample of youth case management records of youth 18 years of age or older to determine if the program obtained written consent for providing youth information with the parent/guardian, the Department of Children and Families (DCF), and/or the Agency for Persons with Disabilities (APD).

Reference:

- F.A.C. 63E-7.011 (3) (a) 2, Residential Services, Delinquency Intervention and Treatment Services
2.04 Classification Factors, Procedures, and Reassessment for Activities

The program utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, as well as effective delivery of treatment services. **Initial classification should be used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor.**

Youth are reassessed and reclassified, if warranted, prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments that may be used as potential weapons or means of escape, or participation in any off-campus activity.

Guidelines/Requirements: The assessment/reassessment of youth should be clearly outlined in the program’s policy and procedures. The policy must include a classification system that promotes safety and security, as well as effective delivery of treatment services, based on determination of each youth’s individual needs and risk factors, which addresses, at a minimum, items outlined in Administrative Rule. The policy should also address when reassessment is warranted based upon changes in the youth’s supervision status, new/updated alerts, relevant information available to the treatment team, and/or behavioral concerns.

Review a sample of youth case management records to validate the documentation includes, at a minimum, the following classification factors:

- Physical characteristics (e.g., sex, height, weight, physical stature);
- Age and maturity level;
- Identified special needs (e.g., mental, developmental, intellectual, physical disabilities);
- History of violence;
- Gang affiliation *(if applicable)*;
- Criminal behavior;
- Sexual aggression or vulnerability to victimization; and
- Identified or suspected risk (e.g., medical, suicide, escape, security).

Review JJIS Alert List for any issues affecting...
Review a sample of youth case management records to validate each youth was assigned a living room or area based on the program’s classification system.

Reassessment of a youth’s needs and risk factors and reclassification, if warranted, prior to considering:

- An increase in the youth’s privileges or freedom of movement;
- The youth’s participation in work projects or other activities that involve tools or instruments that may be used as potential weapons or means of escape; and
- The youth’s participation in any off-campus activity; and

A continually updated, internal alert system that is easily accessible to program staff and keeps them alerted about youth who are security or safety risks, including escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks. The program shall design and implement this system to reduce risks by alerting program staff when there is a need for specific follow-up or precautionary measures or more vigilant or increased levels of observation or supervision, and by assisting staff when making treatment or safety and security decisions. Although a direct care, supervisory, or clinical staff may place a youth on alert status if he or she meets the criteria for inclusion in the program’s alert system, only the following may recommend downgrading or discontinuing a youth’s alert status: A licensed mental health professional or mental health clinical staff person for suicide risks or other mental health alerts; A medical staff person for medical alerts upon verification that the health condition or situation no longer exists; or The program director, assistant program director, or on-site supervisor for security alerts.

Review a sample of youth case management records to validate the documentation for reclassification of youth prior to youth engaging in certain activities was completed. The review could include items such as:

- Applicable programs policy and procedure;
- Youth’s individualized performance plan;
- Facility Log Book(s);
- Treatment team note(s); and/or
- Performance Summaries.
Interview program director to explain how factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning a youth to a living unit and/or sleeping room.

**Reference:**

- F.A.C. 63E-7.004 (8), Residential Services, Youth Intake
- F.A.C. 63E-7.013 (7) (a-c), Residential Services, Safety and Security
- F.A.C. 63E-7.005 (2) (m), Residential Services, Youth Intake
2.05 Gang Identification: Notification of Law Enforcement

The program shall gather information on gangs, (e.g., gang members, tattoos, other body markings) and share this information with law enforcement.

Guidelines/Requirements: There is documentation of the program notifying local law enforcement of youth with suspected criminal gang activity.

Newly Admitted Youth:
If notification of law enforcement in the youth’s home county has already been made on a youth who was admitted and identified as a gang member, the program duplicate notification is not required. (The information should be verified in the note section under the applicable JJIS gang alert.) If notification was not made to the law enforcement agency in the youth’s home county the program should provide documentation notifying law enforcement of the youth’s suspected gang activity.

Post-Admission to the Program:
The residential program shall notify law enforcement of any indication of formal criminal gang activity, either observed or reported, and document the name of the youth identified, enter into the alert system in JJIS, and forward to local law enforcement for review. If the youth is certified as an associate or criminal gang member, the program shall document the information in the alert system within JJIS. If the youth is placed outside of the county of the probation unit or detention center the residential commitment program has the responsibility to notify law enforcement in their county.

Information on a youth’s gang status shall be shared with the following:

- Educational provider or local school district providing education services;
- Youth’s juvenile probation officer (JPO), if identified; and
- His/her post residential services counselor
Review a sample of youth case management records to determine how and when the local law enforcement agency was notified of youth with suspected criminal gang activity.

**Reference:**

- F.A.C. 63E-7.013 (8), Residential Services, Safety and Security
2.06 Gang Identification: Prevention and Intervention Activities

A residential commitment program shall implement gang prevention and intervention strategies. The residential commitment program shall provide intervention strategies when youth are identified as being a criminal street gang member, are affiliated with any criminal street gang, or are affiliated with any criminal street gang, or are at high risk of gang involvement.

Guidelines/Requirements: Identification of youth to participate in gang prevention or intervention activities shall be based on information obtained through the program’s screening, assessment, and classification processes, as well as gang-associated behaviors exhibited or the youth’s expressed interest or intent while in the program.

Gang Prevention: The program should be able to describe the gang prevention-awareness efforts provided to youth. The Impact of Crime curriculum can be viewed as a component of a program’s gang awareness/prevention strategy. The program’s gang prevention specialist should be involved in the development and implementation of the program’s gang prevention overall strategy. Examples of gang prevention strategies may include but are not limited to: policy and procedure outlining proactive strategies in dealing with gangs, a detailed assessment of each youth, education and guest speakers, when applicable.

Gang Intervention(s): The program must provide gang intervention services as determined by the youth’s individualized treatment team, which should include input from the program’s gang intervention specialist. (Note: Include any gang prevention and intervention strategies utilized by the program in the annual compliance report.)

Youth identified with gang affiliation shall have performance plans with include relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program.

Review a sample of youth case management records to determine if the program implemented gang prevention and intervention strategies.

Reference:
- F.A.C. 63E-7.011 (2)6. & (8), Residential Services, Delinquency Intervention and Treatment Services
- Pursuant to Contract Requirements

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2.07 **R-PACT Assessment and Re-Assessments**

The program shall ensure an initial assessment of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS.

The program shall ensure a reassessment of each youth is conducted within ninety days. The program shall ensure any other updates or reassessments are completed when deemed necessary by the intervention and treatment team to effectively manage the youth’s case. The program shall maintain all reassessment documentation in the youth’s official youth case record.

**Guidelines/Requirements:**

Review a sample of youth case management records to determine whether the program assessed youth using the R-PACT to identify criminogenic risk and protective factors and prioritized the youth’s criminogenic needs.

Reviewer/regional monitor(s) shall review the Department’s Juvenile Justice Information System (JJIS) to validate practice.

Review a sample of youth case management records, including those in JJIS, to ensure the program reassesses youth within ninety days after completion of their initial R-PACT assessment, and continues to reassess at ninety-day intervals.

Documentation of reassessments include both items that may be in youth’s hard copy record and documents maintained in JJIS. Examples of document/reports include: actual R-PACT reassessment, R-PACT Comparative Risk and Protective Factor report including dates of all R-PACT assessments, or individual R-PACT Comparative Risk and Protective Factor reports for each assessment completed. There is a R-PACT Overview/Summary available for each reassessment providing a bar chart reflecting the risk and protective factors based on the assessment and reassessment. All assessments and reassessments should remain in the youth’s official case record.
Reference:

- F.A.C. 63E-7.010 (5) (a) 1, Residential Services, Residential Case Management Services
- F.A.C. 63E-7.010 (5) (b), Residential Services, Residential Case Management Services
2.08 Youth Needs Assessment Summary (YNAS)

The program shall ensure a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the YNAS.

Guidelines/Requirements: Review a sample of youth case management records for documentation of a Youth Needs Assessment Summary (YNAS) within thirty days of admission.

Ensure YNAS documented in the Department’s Juvenile Justice Information System (JJIS) on the Youth Needs Assessment Summary.

Reference:

- F.A.C. 63E-7.010 (5) (a), Residential Services, Residential Case Management Services
2.09 Performance Plan Development, Goals, and Transmittal

The intervention and treatment team, including the youth, shall meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission.

For each goal, the performance plan shall specify its target date for completion, the youth’s responsibilities to accomplish the goal, and the program’s responsibilities to enable the youth to complete the goal.

Within ten working days of completion of the performance plan, the program shall send a transmittal letter and a copy of the plan to the committing court, the youth’s juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable.

--- CRITICAL ---

Guidelines/Requirements: Based on the findings of the initial assessment of the youth, the intervention and treatment team, including the youth, shall meet and develop the individualized performance plan within thirty days of the youth’s admission.

Review a sample of youth case management records to determine if the performance plan was developed within thirty days and included input from all members of the treatment team.

Review youth interview results to ensure the youth participated in the development of his/her performance plan.

The Performance Plan is a document developed by the treatment team, including the youth, which stipulates goals the youth shall achieve prior to release from the program.

The performance plan goals shall be measurable, individualized, and based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, to include:
1. Specify delinquency interventions with measurable outcomes for the youth that will decrease criminogenic risk factors and promote strengths, skills, and supports that reduce the likelihood of the youth reoffending;

2. Target court-ordered sanctions that can be reasonably initiated or completed while the youth is in the program; and

3. Identify transition activities consistent with Rule 63B-1.006, F.A.C., and begin early in the youth’s placement to address barriers to successful release.

The plan shall identify the youth’s responsibilities to accomplish the goals and the responsibilities of staff to enable the youth to complete the goals. It shall also stipulate timelines for the completion of each goal. A youth’s release from the program is primarily contingent upon completion of performance plan goals.

The youth, the intervention and treatment team leader, and all other parties who have significant responsibilities in goal completion shall sign the performance plan, indicating their acknowledgement of its contents and associated responsibilities, and shall be returned to the program attached to the youth’s original performance plan. The program shall file the original signed performance plan in the youth’s official youth case record and shall provide a copy to the youth.

- Electronic transmittal of the performance plan to the youth’s JPO and DCF counselor is acceptable.
- If the parent/guardian did not participate in the development of the performance plan, and if the youth is a minor and not emancipated, as provided in Section 743.01 or 743.015, F.S., or is over eighteen years of age and incapacitated, as defined in Section 744.102(12), F.S., the program shall enclose an additional copy of the plan’s signature sheet and shall request in the transmittal letter acknowledgement the parent/guardian received and reviewed the plan by signing the signature sheet and returning it to the program.
- Any signature sheet signed by the parent/guardian and returned to the program shall be attached to the youth’s original performance plan.
Review youth interviews to determine if each youth has a copy of his/her performance plan. Review a sample of youth case management records to determine if the performance plan includes all required elements.

Review youth interviews to determine whether each youth knows his/her current performance plan goals.

If the top three criminogenic goals are not addressed, regional monitor(s)/reviewer should look for documentation of a reason these goals were not addressed.

**References:**

- F.A.C. 63E-7.010 (6), Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (Transition) Residential Commitment Program
- F.A.C. 63E-7.010 (6), Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (Transition) Residential Commitment Program
- F.A.C. 63E-7.010 (6) (d) 1-2, Residential Services, Residential Case Management Services
2.10 Performance Plan Revisions

Performance reviews shall result in revisions to the youth’s performance plan when determined necessary by the intervention and treatment team.

Guidelines/Requirements: The intervention and treatment team may revise the youth’s individualized performance plan based on the R-PACT reassessment results, the youth’s demonstrated progress or lack of progress toward completing a goal, or newly acquired or revealed information.

Review a sample of youth case management records to validate the treatment team is making revisions to the youth’s individualized performance plan based on the R-PACT reassessment results, the youth’s demonstrated progress or lack of progress toward completing a goal, or newly acquired or revealed information.

Reference:
- F.A.C. 63E-7.010 (6) (c), Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (Transition) Residential Commitment Program

Yes ☐ No ☐ N/A ☐
2.11 Performance Summaries and Transmittals

The intervention and treatment team shall prepare a Performance Summary at ninety-day intervals, beginning ninety days from the signing of the youth’s performance plan, or at shorter intervals when requested by the committing court.

Additionally, the intervention and treatment team shall prepare a performance summary prior to the youth’s release, discharge, or transfer from the program.

The program shall distribute the Performance Summary, as required, within ten working days of its signing.

Guidelines/Requirements: The performance summary is the vehicle to inform the youth, committing court, juvenile probation officer (JPO), parent/guardian, and other pertinent parties of the status of each performance goal and describe the youth’s overall adjustment to, and performance in, the program, as well as justification for release.

Each performance summary shall include the following:

- Youth’s status on each performance plan goal,
- Youth’s overall treatment progress if the youth has a treatment plan,
- Youth academic status (grades in progress) and credits earned in the program if the youth is a high school student, including performance and behavior in school,
- Youth’s behavior, including level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment to the program,
- Significant positive and negative incidents or events, and
- A justification for a request for release, discharge, or transfer, if applicable

Review a sample of open and closed youth case management records to validate the program is completing a performance summary every ninety calendar days and includes all required elements.
Prior to the youth signing the document, program staff shall give the youth an opportunity to add comments, providing assistance to the youth, if requested.

The staff member who prepared the Performance Summary, the intervention and treatment team leader, the program director or designee, and the youth shall review, sign, and date the document.

With the exception of a Performance Summary prepared in anticipation of a youth’s release or discharge, the program shall send copies of the signed document to the committing court, the youth’s juvenile probation officer (JPO), and the parent/guardian, and shall provide a copy to the youth.

As notification of its intent to release a youth pursuant to subsection 63E-7.012(2), F.A.C., or discharge a youth pursuant to subsection 63E-7.012(3), F.A.C., the program shall send the original signed Performance Summary, together with the Pre-Release Notification and Acknowledgement form to the youth’s JPO, who is responsible for forwarding the documents to the committing court.

The program shall file the original, signed Performance Summary in the official youth case record except when it is prepared in anticipation of a youth’s release or discharge, in which case, the program shall file a signed copy in the official youth case record.

Review a sample of open and closed youth case management records to determine if the youth was allowed to read and add comments to the Performance Summary prior to distribution.

Review a sample of closed youth case management records to determine if the program is distributing the Performance Summary within ten working days of all required signatures and a release or discharge summary was completed as required.

Review youth interviews to determine if each youth was provided with a copy of his/her Performance Summary sent to the court.
**Reference:**

- F.A.C. 63E-7.010 (9)(b), Residential Services, Residential Case Management
- F.A.C. 63E-7.010 (9)(b) 2 a-c, (11) and (12), Residential Services, Residential Case Management Services
- F.A.C. 63E-7.012 (2) and (3), Residential Services
### 2.12 Parent/Guardian Involvement in Case Management Services

The program shall, to the extent possible and reasonable, encourage and facilitate involvement of the youth’s parent/guardian in the case management process.

**Guidelines/Requirements:** This will include, at a minimum:

- Assessment
- Performance plan development
- Progress reviews
- Transition planning.

To facilitate this involvement, the program invites the youth’s parent/guardian to participate in intervention and treatment team meetings for the purpose of developing the youth’s individualized performance plan, conducting formal performance reviews of the youth’s progress in the program, and planning for the youth’s transition to the community upon release.

If unable to attend, the parent/guardian shall be given the opportunity to participate via telephone or video conferencing, or to provide verbal or written input prior to the meeting.

Observe a treatment team and review treatment team documentation.

Interview program director to determine how the program encourages parental involvement in the case management processes.

Review a sample of youth case management records to determine the parent/guardian involvement in case management services.
Review the provider’s contract to identify the outlined performance measures are being met.

**Review youth interview results.**

**Reference:**

- F.A.C. 63E-7.010 (3), Residential Services, Residential Case Management Services
- Florida Administrative Code 63T-1.004 (Transition) Residential Commitment Program
- Pursuant to Contract Requirements: Performance Measures
2.13 Members of Treatment Team

The team includes, at a minimum, the youth, representatives from the program’s administration and residential living unit, education, and others responsible for providing or overseeing the provision of intervention and treatment services.

Guidelines/Requirements: The program director or designee shall identify a leader for each intervention and treatment team to coordinate and oversee the team’s efforts and facilitate effective management of each case assigned to the team.

At a minimum, a multidisciplinary intervention and treatment team shall be comprised of the youth, representatives from the program’s administration and residential living unit, education staff, and others directly responsible for providing, or overseeing provision of, intervention and treatment services to the youth (e.g., juvenile probation officer (JPO), parent/guardian, and when applicable the facilities gang prevention specialist). Members shall also include members identified as per contract requirements. Each intervention and treatment team member shall participate in the case management processes addressed in paragraphs 63E-7.010(1) (a)-(d), F.A.C., to ensure provision of coordinated treatment services to all youth.

For jointly served youth, the program shall request and encourage the waiver support coordinator if the youth is an identified an Agency for Persons with Disabilities (APD) client, the Department of Children and Families (DCF) counselor, if applicable, and a representative of the educational staff to participate as an intervention and treatment team member. However, at a minimum, the intervention and treatment team shall obtain input from the educational staff for use when developing and modifying the youth’s individualized performance plan, preparing progress reports to the court, and engaging in transition planning.

The sample of youth case management records reviewed will include youth involved with DCF and/or APD.
Review a sample of youth case management records to determine if all required treatment team members are actively participating in the process. Be sure to address the level of the involvement of the JPO (i.e., in person, by phone, invited but did not attend).

**Reference:**

- F.A.C. 63E-7.010 (4) (a-b), Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (Transition) Residential Commitment Program
- Pursuant to Contract Requirements.
2.14 Incorporation of Other Plans into Performance Plans

The youth’s performance plan shall reference or incorporate the youth’s treatment or care plan.

Guidelines/Requirements: Any additional treatment plan information obtained shall be referenced and/or incorporated on the youth’s individualized performance plan.

When a youth in a residential commitment program has a current behavior support plan or case plan through the Agency for Persons with Disabilities (APD), the program shall coordinate the youth’s individualized performance plan with the youth’s APD plan for related issues. A youth’s individualized performance plan and his or her academic progress monitoring plan, as specified in paragraph 6A-6.05281(4)(a), F.A.C., if applicable, shall be coordinated through the multidisciplinary intervention and treatment team process, and the performance plan shall reference or incorporate the academic progress monitoring plan.

Review a sample of youth case management records to validate the program is incorporating other plan into the performance plan.

The sample of youth case management records reviewed should include youth involved with the Department of Children and Families (DCF) and/or APD, if applicable.

References:

- F.A.C. 63E-7.010 (7), Residential Services, Residential Case Management Services
- F.A.C. 63E-7.010 (8), Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (Transition) Residential Commitment Program
2.15 **Treatment Team Meetings (Formal and Informal Reviews)**

A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth’s performance, to include R-PACT reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment progress.

A residential commitment program shall ensure the intervention and treatment team reviews each youth’s performance, including R-PACT reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment progress.

**Guidelines/Requirements:** The team shall plan for and ensure delivery of coordinated delinquency intervention and treatment services to meet the prioritized needs of each youth assigned.

Each intervention and treatment team member shall participate in the case management processes addressed in paragraphs 63E-7.010(1) (a)-(d), F.A.C., to ensure provision of coordinated services to each youth. However, at a minimum, the intervention and treatment team shall obtain input from the educational staff for use when developing and modifying the youth’s individualized performance plan, preparing progress reports to the court, and engaging in transition planning.

Performance reviews shall result in revisions to the youth’s individualized performance plan when determined necessary by the intervention and treatment team, in accordance with paragraph 63E-7.010(6)(e), F.A.C., and reassessments when deemed necessary by the intervention and treatment team, in accordance with paragraph 63E-7.010(5)(b), F.A.C.
Non-secure and secure programs shall conduct biweekly reviews of each youth’s performance. A formal performance review, requiring a meeting of the intervention and treatment team, shall be conducted at least every thirty days. Treatment team members shall include the youth, representatives from program administration and living unit, and others directly responsible for providing, or overseeing provision of, intervention and treatment services to the youth.

The intervention and treatment team shall provide an opportunity for youth to demonstrate skills acquired in the program and shall document each formal performance review in the official youth case record, including the youth’s name, date of the review, meeting attendees, any input or comments from team members or others, and a brief synopsis of the youth’s progress in the program.

Review a sample of youth case management records to determine if the treatment team planned and ensured delivery of coordinated delinquency intervention and treatment services to meet the prioritized needs of each youth assigned.

Review youth interviews to determine if the youth are provided the opportunity during treatment team meetings to demonstrate skills each youth has learned in the program. In addition, interview youth to determine if staff review youth performance to include progress on performance plan goals, positive and negative behavior, and treatment progress.

The intervention and treatment team leader shall invite and encourage participation of the youth’s juvenile probation officer (JPO), the youth’s parent or guardian, and any other pertinent parties through advance notification. If participation cannot be arranged in person, conference line, or if available, through web-based video phone, the intervention and treatment team leader shall request their input (verbal or written) and offer an opportunity for them to provide it prior to the meeting.
Non-secure and secure programs shall conduct biweekly reviews of each youth’s performance. A formal performance review, requiring a meeting of the intervention and treatment team, shall be conducted at least every thirty days. However, one biweekly performance review per month may be informal, wherein the intervention and treatment team leader, including other team members’ input, when needed, meets with the youth. In maximum-risk programs, the intervention and treatment team shall meet at least every thirty days to conduct a formal performance review of each youth, and therefore, this may be rated “Non-Applicable” for secure maximum-risk programs.

One biweekly performance review per month may be informal, wherein the intervention and treatment team leader, including other team members’ input when needed, meets with the youth.

The intervention and treatment team shall provide an opportunity for youth to demonstrate skills acquired in the program and shall document each informal performance review in the official youth case record, including the youth’s name, date of the review, meeting attendees, any input or comments from team members or others, and a brief synopsis of the youth’s progress in the program.

Review a sample of youth case management records to determine if informal treatment team meetings are conducted and documented as required.

Observe treatment team and receive a copy of the treatment plan. Review treatment plan to determine youth’s anticipated release date. Review the Department’s Juvenile Justice Information System (JJIS) anticipated release date to ensure JJIS is updated at least every 90 days and at the 60-day transition conference.

**Reference:**

- F.A.C. 63E-7.010 (9) (a) (1-3), Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (Transition) Residential Commitment Program
2.16 Career Education

Staff shall develop and implement a vocational competency development program.

Guidelines/Requirements: The program must define career education programming that is appropriate based upon the (1) age, (2) assessed educational abilities and goals of the youth to be served, and (3) the typical length of stay and custody characteristics at the program and/or facility to which each youth is assigned.

The career education programming may be one of two types:

- Type 2—Programs which include Type 1 (personal accountability skills and behaviors leading to appropriate work habits for employment and living standards) program content and an orientation to the broad scope of career choices, based upon personal abilities, aptitudes, and interests (e.g., My Career Shines). Exploring and gaining knowledge of occupation options and the level of effort required to achieve them are essential prerequisites to skill training.

- Type 3—Programs which include Type 1 (personal accountability skills and behaviors leading to appropriate work habits for employment and living standards) program content and the competencies or the prerequisites needed for entry into a specific occupation.

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

Youth with employability as one of their goals shall have the following by the completion of the program:

1. A sample completed employment application
2. A résumé summarizing education, work experience, and/or career training
3. A calendar or schedule which will identify an appointment with Career Source Center
4. Appropriate documents essential to obtaining employment (Department of Highway Safety and Motor Vehicles state issued identification card)
5. Documentation the youth’s parent/guardian and juvenile probation officer (JPO) (if continuing on supervision) are aware of the vocational plan for the youth
Conduct interview with program director to determine what career education services are offered to youth in the program.

Conduct interview with the lead teacher and/or principal to determine what career education services and assessments are offered to youth in the program.

Review a sample of closed youth case management records of youth identified with employability as one of his/her goals at the time of release from the program.

Reference:

- F.S. 985.622 Multiagency Plan for Career and Professional Education (CAPE)
- F.A.C. 63B-1.002 (5) Career Related Programs, Definitions
- F.A.C. 63B-1.003 Career Related Programs, Career and Vocational Programming
- F.A.C. 63T-1, Transition Services for Residentially Committed Youth
2.17 **Educational Access**

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

**Guidelines/Requirements:** DJJ education programs operate on a year-round basis. Students 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. Residential programs 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 receive course credit for completion of the education and training experience.

Review the program’s daily schedule and logbook to ensure minimal interference of educational instruction.

Conduct interview with the lead teacher and/or principal to determine what the educational instruction schedule is for the program.

Review youth interview results to ensure minimal interference of education instruction. Review the logbook to ensure education classes are taking place as scheduled. Note any deviations from the education schedule.

**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, Prevention, Residential, or Day Treatment Programs, Florida Administrative Code

▪ F.S. 1003.01(11) Education Code
2.18 Education Transition Plan

Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.

Guidelines/Requirements: The purpose of the transition plan is to prepare the student to successfully function as a member of the community post release. The youth is involved in developing the transition plan to ensure understanding and “buy in.”

Education Transition Plan requirements are:

- For each student/youth in DJJ prevention, residential, or day treatment programs, an individual transition plan based on the student’s/youths’ post-release goals shall be developed, beginning upon a student’s/youths’ entry into the DJJ program. Key personnel relating to entry transition activities for students/youth in juvenile justice programs include: the student/youth; the student’s/youths’ parent(s), legal guardian(s), or caretaker(s); instructional personnel in the juvenile justice education program, DJJ personnel for students/youth in residential programs; personnel from the post-release district; a certified school counselor from the program school district or program personnel who are responsible for providing guidance services; a registrar or a designee of the program district who has access to the district’s Management Information System; and re-entry personnel.

The Education Transition Plan must address, at a minimum:

- Services and interventions based on the student’s/youths’ assessed educational needs and post-release education plans.
- Services to be provided during the program stay and services to be implemented upon release, including, but not limited to, continuing education in secondary school, Career and Professional Education (CAPE) programs, postsecondary education, or career opportunities.
- The recommended educational placement for the
student/youth post-release from a juvenile justice program must be based on individual needs and performance in the juvenile justice programs.

- Specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services.

Review a sample of active case management records of youth in transition or closed youth case management records to review the education transition plan.

Review a sample of youth Education Transition Plan to determine if the youth had an education transition plan, meeting the requirements.

**Reference:**

- F.A.C. 63B-1.006 (7), Career Related Programs
- F.S.1003.52 (10) Educational Services in Department of Juvenile Justice Programs
- F.A.C 63T-1.004 (Transition) Residential Commitment Programs
- F.A.C 6A-6.05281(5)
2.19 **Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)**

A residential commitment program shall ensure the intervention and treatment team is planning for the youth’s successful transition to the community upon release from the program, when developing each youth’s performance plan and throughout its implementation during the youth’s stay.

During the transition conference, participants shall review transition activities on the youth’s performance plan, revise them if necessary, and identify additional activities/services as needed. Target completion dates and persons responsible for their completion shall be identified during the conference. The intervention and treatment team leader shall obtain conference attendees’ dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth’s performance plan.

*Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.*

**Guidelines/Requirements:** The intervention and treatment team conducts a transition conference at least sixty days prior to the youth’s targeted release date. In programs with a length of stay of ninety days or less, the exit conference addresses all necessary pre-release transition activities. The program director or designee, team leader, and youth attend the transition conference. Other team members who are not in attendance provide written input prior to the conference. The youth’s teacher, juvenile probation officer (JPO), parent/guardian, the Department of Children and Families (DCF) counselor (if applicable), and others (as required) are invited to attend or provide input prior to the conference. *(Note: A best practice would be for each youth, regardless of length of stay, to have a transition conference sixty days prior to the youth’s anticipated release date.)*

Transition conference participants review transition
goals on the performance plan, revise them, if necessary, and identify additional goals as needed. Target completion dates and persons responsible are identified during the conference. The team leader obtains participant signatures (or electronic verification) acknowledging transition goals and accountability for completion. Electronic transmittal of the plan to the youth’s JPO and, if applicable, the DCF counselor, is acceptable. If transmitted electronically, a return email acknowledging receipt and review suffices and shall be printed and filed with the youth’s plan.

Review a sample of closed youth case management records to validate the transition conference was conducted at least sixty days prior to the youth’s targeted release date and included all required parties.

The intervention and treatment team leader shall invite and encourage participation of the youth’s JPO, the youth’s parent or guardian, education staff, and any other pertinent parties through advance notification. If participation cannot be arranged in person, conference line, or if available, through web-based video phone, the intervention and treatment team leader shall request their input (verbal or written) and offer an opportunity for them to provide it prior to the meeting.

Review a sample of closed youth case management records to validate the Community Re-entry Team meeting was conducted prior to the youth’s release.

Reference:

- F.A.C. 63E-7.010 (10), Residential Services, Residential Case Management Services
- F.A.C. 63T - 1.004, (1) (a) (Transition)
- F.A.C. 63T-1.002 Transition Services for Residentially Committed Youth, Definitions
2.20 Exit Portfolio

The residential commitment program will assemble an exit portfolio for each youth to assist the youth once he/she is released back into the community.

Guidelines/Requirements: An exit portfolio is to be discussed and initiated for the youth at the transition conference.

Included in the exit portfolio is a Department of Highway Safety and Motor Vehicles state issued identification card, copy of the youth’s transition plan, and a calendar with all dates/times/locations of follow-up appointments in the community.

If the youth is over the age of fifteen, his/her portfolio shall include a Social Security card, birth certificate, vocational certificate(s) earned in the program, all educational records/documents, school transcripts, resume, and a completed sample job application (these additional documents may be required per the contract requirements).

Program staff will forward the exit portfolio information to the youth juvenile probation officer (JPO) and document in the youths’ case management record.

Completion of the youth’s exit portfolio will be verified at the exit conference, at which time the confirmed times and location of follow-up appointments will be placed in the exit portfolio. Note: School transcripts may not be completed at the time of the exit conference as youth may still be in the program after the exit conference for 14 days/2 weeks before they are withdrawn and leave the program.

Review a sample of closed youth case management records to validate the exit portfolio was completed and given to the youth upon release.

For secure programs, the youth will be provided completed forms and clear instructions as to how to obtain the information. During the transition conference, a plan should be put in place as to who will be responsible for working with the youth to obtain those items.
Review the provider’s residential contract to ensure they are meeting all requirements, in addition to administrative rule requirements. **Note:** Some contracts may contain expectations exceeding administrative rule requirements.

**Reference:**

- F.A.C. 63T-1, Transition Services for Residentially Committed Youth
- Pursuant to Contract Requirements

Yes ☐  No ☐  N/A ☐
2.21 Exit Conference

An exit conference shall be conducted, in addition to a formal or informal meeting, to review the status of goals developed at the transition conference and finalize release plans.

Guidelines/Requirements: The conference is conducted after the program has notified the juvenile probation officer (JPO) of the release, no less than fourteen days prior to the youth’s targeted release date (no less than one week prior to the targeted release date, if the program has a length of stay of forty-five days or less). The exit conference is documented in the case record, including the date, signatures (names if by telephone), and a summary of pending transition goals.

Review a sample of closed youth case management records to determine the exit conference was conducted within the required time frames and included all required parties (program director or designee, youth, and intervention/treatment team leader).

The intervention and treatment team leader shall invite and encourage participation of the youth’s JPO, the youth’s parent or guardian, education representative, and any other pertinent parties through advance notification. If participation cannot be arranged in person, conference line, or if available, through web-based video phone, the intervention and treatment team leader shall request their input (verbal or written) and offer an opportunity for them to provide it prior to the meeting.

Exit conferences should be separate from the Transition and Community Re-Entry Team meetings.

Reference:

- F.A.C. 63E-7.010 (10) 3 (b), Residential Services, Residential Case Management Services
- F.A.C. 63E-7.010 (10) (a) 1, Residential Services, Residential Case Management Services
- F.A.C. 63E-7.010 (10) (b) 1, Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (1) 3. (b) (Transition) Residential Commitment Program
### Standard 3: Mental Health and Substance Abuse 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.
3.01 **Designated Mental Health Clinician Authority or Clinical Coordinator**

Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program. Programs with an operating capacity of 100 or more youth, or those providing specialized treatment services, must have 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 in the facility/program.

Programs with an operating capacity of fewer than 100 youth or those not providing specialized treatment services, may have either a DMHCA or a Clinical Coordinator.

**Guidelines/Requirements:**

The DMHCA is a licensed mental health professional which means a psychiatrist licensed, pursuant 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, a 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 shall 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 license and agreement or position description is available for review.

Conduct an informal interview with the DMHCA to verify the role in the coordination and implementation of mental health and substance abuse services at the facility to include how often the DMHCA is on-site and verify if the program provides any specialized services.

**Yes ☐ No ☐ N/A ☐**
A clinical coordinator may be a licensed mental health professional or a non-licensed mental health clinician with training in mental health and substance abuse services coordination. Clinical coordinator is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in the facility or program.

**Reference:**

- F.A.C. 63E-7, Residential Services
- F.A.C. 63N-1.0035, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- F.S. 985.03 44 (b)
3.02 Licensed Mental Health and Substance Abuse Clinical Staff

The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall 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.

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 all licensed mental health professionals and licensed qualified professionals and make copies for the annual compliance review file.

Reference:

- F.A.C. 63E-7, Residential Services
- F.A.C. 63N-1.002(46) and (47), Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff

The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall 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. Review documentation which confirms each non-licensed clinical staff person holds the education and training specified in Rule 63N-1 and the contract.

Non-Licensed Mental Health Clinical Staff Person

A non-licensed mental health clinical staff person shall have one of the following:

- Hold 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;
- Hold 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
- Hold 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, as described in Rule 63N-1 F.A.C., prior to working with youth. The fifty-two hours of pre-service training shall 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 person may begin working with youth, but shall 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 clinical staff person who holds a master’s degree.

**Non-Licensed Substance Abuse Clinical Staff Person**

- A Non-Licensed Substance Abuse Clinical Staff Person may provide substance abuse services in a departmental facility or program only as an employee of a Service Provider licensed under Chapter 397, F.S. or in a facility licensed under Chapter 397, F.S. A Non-Licensed Substance Abuse Clinical Staff Person 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 person is an employee of a service provider licensed under Chapter 397 or in facility licensed under Chapter 397, Florida Statutes, 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 experience shall have fifty-two hours pre-service training to include sixeen hours training in their duties and responsibilities. Training shall 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 person who conducts Assessments of Suicide Risk shall have received twenty hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training shall have included administration of, at a minimum, five assessments of suicide risk or crisis assessments conducted on site in the physical presence of a licensed mental health professional and documented on Non-Licensed Mental Health Clinical Staff Person’s...
Training in Assessment of Suicide Risk form (MHSA 022).

- A non-licensed substance abuse clinical staff person providing substance abuse services in a DJJ facility or program shall 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 per week of on-site face-to-face interaction with a non-licensed Mental Health Clinical Staff Person individually or in group format, for the purpose of overseeing and directing the mental health services that he or she is providing in the facility, as permitted by law within his or her state licensure.

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

“Direct Supervision for Substance Abuse Clinical Staff” means that a Qualified Professional has at least one hourly session per week of on-site face-to-face interaction with a non-licensed or non-certified Substance Abuse Clinical Staff Person who is an employee of a Service Provider licensed under Chapter 397, F.S., or an employee in a facility licensed under Chapter 397, F.S., individually or in group format, for the purpose of overseeing and directing the substance abuse services that he or she is providing in the facility.

- Each non-licensed substance abuse clinical staff person shall 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 person shall receive at least one hour per week of on-site face-to-face direct supervision by the "qualified professional."
Documentation of direct supervision shall be recorded on form MHSA 019 or a form which includes all the information in the “Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log” form (MHSA 019).

If any non-licensed mental health clinical staff person or non-licensed substance abuse staff person is on-site to provide mental health or substance abuse services at any time during the week (Sunday-Saturday), full-time, part-time or intermittent, the licensed professional must provide at least one hour of direct supervision to the non-licensed person during that week.

The Licensed Mental Health Professional providing direct supervision is responsible for reviewing and signing Comprehensive Mental Health Evaluations, Updated Comprehensive Mental Health Evaluations, Initial Mental Health Treatment Plans and Individualized Mental Health Treatment Plans prepared by the non-licensed Mental Health Clinical Staff Person within ten calendar days of administration of the instrument.

The Licensed Mental Health Professional providing direct supervision is responsible for reviewing each Assessment of Suicide Risk and Follow-Up Assessment of Suicide Risk, Crisis Assessment and Follow-Up Crisis Assessment conducted by the non-licensed Mental Health Clinical Staff Person within 24 hours of the referral for assessment. The Assessment of Suicide Risk, Follow-Up Assessment of Suicide Risk, Crisis Assessment or Follow-Up Crisis Assessment conducted by the non-licensed Mental Health Clinical Staff must be signed by the Licensed Mental Health Professional the next scheduled time he/she is on-site.

The Qualified Professional providing direct supervision to Substance Abuse Clinical Staff is responsible for reviewing and signing Comprehensive Substance Abuse Evaluations, Updated Comprehensive Substance Abuse Evaluations, Initial Substance Abuse Treatment Plans and Individualized Substance Abuse Treatment Plans prepared by the non-licensed Substance Abuse Clinical Staff Person within ten calendar days.

Reference:

F.A.C. 63E-7, Residential Services
▪ F.A.C. 65D-30.003(15), Department Licensing and Regulatory Standards, Department of Children and Families

▪ F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.04 Mental Health and Substance Abuse Admission Screening

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.

Guidelines/Requirements: Mental Health and Substance Abuse Screening in residential commitment programs is accomplished through administration of the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) or Clinical Mental Health and Substance Abuse Screening. Suicide Risk Screening is accomplished through the MAYSI-2 – Suicide Ideation Subscale, or Clinical Mental Health and Substance Abuse Screening, which includes administration of a valid and reliable suicide risk screening instrument such as the Suicide Ideation Questionnaire or Suicide Probability Scale.

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

- Standardized screening process which includes review of commitment packet information, reports and records; administration and scoring of the MAYSI-2 on the Department’s Juvenile Justice Information System (JJIS) or Clinical Mental Health Screening by a licensed mental health professional and Clinical Substance Abuse Screening by a “qualified professional” and referral of juvenile offenders identified by screenings as in need of further evaluation or immediate attention.
- Staff training in mental health and substance abuse issues and administration of the MAYSI-2.
- Standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider/professional or, when immediate attention is needed, to a hospital or Baker Act or Marchman Act receiving facility.
Review of Commitment Information

- Residential program staff conducting screening shall review each youth's commitment packet information, reports, and records for existing documentation of mental health or substance abuse problems. Residential staff shall note any existing documentation of mental health and/or substance abuse problem, needs, or risk factors and report the documentation to clinical and administrative staff. Procedures shall be in place for mental health clinical staff to review existing documentation of mental health and/or substance abuse problems, risk factors, or needs.

Massachusetts Youth Screening Instrument - Second Version (MAYSI-2)

- Either the MAYSI-2 or Clinical Mental Health/Substance Abuse Screening shall be administered upon each youth's admission to a residential commitment program.
- MAYSI-2 is administered on the day of admission in a confidential manner.
- MAYSI-2 is administered on JJIS by a staff member who has completed the DJJ training specific to its administration.
- If MAYSI-2 indicates further assessment is required, a referral shall be made for further evaluation or immediate attention.
- If staff believes youth has a mental health or substance abuse problem or is a suicide risk, the staff should make a referral for further evaluation, regardless of MAYSI-2 findings.
- If staff determines referral for further evaluation is needed, but MAYSI-2 does not indicate referral is necessary, staff person enters into JJIS the information, observations, events, or concerns leading to the determination a referral was needed.
- When the MAYSI-2 or other admission information indicates the need for an assessment, crisis intervention, or emergency services, the residential program director or designee shall be notified and referral made.
- The program director shall ensure an Assessment of Suicide Risk (ASR) is conducted within twenty-four hours when the MAYSI-2 category "Suicide Ideation" indicates further assessment is needed, or other information obtained at intake/admission suggests potential suicide risk (and ensure the youth is referred
for an immediate assessment or emergency services if he/she is in crisis).

**Clinical Mental Health and Substance Abuse Screening**

- Clinical Mental Health Screening and Clinical Substance Abuse Screening are screening processes at intake/admission to a residential commitment program providing in-depth mental health and substance abuse screening as an alternative to administration of the MAYSI-2.
- Either the MAYSI-2 or Clinical Mental Health/Substance Abuse Screening shall be administered upon each youth's admission to a residential commitment program.
- Clinical mental health screening shall be completed and signed by a licensed mental health professional.
- Clinical Screening shall utilize valid and reliable mental health screening instruments.
- Clinical Substance Abuse Screening shall be conducted and signed by a licensed "qualified professional" and utilize valid and reliable substance abuse screening instruments.
- Screenings shall include a valid and reliable suicide risk screening instrument.
- Clinical Mental Health/Substance Abuse Screenings shall include the following: recent mental health/substance abuse history; recent history of trauma and/or victimization; mental status; behavioral observations; suicide risk screening; findings and recommendations for further evaluation or treatment; and disposition.
- Form used shall be identified as Clinical Mental Health Screening, Clinical Substance Abuse Screening, or "Clinical Mental Health/Substance Abuse Screening."
- The Screening shall provide details of the information obtained by the youth (youth's statements, behavioral observations, collateral information). The specific information supporting the Clinical Mental Health/Substance Abuse Screening findings and recommendation shall be documented on the form.
- Clinical screenings indicating the need for an Assessment of Suicide Risk (ASR) or emergency mental health evaluation shall result in notification to the program director or designee immediately. The program director is responsible for contacting the DMHCA or licensed mental health professional who conducts or supervises Assessments of Suicide Risk to discuss the case and request an Assessment of Suicide Risk be
conducted within twenty-four hours, or immediately if the youth is in crisis.

▪ The program director/designee and DMHCA or licensed mental health professional responsible for mental health evaluations confer regarding cases viewed as urgent, and if determined emergency exists, act according to the facility operating procedures for emergency care.

▪ The staff person making the referral shall document a consultation with the DMHCA or licensed mental health professional on the mental health/substance abuse referral summary.

Interview the program director to determine the screening process utilized to identify youth at risk for mental health and substance abuse problems and suicide.

Reference:

▪ F.A.C. 63E-7.004 (2)(b), Residential Services, Youth Intake

▪ F.A.C. 63N-1.002(12), 63N-1.0051, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.05 Mental Health and Substance Abuse Assessment/Evaluation

Youth identified by screening, staff observation, or behavior after admission as in need of further evaluation must be referred for a Comprehensive Mental Health Evaluation and/or Comprehensive Substance Abuse Evaluation or Updated Evaluation.

Guidelines/Requirements: The program ensures a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation is conducted when the need is identified during screening. If a comprehensive evaluation was conducted within twelve months of admission to the program, the program may update that evaluation instead of conducting a new evaluation. Update is identified as “Updated Comprehensive Mental Health Evaluation,” “Updated Comprehensive Substance Abuse Evaluation,” or “Updated Comprehensive Mental Health/Substance Abuse Evaluation” and is attached to the evaluation(s) being updated.

New or Updated Comprehensive Mental Health/Substance Abuse Evaluations

New or updated comprehensive mental health and/or substance abuse evaluations shall be completed within thirty calendar days of admission. If a non-licensed mental health clinical staff person or non-licensed substance abuse clinical staff person completes the evaluation, it shall be reviewed and signed by a licensed mental health professional or “Licensed Qualified Professional” respectively, within ten calendar days after the evaluation is conducted.

The updated Comprehensive Mental Health Evaluation and/or updated Comprehensive Substance Abuse Evaluation must provide any new or additional information applicable to each area, based upon current information provided by the youth, his or her family/legal guardians and the youth’s records.

Reference:

- F.A.C. 63E-7.010 (5), Residential Services, Residential Case Management Services
- F.A.C. 63N-1.0056, Mental Health, Substance Abuse
and Developmental Disability Services Delivery, Comprehensive Substance Abuse, Evaluations

- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.06 Mental Health and Substance Abuse Treatment

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

The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.

Guidelines/Requirements:

Multidisciplinary Treatment Teams

- Each youth is assigned to a treatment team upon arrival to the program.
- The team is comprised of the youth, representatives from the program’s administration and residential living unit, and others responsible for delinquency intervention and treatment services for the youth.

Mental Health and Substance Abuse Treatment Services

- Youth determined in need of mental health treatment shall receive individual, group, or family counseling by a licensed mental health professional or a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional in accordance with the youth's initial or individualized mental health treatment plan.
- Youth determined in need of substance abuse treatment shall receive individual, group, or family counseling provided by a licensed qualified professional or a non-licensed substance abuse clinical staff person who is an employee in a facility licensed under Chapter 397 or 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.
Standard 3

Mental Health and Substance Abuse Services

- All youth receiving mental health treatment shall have a properly executed Authority for Evaluation and Treatment form (AET).
- All youth receiving substance abuse treatment shall have signed a Youth Consent for Substance Abuse Treatment Form and a Youth Consent for Release of Substance Abuse Treatment Records form (MHSA 012 and MHSA 013), or a court order for substance abuse evaluation and treatment. If the youth does not sign a Consent for Release of Substance abuse treatment records (MHSA 013), then no Substance Abuse treatment records shall be released except as required by law.
- Mental health treatment notes or substance abuse treatment notes shall be documented on the Counseling/Therapy Progress Note form MHSA 018, or a form which contains all of the information in form MHSA 018.

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.

Observe multidisciplinary treatment team meeting.

Observe mental health and substance abuse groups to determine if ten youth or fewer for mental health focused groups and fifteen or fewer youth for substance abuse treatment groups.

Review progress notes to determine if youth are receiving treatment services as stipulated on the treatment plan (weekly individual, daily group, family monthly as examples).

Review staff interviews to determine if mental health and substance abuse treatment groups are provided.

Conduct an informal interview with the DMHCA regarding the treatment services provided in the program.

Yes □ No □ N/A □

Yes □ No □ N/A □

Yes □ No □ N/A □

Yes □ No □ N/A □

Yes □ No □ N/A □

Yes □ No □ N/A □
Reference:

- F.A.C. 63E-7.002 (41), Residential Services, Definitions
- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.07 Treatment and Discharge Planning

Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed.

All youth who receive mental health and/or substance abuse treatment while in a residential program 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 facility.

— CRITICAL —

Guidelines/Requirements:

Initial Mental Health Treatment Plans, Initial Substance Abuse Treatment Plans, and Initial Treatment Note

- An Initial Treatment Plan is developed when treatment is provided on an expedited basis.
- An Initial Mental Health Treatment Plan is documented on the Initial Mental Health/Substance Abuse Treatment Plan sample form MHSA 015, or an initial treatment plan form which provides all of the mental health information in form MHSA 015. An exception is provided in DJJ residential commitment programs designated for Specialized Treatment Services where youth receive an Individualized Mental Health/Substance Abuse Treatment Plan within thirty days of admission as part of established procedure. Such programs may utilize an Initial Mental Health Treatment Plan or treatment note to document the initiation of a youth’s mental health treatment. (See Rule 63N-1.0072(2)(b) F.A.C.)
- An Initial Substance Abuse Treatment Plan is documented on the sample form MHSA 015, or an initial treatment plan form which provides all of the substance abuse information in form MHSA 015.
- An Initial Mental Health Treatment Plan or Initial Substance Abuse Treatment Plan is developed within seven days of the onset of treatment, or for youth...
prescribed psychotropic medication, within seven days of the initial psychiatric diagnostic interview.

- An Initial Treatment Plan (MHSA 015) is signed by the mental health clinical staff person or substance abuse clinical staff person completing the form. When the form MHSA 015 is completed by a non-licensed mental health clinical staff person, the form must be signed by the licensed clinical supervisor (licensed mental health professional), within ten days of completion. When form MHSA 015 is completed by a non-licensed substance abuse clinical staff person, the form must be signed by the clinical supervisor (“qualified professional” under Section 397.311, F.S.) within ten days of completion. The Initial Treatment Plan is also signed by treatment team members, who participated in development of the plan, youth, and parent/guardian (as allowed).

- Psychiatric services (when relevant), including psychotropic medication and frequency of monitoring by psychiatrist, shall be included in the initial treatment plan at item three, which states: “For youth receiving psychiatric care record: 1) Psychotropic medications currently prescribed and 2) Frequency of monitoring by a psychiatrist.”

Individualized Mental Health/Substance Abuse Treatment Plans

- Individualized treatment plan is signed by the mental health clinical staff person or substance abuse clinical staff person completing the plan. If the mental health clinician is unlicensed, 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 must review and sign the plan within ten days of completion. Plan is also signed by treatment team members, youth, and parent/guardian (as allowed).

- Individualized plan is developed on Individualized Mental Health/Substance Abuse Treatment Plan form MHSA 016, or a form which contains all of the information in form MHSA 016.

- Individualized treatment plan is also signed by 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, shall be included for youth receiving psychotropic medication.

- Individualized treatment plan reviews shall be completed on the Individualized Mental Health Treatment Plan Review form MHSA 017 or a form which contains all of
the information in MHSA 017, at a minimum, every thirty days following the development of the individualized treatment plan.

Discharge Plans

- All youth who received mental health and/or substance abuse treatment while in the facility shall have a discharge plan documented on the Mental Health/Substance Abuse Treatment Discharge Plan form MHSA 011, the Mental Health/Substance Abuse Treatment Discharge Summary.
- Notification of suicide risk shall be made to youth's parent/guardian and juvenile probation officer (JPO) for youth being discharged from program on suicide risk alert/suicide precautions. Notification shall be documented in the youth’s individual healthcare record.
- The Mental Health/Substance Abuse Treatment Discharge Summary shall consider the services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by youth during treatment.
- The discharge plan should be discussed with the youth, parent/guardian (when available), and JPO during exit conference.
- A copy of the Mental Health/Substance Abuse Treatment Discharge Summary shall be provided to the youth, youth's JPO, and to the parent/guardian (as allowed).

Review a 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 the youth, parent/guardian (as allowed), and the JPO.

Review exit staffing documentation comparing the date of the discharge plan to determine if it was available for review at the exit staffing.
The Mental Health/Substance Abuse Treatment Discharge Summary should be discussed with the youth, parent/legal guardian (when available) and Juvenile Probation during the exit conference conducted prior to a youth’s release from a residential commitment program.

Reference:

- F.A.C. 63E-7, Residential Services
- F.A.C. 63E-7.010 (7), Residential Services, Residential Case Management Services
- F.A.C. 63T-1.004 (2)(b) (Transition) Residential Commitment Program
- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.08 Specialized Treatment Services

Specialized treatment services shall be provided in programs designated as “Specialized Treatment Services Programs” or are designated to provide “Specialized Treatment Overlay Services.”

— CRITICAL —

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” if the program does not provide specialized treatment services or specialized treatment overlay services.

Treatment services are provided in accordance with Florida Statute, Administrative Rule, Rule 63N-1, F.A.C., and the provider’s contract (if applicable), including:

Specialized Treatment Services

▪ Substance Abuse Treatment Services
▪ Substance Abuse Treatment Overlay Services
▪ Comprehensive services for Major Disorders
▪ Developmental Disability Treatment Services
▪ Intensive Mental Health Treatment Services
▪ Mental Health Overlay Services
▪ Sex Offender Treatment Services
▪ Specialized Mental Health Services

Juvenile Sex Offender Treatment Services

Juvenile sexual offender therapy and juvenile sexual offender treatment shall be conducted, managed or supervised in accordance with Section 490.012(8) or 491.012(1)(n), F.S.

Conduct interview with program director to determine if the program provides any specialized treatment services, and if so, what types of services are provided.

Reference:

▪ F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.09 Psychiatric Services

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 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.

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 DJJ facilities or programs, but must have prior experience and training in psychiatric treatment with children or adolescents. A Psychiatrist or psychiatric ARNP providing Psychiatric Services in the program 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 program on psychotropic medication/or referred for psychiatric interview shall receive an initial diagnostic interview within fourteen days. The initial diagnostic psychiatric interview shall include the elements specified in Rule 63N-1, F.A.C.

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

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

Each youth who is receiving psychotropic medication must be seen for medication review by the psychiatrist or psychiatric ARNP, at a minimum, every 30 days.

The psychiatrist or psychiatric ARNP providing psychiatric services must either be a member of the multidisciplinary treatment team, or must brief a representative of the treatment team on the psychiatric status of each youth receiving psychiatric services who is scheduled for treatment team review. The briefing may be accomplished through face-to-face interaction or telephonic communication with the representative or treatment team.

Conduct an informal interview with the psychiatrist, if possible, to determine what services the psychiatrist is providing and how often the psychiatrist is on site.

Consent for Psychotropic Medication
The AET (HS 002) provides the parent/legal guardian’s authorization to continue administration of only those Psychotropic Medications for which the youth has a bona fide prescription at the time of his/her entry into the physical custody of the Department, as long as there are no changes in the Psychotropic Medication dosage or route of administration.

Whenever a new Psychotropic Medication is prescribed, Psychotropic Medication is discontinued, or the drug dosage is significantly changed, parental/legal guardian verbal consent for Psychotropic Medication is documented through the CPPN (form HS 006) at page 3 or a form containing all the information require in HS 006 at page 3, and written consent is documented on the Acknowledgment of Receipt of CPPN Form or Practitioner Form (HS 001) in accordance with Rule 63N-1.0085, F.A.C.

Consent requirements for provision of Psychotropic Medication for youth in foster care whose parent or legal guardian’s rights have been terminated are addressed in Chapter 65C-35, F.A.C.
If a youth reaches 18 years of age while in the detention center and is not incapacitated or otherwise emancipated, the youth is responsible for authorizing his/her health care and authorizing release of his/her healthcare records.

Review collaborative practice protocol with ARNP and verify it was submitted to the Department of Health. If the regional monitor(s)/reviewer(s) cannot find the protocol uploaded on the Department of Health website, the ARNP should be able to produce a letter of confirmation from the Board of Nursing.

Review the license for the psychiatric ARNP, if applicable.

Reference:

- F.A.C. 63E-7, Residential Services
- F.A.C. 63N-1.0085 and 63N-1.014, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- F.A.C. 63M-2.010-2.023
- F.A.C. 63M-2.025-2.027
3.10 Suicide Prevention Plan

The program 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 the Rule 63N-1, Florida Administrative Code.

— CRITICAL —

Guidelines/Requirements: Residential program 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 facility or program 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).
- Suicide precautions (i.e., Precautionary Observation or Secure Observation).
- Levels of supervision
  o One-to-One Supervision: During suicide precautions refers to the supervision of one youth by one staff member who must remain within five feet of the youth at all times (including when the youth uses the shower or toilet). The staff member must maintain constant visual and sound monitoring of the youth at all times. If the youth is in a Secure Observation room, the staff member assigned to one-to-one supervision of the youth must be stationed at the entrance to the room, with constant visual and sound monitoring of the youth maintained at all times.
  o Constant Supervision: During suicide precautions refers to the continuous and uninterrupted observation of a youth by a staff member who has a clear and unobstructed view of the youth and unobstructed sound monitoring of the youth at all times. Constant supervision shall not be accomplished through video/audio surveillance. If video/audio surveillance is utilized in the facility, it shall be used only to supplement physical observation by staff.
  o Step-down to Close Supervision: Upon removal from suicide precautions requires supervision of youth at five-minute intervals throughout their stay in their rooms and/or sleeping area. Visual checks must be made of the youth’s condition (i.e., outward
appearance, behavior, position in the room) while in his/her room at intervals not to exceed five minutes.

- Referral
- Communication
- Notification
- Documentation
- Immediate staff response
- Review process

Conduct an interview with program director to determine how often the program provides training or mock drills for staff, which includes emergency response to suicide attempts or self-inflicted injury.

Reference:

- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.11 Suicide Prevention Services

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.

Any youth exhibiting suicide risk behaviors shall be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.

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

— 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 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 facility.
- Precautionary Observation shall not limit a youth's activity to an individual cell or restrict him/her to his/her sleeping room.
- The youth shall remain on Precautionary Observation until he/she has received an Assessment of Suicide Risk (ASR) or Follow-Up ASR which indicates 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 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 warrants Controlled Observation are to be placed on Secure Observation instead of Controlled 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 program director 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 shall 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 and Follow-Up Assessments of Suicide Risk

Each Assessment of Suicide Risk (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 Form MHSA 004.
- ASR shall be completed within twenty-four hours or immediately if the youth is in crisis.
- ASR shall be administered by a licensed mental health professional, or a non-licensed mental health clinical staff person, who has completed the required twenty hours ASR training, working under the direct supervision of a licensed mental health professional.
- If the ASR if completed by a non-licensed mental health clinical staff person, the ASR shall be reviewed and signed by licensed mental health professional in accordance with Rule 63N-1, F.A.C.
- If 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 person confers with both a licensed mental health professional and the program director/designee.
- Licensed mental health professional shall confer with program director/designee prior to revising supervision level.
• Documentation of the actual date/time clinician conferred with program director/designee and licensed mental health professional shall be recorded on the ASR in the date/time sections. If the ASR is not entered in real time in an electronic system, the actual date/time ASR functions were conducted shall be recorded in the applicable narrative sections of the ASR entered into an electronic system.

• Youth placed on Precautionary Observation prior to ASR whose ASR determines the youth is not a potential suicide risk and suicide precautions may be discontinued, may be transitioned to standard supervision.

• Youth whose ASR indicates potential suicide risk shall 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 shall be recorded on form MHSA 005.

• When the youth's Follow-Up ASR (MHSA 005) indicates suicide precautions may be discontinued, the youth shall be stepped down to close supervision prior to transition to normal routine/standard supervision.

• Youth on Secure Observation are to receive an ASR within eight hours of placement in the room, or if placed during the evening shift, the ASR shall be completed the following morning.

• Procedures must be in place to verbally notify the juvenile probation officer and the parent or legal guardian of the youth’s potential suicide risk, as indicated by an Assessment of Suicide Risk.

• Parent or legal guardian must be notified of a youth’s potential suicide risk as indicated by an ASR. The parent/legal guardian and juvenile probation officer (JPO) notification is to be documented on the ASR (form MHSA 004). Written notification is acceptable when verbal notification cannot be accomplished.

Review a sample of youth mental health and substance abuse records of youth requiring suicide prevention services, to include youth on Precautionary Observation and youth on Secure Observation. Ensure suicide risk assessments and/or follow-up suicide risk assessments are completed prior to removal from Precautionary Observation or Secure Observation.

Review logbooks to determine if beginning and ending times are documented for youth placed on precautions.
Review the Department’s Juvenile Justice Information System (JJIS) to determine if alerts are appropriately entered and to determine if JJIS alerts were removed immediately after following youths’ removal from Precautionary Observation step down.

Review training records for non-licensed staff who complete Assessments of Suicide Risk to determine if they completed the required twenty hours of training and five supervised assessments under the direct supervision and within the physical presence of a licensed mental health professional.

Review staff interviews to determine what staff are required to do when a youth expresses suicide ideation and to determine if staff know the location of the program’s suicide response kit.

Interview a sample of staff to determine if staff know what to do in the event a youth expresses suicidal thoughts.

Suicide Risk is automatically populated by the Massachusetts Youth Screening Instrument (MAYSI) and Suicide Risk Screening Instrument (SRSI) in JJIS. The PACT does not automate a suicide risk alert based on risk factors and staff must complete and document manually. This alert does not have to be verified prior to creating the alert, only when they are downgraded or removed from the alert.

**Reference:**

- F.A.C. 63E-7, Residential Services
- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.12 Suicide Precaution Observation Logs

Youth placed on suicide precautions shall be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth shall provide the appropriate level of supervision and record observations of the youth's behavior at intervals of thirty minutes, at a minimum.

— CRITICAL —

Guidelines/Requirements: Suicide Precaution Observation Log (MHSA 006) shall be maintained for the duration a youth is on suicide precautions. Suicide Precaution Observation Logs document staff observations of youth's behavior in real time, at intervals not exceeding thirty minutes.

When "warning signs" are observed, notification of facility superintendent/designee and mental health clinical staff is documented on 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 were met.

Conduct informal interviews with youth on suicide precautions to determine supervision practices. Were staff with them at all times? Were they left alone for any period of time?

Reference:

- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.13 Suicide Prevention Training

All staff who work with youth shall 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. (The Department’s “Suicide Prevention” course in SkillPro can count as two of the six required hours.)

Review a sample of direct care staff, supervisory staff, mental health and substance abuse staff (licensed and non-licensed), and nursing staff training records to determine if each received six hours suicide prevention and implementation of suicide precautions training annually.

Training shall include mock suicide drills. Mock suicide drills are to be held no less than quarterly on each shift.

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 that not all staff on a particular shift may be present when a Mock Drill (which includes: Methods for contacting other facility staff, medical personnel and emergency medical services, CPR techniques, and the use of the Suicide Response Kit) 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 in the facility. All staff with direct contact, on a day-to-day basis, with youth, must participate in at least one quarterly Mock Drill semi-annually.

Reference:

- F.A.C. 63H-2.003
- F.A.C. 63H-2.005

Yes ☐  No ☐  N/A ☐
- F.A.C. 63N-1.0091, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.14 Mental Health Crisis Intervention Services

Every program shall 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 shall 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 shall 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, which contain and meet all of the elements identified in Rule 63N-1, F.A.C.

Reference:

- F.A.C. 63E-7, Residential Services
- F.A.C. 63N-1.010, 63N-1.0101, 63N-1.0102 Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.15 Crisis Assessments

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, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, 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 program director or designee shall 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 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

A Crisis Assessment is documented on the Crisis Assessment 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, or by a non-licensed mental health clinical staff working under the direct supervision of a licensed mental health professional (LMHP). A Crisis Assessment shall be conducted immediately or within two hours, based on the needs of the youth.
A mental health alert is entered into JJIS for youth requiring a Crisis Assessment. Youth determined through assessment to pose a safety and security risk shall remain on mental health alert until follow-up mental status examination by, or under the direct supervision of, a licensed mental health professional. (If a youth is identified by direct care staff or clinical staff as having acute emotional or behavioral problems or acute psychological distress which may pose a safety/security risk, this must be brought to the attention of the superintendent/program director and other staff through the facility’s alert system which must include a Mental Health Alert in JJIS. A youth determined by Crisis Assessment to pose a safety or security risk must remain on Mental Health Alert status (in JJIS) until subsequent mental status examination indicates the youth no longer poses a safety or security risk.)

Review the program’s policy, Crisis Assessment tool, and staff training records to ensure the program is adequately prepared to conduct Crisis Assessments.

Review a sample of youth mental health and substance abuse records of youth receiving a Crisis Assessment to determine if it was completed as required.

Review JJIS for each of the sample reviewed records to determine if the appropriate alert was entered as required.

**Reference:**

- F.A.C. 63N-1.0103, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.16 Emergency Mental Health and Substance Abuse Services

Youth determined to be an imminent danger to themselves or others due to mental health or substance abuse emergencies occurring in the facility require emergency care provided in accordance with Rule 63N-1, F.A.C., and the facility's emergency care plan.

— CRITICAL —

Guidelines/Requirements: The program's emergency care plan shall 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 (including mock drills)
- Review

Program may develop an integrated mental health crisis intervention and emergency mental health and substance abuse services plan which contain and meet all of the elements identified in Rule 63N-1, F.A.C.

Review the program’s written policies and procedures regarding Baker and Marchman Acts.

Reference:

- F.A.C. 63E-7, Residential Services
- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
3.17 Baker and Marchman Acts

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 program has not had any Baker or Marchman Acts during the review period.

Youth returning to the program from a Baker Act or Marchman Act (off-site Assessment of Suicide Risk (ASR) or off-site crisis assessment) are placed at least on constant supervision upon readmission (Mental Health Alert and constant supervision for youth transported due to mental health crisis or Suicide Risk Alert, Suicide Precautions and constant supervision for youth who were transported due to suicide risk).

A mental health referral is completed indicating a Mental Status Examination (MSE) is to be conducted. 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.

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 (ASR) 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.)

Youth's supervision level is not lowered until appropriate assessment conducted and mental health staff confers with the licensed mental health professional and program director or designee.

If a Baker Act or Marchman Act occurred, review the policy to ensure the program followed the proper procedures.
Review a sample of youth who have received a Baker Act and/or Marchman Act over the last six months. If none in the last six months, the regional monitor(s)/reviewer may review for the past year or since the last annual compliance review.

**Reference:**

- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services

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### MQI Standards for Residential Services

#### 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

The Designated Health Authority (DHA) shall be clinically responsible for the medical care of all youth at the facility.

— CRITICAL —

Guidelines/Requirements: The facility has a contract 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 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 healthcare needs of adolescents.

The designee (ARNP or PA) shall hold an unrestricted license to practice in Florida. The ARNP’s academic/clinical specialty shall be in Family Health or Pediatrics.

The ARNP shall have a Collaborative Practice Protocol in place and it shall state the physician is serving as the facility’s designated health authority (DHA).

When a physician assistant (PA) is utilized, the DHA shall have a supervisory relationship with the PA.

The DHA shall be on site at least once per 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.

If the DHA designates another MD, DO, PA, or advanced registered nurse practitioner (ARNP) to provide the clinical services on site, the actual DHA shall perform administrative duties.
The DHA is responsible for communication with facility staff regarding youth medical needs, and electronic availability twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care.

Review provider contract, interview DHA, and review sign in/out logs to confirm weekly visits for the past six months.

Check licenses of all medical professionals providing care to youth provided by the facility or on Department of Health’s website. Review collaborative practice protocol with ARNP. The protocol is to be maintained on-site at the program.

Review the license for the ARNP (if applicable).

Interview the DHA or designee to verify the role in the coordination and implementation of health services at the facility to include how often the DHA is on site.

Reference:

- F.A.C. 63M-2.0031, Health Services, Office of Health Services
- Per Contract Requirements
- F.A.C. 63E-7.011 (3) (c), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services
4.02 Facility Operating Procedures

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

Guidelines/Requirements: The designated health authority (DHA), the Psychiatrist (if applicable), and the Dentist (if applicable) shall sign and date all of their respective written treatment protocols. This process shall be followed each time a new policy, procedure, or protocol is developed and/or an existing one is changed at a time other than the annual compliance review.

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.

At a minimum, an annual review of all FOPs and protocols is required. It is demonstrated by the signature and date of the DHA, Facility Administrator, 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 policies.

All newly employed health care personnel shall receive a comprehensive clinical orientation to DJJ health care policies and procedures, given by a Registered Nurse or designated, licensed health care professional.

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

The review and development of facility operating procedures, or other protocols related to psychiatric services and psychotropic medication management may only be performed by the facility’s Psychiatrist or Psychiatric ARNP.

“Blanket” or general corporate policies, procedures, or protocols are not acceptable for individual facilities.
Review the program’s health-related policies, procedures, and protocols to ensure they properly outline the program’s health care services.

Ensure the policies, procedures, and treatment protocols have been reviewed and signed by the DHA.

Review all orientation documentation for new health care staff.

**Reference:**

- F.A.C. 63E-7.011 (3)(c), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services

- F.A.C. 63M-2.0035, Health Services, Office of Health Services
4.03 Authority for Evaluation and Treatment

Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) 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 Health Care Record (IHCR).

The AET shall be signed by the parent/guardian and witnessed by a DJJ representative. It is the responsibility of the DJJ 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 cannot be located after all reasonable attempts have been made, there shall be a court order, and the court order filed in the IHCR.

The AET shall be valid. 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/legal guardian, whichever comes later, OR until the youth’s 18th birthday.

If, for some reason, the original AET is not placed in the IHCR, a legible copy shall suffice, as long as the word ‘COPY’ is legibly handwritten or stamped.

An AET is required prior to providing medical services (with the exception of emergency care and routine medical/mental health intake screenings).

Review the AET from each sampled IHCR.

Those youth in the care of the Department of Children and Families (DCF), where there has been a termination of parental rights, the court must authorize all treatment and procedures. Under no circumstances is a DCF caseworker authorized to sign for consent in the place of the parent/guardian or court.

Reference:

- F.A.C. 63M-2.0051, Health Services, Office of Health Services
- F.A.C. 63E-7.011 (3) (a-b), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services
4.04 Parental Notification

The program 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: Review the program’s Facility Operating Procedure. Form HS 020 must be utilized for changes in a youth’s health status. Form 021 must be utilized when a practitioner has ordered medication treatment or medication changes. Form HS 022 must be utilized for Vaccination/Immunizations ordered and not consented for as per the Authority for Evaluation and Treatment (AET). Examples include the following:

- Over-the-counter (OTCs) 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 DJJ.
- Changes in youths’ medical condition/medication for youth with chronic conditions.
- Off-site emergency care, notification made by phone and, subsequently, in writing.
- Hospitalizations, surgeries/invasive procedures, non-routine dental procedures.
- Whenever a youth is taken off-site for medical treatment

For new medication, verbal attempts/contacts/consents shall be documented in the chronological Progress Notes in the Individual Health Care Record (IHCR) by the person attempting and/or making contact with the parent/guardian. A staff member should witness all telephone call attempts and conversations. If additional staff member is unavailable to witness call attempts then the facility or program shall have an internal process by which the attempts are verified. (If not documented, explain the process used to verify attempts)

Any verbal notification (in person or by phone) shall be followed up with a written Parental Notification, returned and signed by the parent/guardian.

Yes ☐ No ☐ N/A ☐
Review a sample of youth healthcare records to determine if parental notifications are completed when required (additional healthcare records may be reviewed to ensure sample size is met).

Those youth in the care of the Department of Children and Families (DCF), where there has been a termination of parental rights, the court must authorize all treatment and procedures. Under no circumstances is a DCF caseworker authorized to sign for consent in the place of the parent or court.

Reference:

- F.A.C. 63E-7.011 (3) (a-b), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services
- F.A.C. 63M-2, Health Services, Office of Health Services
- Facility Operating Procedure
4.05 Notification - Clinical Psychotropic Progress Note

The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.

Guidelines/Requirements: When a psychotropic medication is initially prescribed, discontinued, and/or significant dosage adjustment is made, parent/guardian notification and consent shall be obtained.

Notification is mailed, along with the CPPN (page 3), and explanatory information, for the initiation of psychotropic medications.

Notification is sent for significant changes or discontinuation of psychotropic medications.

Review progress notes to confirm parental consent when obtained verbally. This entry should include a witness. A written notification shall also be sent using the required CPPN Parental Notification form.

Review certified receipts from CPPNs sent to the parent/guardian for consent (only if specifically required by contract). Confirm signatures on the Acknowledgment of Receipt of CPPNs returned by the parent/guardian.

Those youth in the care of the Department of Children and Families (DCF), where there has been a termination of parental rights, the court must authorize all treatment and procedures. Under no circumstances is a DCF caseworker authorized to sign for consent in the place of the parent or court.

Reference:

- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
- As Required Per the Program’s Contract
- Review Facility Operating Procedures and contract to determine if certified mail is required
4.06 Immunizations

All youth’s immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).

Guidelines/Requirements: For youth to attend school, the facility has thirty days in which to obtain the consent for and administer necessary vaccinations.

If a parent/guardian claims exemption and does not consent to vaccinations for religious reasons, then 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 facility. Copies of the exemption shall be filed in the Individual Health Care Record (IHCR).

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

Review immunizations in each sampled youth’s IHCR along with any exemption forms when applicable.

Interview nursing staff to determine how immunizations records are obtained and what is the time frame in reviewing the records.

Shot records may be obtained from the school youth is/has been attending and/or Florida Shots.

Reference:

- F.A.C. 63E-7.011 (3)(a-b), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services
- Rule 63D-3.046, F.A.C., Immunization
- Facility Operating Procedures
4.07 **Healthcare Admission Screening Form**
*(Facility Entry Physical Health Screening Form)*

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

**Guidelines/Requirements:** Facility Entry Physical Health Screening Form (FEPHS) shall be completed on date of admission.

Screening shall be completed by an RN, LPN, Direct Care staff, MD/ARNP.

If completed by direct care staff, it must be reviewed by LPN or higher within 24 hours.

Review a sample of youth healthcare records to determine if the youth was screened utilizing the Facility Entry Physical Health Screening (FEPHS) form to include who completes the form and the review process.

**Reference:**

- F.A.C. 63E-7.003 (5) (b), Residential Services, Youth Admission
- F.A.C. 63E-7004 (2) (a), Residential Services, Youth Intake
- F.A.C. 63E-7.011 (3) (a-b), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Intake Screenings and Assessment
- F.A.C. 63M-2.0041, Health Services, Office of Health Services
4.08 Medical Alerts

Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.

Guidelines/Requirements: The facility shall have a Medical Alert system in place.

All youth with Medical Grades of 3-5 shall be placed on the facility’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; and
(h) Medication side effects.

Nursing staff shall verify all alerts in the medical alert system are accurate and up-to-date.

Review the program’s internal alert system to determine if all youth alerts identified in the Individual Health Care Record (IHCR) are captured in the program’s system.

Interview a sample of staff to determine how staff are informed of the youth’s medical alerts.

Reference:

- F.A.C. 63E-7004 (9), Residential Services, Youth Intake
- F.A.C. 63M-2.0045, Health Services, Office of Health Services
4.09 Youth Orientation to Healthcare Services

All youth shall be oriented to the general process of health care delivery services at the facility.

Guidelines/Requirements: Youth receive general health care orientation upon admission or at the next available opportunity. Review Facility Operating Procedure. Examples of topics to be covered include the following:

- Access to medical care
- Sick Call (e.g., use, how to access)
- What constitutes an "emergency" and when to notify staff
- Medication process to include 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 health care providers

Review the orientation packet for each youth sampled.

Review of the list of Health Care Contacts to ensure accuracy.

Reference:

- F.A.C. 63M-2.0046, Health Services, Office of Health Services
- Facility Operating Procedure
4.10 Designated Health Authority (DHA)/Designee Admission Notification

A referral to the facility’s Physician, PA, or ARNP shall be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission.

Guidelines/Requirements: The 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 ARNP. The DHA or designee must be notified of all youth admitted with a medical condition. This notification may be by telephone or verbally. Review Facility Operating Procedure for appropriate timeframes for notification.

Review progress notes and/or any internal forms or processes created to document this requirement. (Additional healthcare records may be reviewed to ensure sample size is met).

Reference:

- F.A.C. 63E-7.003 (5)(b), Residential Services, Youth Admission
- F.A.C. 63E-7.011 (c) 1, Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Intake Screenings and Assessment
- F.A.C. 63M-2.0043, Health Services, Office of Health Services
- Facility Operating Procedures
4.11 Healthcare Admission Rescreening

A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.

Guidelines/Requirements: A change in physical custody since the youth’s arrival requires a complete rescreening after youth's return to the facility.

Review the logs or STAR (Statewide Transportation and Relocation Policy) forms for change in custody (HS 053, HS 054 and HS 055 where applicable). A new Facility Entry Physical Health Screening (FEPHS) shall be completed for each returning date after a change of custody happened (additional healthcare records may be reviewed to ensure sample size is met, such as records for youth returning from detention and crisis stabilization units).

Screening shall be completed by an RN, LPN, direct care staff, or MD/ARNP. If completed by a direct care staff, it shall be reviewed by LPN or higher within twenty-four hours.

Reference:

- F.A.C. 63E-7.003 (5)(b), Residential Services, Youth Admission
- F.A.C. 63E-7004 (2)(a), Residential Services, Youth Intake
- F.A.C. 63E-7.011 (3)(a-b), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Intake Screenings and Assessment
- F.A.C. 63M-2.0041, Health Services, Office of Health Services
4.12 **Health Related History**

The standard Department Health-Related History (HRH) form shall be used for all youth admitted into the physical custody of a DJJ facility.

**Guidelines/Requirements:** HRH shall be updated/conducted within seven days of admission.

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

The designated health authority (DHA) or designee shall document he/she reviewed the HRH. This can be accomplished by the checkbox on the CPA that the HRH was reviewed and/or by documentation on the focused note the admission documents/HRH was reviewed.

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

The most recent Department form shall be used.

Review HRHs for signatures and dates for the most current admission.

**Reference:**

- F.A.C. 63E-7.010 (5)(a), (2)(b), Residential Services, Residential Case Management Services, Assessment, Initial Assessment, Education and Treatment Needs, Physical Health

- F.A.C. 63M-2.0047, Health Services, Office of Health Services
4.13 Comprehensive Physical Assessment

The standardized comprehensive physical assessment form shall be used for all youth admitted into the physical custody of a DJJ facility.

Guidelines/Requirements: Documentation of completion of a current Comprehensive Physical Assessment (CPA) within seven calendar days from the date of admission.

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

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

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

All fields on the CPA shall be completed, as required, (BMI, visual acuity field, Tanner stage, scalp/head, cardiovascular, medical grade, TST, etc.).

All areas of the physical examination on the CPA form are to be completed by the examining practitioner. Review Facility Operating Procedure for appropriate documentation when any part of the exam is not conducted and/or is refused by the youth.

Review the CPAs of all youth sampled.

Review the DJJ Problem List to determine if it was updated as required.

Reference:

- F.A.C. 63E-7.010 (5) (a), (2) (b), Residential Services, Residential Case Management Services, Assessment, Initial Assessment, Education and Treatment Needs, Physical Health
- Facility Operating Procedures
- F.A.C. 63M-2.0048, Health Services, Office of Health Services
4.14 Female-Specific Screening/Examination

All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.

Guidelines/Requirements: This indicator should be rated “Non-Applicable” for all male programs.

All girls who are sexually active, identifying her 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.

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

Review Comprehensive Physical Assessments (CPA), progress notes, and/or dictated designated health authority (DHA) evaluations for documentation of exam and consent by the youth.

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

Reference:

- F.A.C. 63E-7.010 (5) (a), (2) (b), Residential Services, Residential Case Management Services, Assessment, Initial Assessment, Education and Treatment Needs, Physical Health
- F.A.C. 63M-2.010, Health Services, Office of Health Services
4.15 Tuberculosis Screening

All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.

Guidelines/Requirements: There shall be at least one verified tuberculin skin test (TST), formerly PPD test, documented in the Individual Health Care Record (IHCR).

Tier I TB screening shall be completed within 72 hours of admission.

Any youth with symptoms suggestive of active TB shall not be placed in the general population until medically assessed by the facility designated health authority (DHA) or designee, PA, or ARNP (see below):

- Symptoms include a cough productive of mucous for greater than three weeks AND any three of the following symptoms: fever greater than 101 degrees; significant weight loss without dieting; fatigue; night or early evening profuse sweating.

Review the Facility Entry Physical Health Screening (FEPHS) form and the Comprehensive Physical Assessment (CPA) and/or Infectious and Communicable Disease (ICD) form for documentation of completed TST results.

- Annual screening may be indicated, but can be done through interview and assessment. A new TST is not required unless there was a break in custody.

Reference:

- F.A.C. 63E-7.010 (5)(a), (2)(b), Residential Services, Residential Case Management Services, Assessment, Initial Assessment, Education and Treatment Needs, Physical Health
- F.A.C. 63E-7004 (2)(a), Residential Services, Youth Intake
- F.A.C. 63M-2.0044, Health Services, Office of Health Services
4.16 Sexually Transmitted Infection Screening

The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).

Guidelines/Requirements: All sexually active youth should be clinically screened and evaluated for STIs. If further evaluation is needed, youth shall be referred to the MD/DO/PA/ARNP.

When applicable, the results of tests should be noted on the Infectious and Communicable Disease (ICD) form and located in the Individual Health Care Record (IHCR). (Excluding HIV results – which are addressed in indicator 4.17)

Rescreening should be conducted if the sexually active youth has been out of DJJ physical custody for over thirty days, and/or symptoms present.

Review the Health Related History (HRH) and STI forms for documentation of screenings and rescreenings, when applicable, for each youth sampled. Referrals should be documented on the STI and/or the Comprehensive Physical Assessment (CPA) or progress notes. Testing may be documented in the progress notes. The ICD forms for each applicable youth shall be reviewed for documented STI results. Results shall also be filed in the lab section of the Individual Health Care Record (IHCR).

Reference:

- F.S. 381.004, HIV Testing
- F.A.C. 63E-7.010 (5)(a) 2 (b), Residential Services, Assessment, Initial Assessment, Education and treatment, Physical Health
- F.A.C. 63M-2.0041, Health Services, Office of Health Services
4.17 HIV Testing

The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.

Guidelines/Requirements: HIV test results shall be filed in a confidential manner consistent with FS 381.004.

A certified HIV counselor shall conduct the testing.

All pregnant youth shall have an HIV test unless, after counseling by the Physician, PA, or ARNP, she refuses testing. She shall sign a waiver (refusal) to decline the test and filed in the Individual Health Care Record (IHCR).

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

Documentation of pre/posttest counseling shall be documented on the Individual Health Education Record and/or in the progress notes (not test results).

Review HIV Risk Assessments and/or Sexually Transmitted Infections (STI) (HSM 029) form as well as the Health Education Record form (HSM 013), and/or progress notes.

Review IHCR to ensure HIV results are filed confidentially in a sealed envelope marked “CONFIDENTIAL.”

The youth’s HIV status should never be included on the program’s internal alert system.

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 the course of 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 (not applicable to DJJ);
- Medical personnel who have been subject to a significant exposure.
- Health care facility personnel or agents for the health...
care provider who have a need to know in the course of 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.

**Reference:**

- F.S. 381.004, HIV Testing
- F.A.C. 63E-7.010 (5)(a) 2(b), Residential Services, Assessment, Initial Assessment, Education and treatment, Physical Health
- F.A.C. 63M-2.052, Health Services, Office of Health Services

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4.18 Sick Call Process - Requests/Complaints

All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.

Guidelines/Requirements: There shall be regularly scheduled hours in each facility for a youth to be evaluated by a licensed nurse. Only a licensed nurse shall conduct Sick Call.

When no licensed nurse is on-site, the program shall have a procedure whereby the shift supervisor reviews all sick call requests no longer than four hours after request is submitted.

The completed Sick Call Request form shall be placed in a secure location inaccessible to youth (e.g., locked box, sealed envelope) to then be provided to the nurse.

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

Review youth complaints of any severe pain with which staff was unfamiliar shall be treated as emergencies and an immediate referral made to the licensed healthcare professional.

Sick call frequency according to program size shall be conducted as per contract requirements.

The completed Sick Call Request form is to be filed with the progress notes in the Individual Health Care Record in reverse chronological order.

Review sick call request forms from Individual Health Care Records (IHCR) sampled. Look for referrals when required and/or documented follow-up when needed for youth in severe pain.

Reference:

- F.A.C. 63E-7.011 (3)(c) 3, Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Sick Call
- F.A.C. 63M-2.006, F.A.C., Health Services, Office of Health Services
▪ Per Contract Requirements
4.19 Sick Call Process – Visits/Encounters

The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.

Guidelines/Requirements: If LPN conducts sick call, it shall be reviewed daily, either telephonically or in person, with the MD, DO, PA, ARNP, or RN.

Sick call forms or progress notes shall be documented in accordance with rule (e.g., vital signs, treatment, education, follow-up plans).

All sick calls are to be documented on the Sick Call Index.

All sick calls are to be documented on the Sick Call Referral Log. This may also be the process for youth to sign they have been seen for sick call when the sick call form (HS 032) is not able to be printed at the time the youth is seen. Confirm reviews by a RN or higher when sick calls are conducted by a LPN daily (either by telephone or in person) and documented.

The completed Sick Call Request form is to be filed with the progress notes in the Individual Health Care Record in reverse chronological order.

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

Review each youth’s corresponding sick call index, referral log, or electronic generated sick call referral log and corresponding Sick Call form in the chronological progress notes.

Review staff interviews to determine which staff conduct sick call.

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

Reference:

- F.A.C. 63E-7.011 (3)(c) 3, Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Intake Screenings and Assessment
- F.A.C. 63M-2, Health Services, Office of Health Services
4.20 **Room Restriction/Controlled Observation**

All youth in Room Restriction/Controlled Observation shall have timely access to medical care, as required by the Department.

**Guidelines/Requirements:** This indicator shall be rated “Non-Applicable” if the program’s policy, procedure, or contract stating they do not use restricted housing (e.g., seclusion, room restriction, controlled or secure observation).

Youth in restricted housing (including room restriction/controlled observation) of any kind are questioned daily for Sick Call/health complaints.

Nursing staff shall make a daily visit (when on site) and document in the Individual Healthcare Record for each youth in restricted housing.

All youth in restricted housing (including room restriction/controlled observation) shall receive all prescribed medications as ordered and on time.

Review progress notes and/or internal reports to document daily visits to youth.

If the program has not had any instances of room restriction/controlled observation, review the program’s policy.

Review medical records of youth placed in room restriction/controlled observation, if applicable. Confer with the team member assigned to behavior management (Standard 5) to determine if room restriction/controlled observation is used at the program.

Conduct informal interviews with youth to determine if they receive medical services while in room restriction/controlled observation.

**Reference:**

- F.A.C. 63E-7.011 (3) (c), Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Intake Screenings and Assessment
- F.A.C. 63M-2.002, F.A.C., Health Services, Office of Health Services
4.21 Episodic/First Aid Care

The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.

Guidelines/Requirements: Every DJJ facility shall provide episodic care to include: basic first aid procedures and interventions. Twenty-four hours per day emergency medical and dental care is available, including EMS services.

Non-healthcare staff Episodic Care documentation shall include:

- Date/time of episodic care
- Nature of the complaint
- Findings of person rendering care
- Treatment rendered
- Referral to off-site care, if needed
- Education/instruction to youth, if needed
- Plans for follow-up/future care,
- Placement on alert list, if needed
- Parental notification
- Name, and credentials of staff providing care

On-site episodic care by healthcare staff episodic care documentation requires either problem-oriented (subjective, observation, assessment, and plan (SOAP) elements or standard narrative charting was used (this shall contain all elements of non-healthcare staff requirements as well).

First aid kits (inclusive of transportation vehicles) are located in designated areas and the designated health authority (DHA) approves contents. They are monitored monthly and replenished as needed.

There shall be an on-site tracking log for Episodic Care. Youth shall receive a follow-up evaluation by licensed healthcare staff.

Review First Aid kits in areas frequented by youth. Review kits for expired and approved contents.

Review Episodic Care Log for past six months and compare with all on/off-site events from IHCRs sampled.
Review progress notes and non-healthcare staff forms for each on/off-site event.

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

**Reference:**

- F.A.C. 63E-7.011 (3) (c) 2, Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Episodic Care

- F.A.C. 63M-2.009, Health Services, Office of Health Services
4.22 Emergency Care

The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.

Guidelines/Requirements: All health care and non-health care staff persons shall know they have the right and responsibility to immediately call 9-1-1 at any time a youth’s condition appears compromised.

Ask the program how they document emergency response and mental health drills. Programs may input the documentation into facility logs or paperwork specifically designed to record and report results of drills.

All non-health care 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 (when an AED is on site).

All licensed health care staff shall maintain, at a minimum, current certification in Basic Cardiopulmonary Resuscitation (with AED training, as applicable).

If the facility has an Automated External Defibrillator (AED), it is placed in a secured area easily accessible by staff and procedures are established to ensure the batteries, pads, etc. are replaced at the requisite intervals.

Emergency drills, both announced or unannounced, shall be conducted for each shift, on a quarterly basis at a minimum, and simulate an episodic care event that calls for immediate First Aid and/or administration of CPR techniques and the initiation of the emergency procedures to follow when a life-threatening emergency does occur. Documentation of these drills shall also be maintained per facility.

A list of emergency telephone numbers and cellular phones numbers, including the number of the statewide Poison Information Center, shall be posted or located accessible to all staff, on all shifts. This list should not be in a location accessible to juveniles.

When a youth requires the use of an EpiPen auto injector, all health care and direct care staff (at the Supervisory level) shall be appropriately trained on the administration of the
EpiPen auto injector and shall administer the EpiPen auto injector when indicated. An appropriately trained RN can train other healthcare staff and non-healthcare staff on the use of the EpiPen auto injector.

Using an active emergency as a drill is allowable, as long as follow-up protocol is conducted.

Determine if the minimum required frequency of drills is in compliance by review of applicable documentation.

Confirm staff training requirements with team member assigned to training indicators.

Review any documented drills related to above Guidelines/Requirements.

Observe medical staff complete a test on each AED.

Review staff interviews to determine if staff are permitted to call 9-1-1 when a youth is identified with a medical emergency.

Reference:

- F.A.C. 63E-7.011 (3)(c) 2, Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Episodic Care
- F.A.C. 63M-2.009, Health Services, Office of Health Services
- F.A.C. 63M-2.034, Health Services, Office of Health Services, Administration of Parenteral Medications
- F.A.C. 63N-1.0091(2) (c) Suicide Prevention Plans
4.23 Off-Site Care/Referrals

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

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

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

The designated health authority (DHA) or designee reviewed and signed/initialed all off-site care findings, instructions, and information.

All follow-up testing, referrals, and appointments require documentation these referrals were tracked and youth received appropriate, timely follow-up care, as needed.

Review all off-site care forms, returning off-site orders, and progress notes for all events in each youth’s IHCR sampled.

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

**Reference:**

- F.A.C. 63E-7.011 (3) (c) 2, Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Episodic Care
- F.A.C. 63M-2.008, 63M-2.063, Health Services, Office of Health Services
4.24 Chronic Illness/Periodic Evaluations

The facility shall ensure youth who have chronic illnesses 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.

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

Review each youth’s FEPHS form and the facility’s chronic condition roster to determine if the youth is applicable for this requirement.

Review progress notes for documentation of each completed periodic evaluation.

Interview program director to determine what formalized procedures are in place with the healthcare staff to review the important medical issues pertaining to youth in the program and how often do they meet.

Interview medical staff, especially the designated health authority (DHA) to ensure compliance to indicator.

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

Reference:
- F.A.C. 63E-7.011(3) (c) 2, Residential Services, Delinquency Intervention and Treatment Services, Treatment Services, Physical Health Services, Intake Screening And Assessment, Chronic Care
- F.A.C. 63M-2.008, Health Services, Office of Health Services
4.25 Medication Management – Verification

A youth’s medication regimen shall be ascertained upon admission to the facility.

Guidelines/Requirements: Only medications from a licensed pharmacy, with a current, patient-specific label intact on the original medication container may be accepted into a DJJ facility.

Prescription medications verified and confirmed by a DJJ facility and which remained exclusively in the control of the DJJ facility do not require re-verification or confirmation by the facility to which the youth is being transferred.

When the verification process is successfully completed, the licensed nurse shall call to obtain an order from the designated health authority (DHA) or Physician Designee, PA, or ARNP to resume the specified medications.

Documentation of prescription verification shall occur in the chronological Progress Notes in the Individual Health Care Record.

When youth are admitted to a facility and licensed nurses are not on duty (e.g., at night), there shall be a Facility Operating Procedure developed by the DHA permitting the trained non-health care staff person to verify the medications (as described above) and assist the youth with self-administration.

Review the Facility Entry Physical Health Screening (FEPHS) form and progress notes to confirm if youth was admitted with medication and subsequent verification.

Review progress notes for notification to the DHA and parent/guardian when applicable.

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

Reference:

- F.A.C. 63E-7.004 (7), Residential Services, Youth Intake
- F.A.C. 63M-2.022, Health Services, Office of Health Services
### 4.26 Medication Management - Orders/Prescriptions

All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.

**Guidelines/Requirements:** Continue the administration of ALL current medications for which the youth has a verified prescription at the time of admission to a facility.

The current medications prescribed prior to admission shall be renewed or refilled for the life of the prescription(s) as long as there are no changes in the total dosage or route.

The designated health authority (DHA) or physician designee, PA, or ARNP shall place an order on the Practitioner Order Form or other designated area in the Progress Notes indicating which current medications are to be continued, discontinued, and when medications are changed or new medications are ordered subsequent to admission to the facility.

Over-the-Counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) shall be administered per approved protocols or Practitioner’s Order, unless the parent/guardian has prohibited the administration of OTC medications by way of the AET (refer to 4.04 Parental Notification).

Review progress notes and/or DHA order section to verify medication regimen.

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

**Reference:**

- F.A.C. 63E-7.004 (7), Residential Services, Youth Intake
- F.A.C. 63E-7011 (3) (c) 4, Residential Services, Delinquency Intervention and Treatment Services.
- F.A.C. 63M-2.022, 63M-2.024, 63M-2.030, Health Services, Office of Health Services
4.27 Medication Management – Storage

All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.

Guidelines/Requirements: All medications shall be identified and secured in the locked area designated for storage of medications.

All non-controlled medications, prescribed and over-the-counter (OTC), shall be stored in a separate, secure, locked area inaccessible to youth.

Separate storage of different medication forms (i.e. injectable, topical medications, drops, liquids) (see below):

- Refrigerated medications in a location separate from food storage;
- Non-controlled prescription medication;
- OTC medications;
- Controlled Medications (Narcotics, Psychotropics);
- Secure storage of sharps (needles, syringes, scissors, suture removal kits, etc.);
- Clearly designated youth-specific sections.

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

Observe area designated to store youth medication.

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

Reference:

- F.A.C. 63E-7011 (3)(c) 4, Residential Services, Delinquency Intervention and Treatment Services

- F.A.C. 63M-2.024, 63M-2.025, 63M-2.027, Health Services, Office of Health Services
4.28 Medication Management - Medication and Sharps Inventory

All medications and sharps shall be inventoried as per department requirements.

Guidelines/Requirements: Any medical equipment classified as sharps (e.g., syringes, needles, scissors, suture removal kits) shall be secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed of.

The stocked supply shall be securely stored.

A perpetual inventory and a weekly inventory of all sharps (stocked and working supplies) shall be conducted.

A perpetual daily running inventory of medication utilization for all prescription and over-the-counter (OTC) medications shall be maintained.

There shall be weekly inventory counts for all opened OTC medications.

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

Review facility inventories for the past six months along with the area designated to store sharps.

Randomly select three different sharps, document and observe a count completed by the nurse. Verify if count matches ending inventory numbers.

Inventory three (3) sharps, three (3) youth medications, and three (3) OTC medications.

Reference:

- F.A.C. 63E-7.004 (7), Residential Services, Youth Intake
- F.A.C. 63E-7011 (3) (c) 4, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63M-2.024, 63M-2.025, 63M-2.026, Health Services, Office of Health Services
4.29 Medication Management - Controlled Medications

All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.

**Guidelines/Requirements:** All controlled substances, such as narcotics, shall be kept in a medication storage area, securing them behind a double-lock system.

Pursuant to Pharmacy regulatory requirements, a shift-to-shift inventory count of each narcotic shall be performed and 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 narcotic shall be maintained. Supervisory level non-health care staff trained in the delivery and oversight of medication self-administration may perform these duties, but only 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.

Observe area designated to store controlled medication.

Review inventories from past six months.

Review the program’s Medication Management facility operating procedures (FOP) regarding Controlled Medication Inventory. The FOP should articulate the facility’s shift-to-shift procedure

Randomly select three different controlled medications, document and observe a count completed by the nurse or a supervisory level non-healthcare staff trained in the delivery and oversight of medication self-administration. Verify if count matches ending inventory numbers.
Reference:
- F.A.C. 63E-7011 (3) (c) 4, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63M-2.024, 63M-2.026, Health Services, Office of Health Services
4.30 Medication Management - Medication Administration Record

The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.

Guidelines/Requirements: The standard DJJ form, or pre-printed pharmacy MAR, shall be used.

The MAR shall contain all elements required (youth name, DJJID, date of birth, youth allergies, precautions, medical grade, medical alerts, current picture of youth). The picture of the youth may be attached or adjacent to the current MAR.

For youth taking medication at admission, the initial MAR shall match the medication list.

The MAR shall indicate the youth received medications as ordered.

The MAR shall clearly indicate medication start/stop dates. Staff shall initial each administered medication entry (also required for youth when non-healthcare staff provide medications).

There shall be no lapses/errors in medication administration.

At a minimum, the nursing staff shall document weekly side effect monitoring on the MAR.

Review each sampled youth’s MAR, when applicable, for the above requirements.

Review the FEPHS form to determine if youth was admitted with medication.

Yes ☐ No ☐ N/A ☐

Yes ☐ No ☐ N/A ☐
Review progress notes and/or the Authority for Evaluation and Treatment (AET) order section to determine if medication was continued, changed, or discontinued. Compare orders to initial MAR.

Reference:

- F.A.C. 63E-7.004 (7), Residential Services, Youth Intake
- F.A.C. 63E-7011 (3) (c) 4, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63M-2.030, Health Services, Office of Health Services
4.31 Medication Management - Medication Administration by Licensed Staff

Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.

Guidelines/Requirements: Medication administration shall be the sole responsibility of the nurse during the time of scheduled medication pass (sick call may not be conducted during med pass).

The working space shall be clean and organized.

The nurse shall have control of medication containers and cart. (Under no circumstances are medications to be pre-poured).

There shall be a structured process for youth to approach licensed staff person individually. The nurse shall verify the Five Rights of Medication Administration and a correct Medication Administration Records (MAR).

The nurse shall verify the youth's allergy and alert status.

Nursing staff document on the MAR, at a minimum weekly prior to administering medications, about relevant side effects.

Parenteral medications shall only be administered by licensed healthcare staff.

Review youth interviews, MARs, facility operating procedures (FOPs), and observe area designated to administer youth medication.

Refusals are clearly documented on the MAR.

When possible, observe at least one medication pass.

Reference:

- F.A.C. 63E-7.004 (7), Residential Services, Youth Intake
- F.A.C. 63E-7011 (3) (c) 4, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63M-2.030, Health Services, Office of Health Services
4.32 Medication Management – Medications Provided By Non-Licensed Staff

Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter (OTC) medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.

Guidelines/Requirements: Only when licensed nurses are not on site to administer oral prescription medications or OTC medications, shall trained non-health care staff deliver medications to youth.

Trained non-health care staff shall only assist youth with the self-administration of oral, topical, or inhaled prescribed medication(s).

The nurse shall delegate this responsibility only to non-healthcare staff who have completed the facility's training curriculum for Assisting with Youth Self-Administration of Medications, and verified as competent by the nurse.

The Five Rights of Medication Administration shall be maintained.

The designated staff member assisting youth with medication delivery shall not be required to conduct or supervise any facility activities during this time. (Note: Under no circumstances are medications to be pre-poured.)

There shall be a structured process for youth to approach the non-healthcare staff person individually.

The non-healthcare staff shall confirm the allergy status of the youth any current perceived side effects or adverse reactions to the medication.

Both the youth and the staff member shall initial that the dosage was given.

Review youth Medication Administration Records (MARs), staff training records, facility operating procedures (FOPs), and observe area designated to administer youth medication.

Yes ☐  No ☐  N/A ☐
Refusals are clearly documented on the MAR and Refusal form when applicable.

Review staff and youth interviews to determine if staff administer medications to youth.

This indicator may be made “Non-Applicable” if the program has 24/7 nursing staff provide all of the medications and the program’s policies and procedures reflect there will always be nursing staff giving the medications.

**Reference:**

- F.A.C. 63E-7.004 (7), Residential Services, Youth Intake
- F.A.C. 63E-7011 (3) (c) 4, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63M-2.031, Health Services, Office of Health Services
4.33 Medication Management - Psychotropic Medication Monitoring

The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths’ safety, as required by the Department.

Guidelines/Requirements: Youth currently prescribed psychotropic medications upon admission require notification of the designated health authority (DHA); the facility’s prescribing Psychiatrist or Psychiatric ARNP, and the Designated Mental Health Clinician Authority (DHMCA).

The psychotropic medications the youth was receiving prior to admission shall continue to be administered until the facility Psychiatrist or Psychiatric ARNP conducts an initial diagnostic psychiatric interview of the youth.

The initial diagnostic psychiatric interview shall be conducted within fourteen days of the youth’s admission.

Youth receiving psychotropic medication prescribed prior to admission shall receive medication monitoring/review by the facility Psychiatrist or Psychiatric ARNP.

If psychiatric referral is needed, the mental health clinical staff or licensed mental health professional shall refer the youth to the Psychiatrist or Psychiatric ARNP within twenty-four hours of the mental health evaluation.

Upon examination, if the Psychiatrist or Psychiatric ARNP determines psychotropic medication is needed, the youth shall receive an initial diagnostic psychiatric interview or psychiatric evaluation within fourteen days by the facility’s Psychiatrist or Psychiatric ARNP.

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.

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

The following information shall be documented for each psychotropic medication monitoring/review visit:

- 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 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 ARNP;
- Date of signature.

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

The Psychiatrist, Psychiatric ARNP, and nursing staff shall have documentation of monitoring for Tardive Dyskinesia on a monthly basis for youth prescribed antipsychotic medications.

A monthly CPPN shall be completed if youth are continued on the psychotropic medication.

All youth currently receiving psychotropic medications at the time of admission or prescribed psychotropic medication subsequent to admission must receive an in-depth psychiatric evaluation or an updated psychiatric evaluation by a licensed Psychiatrist or Psychiatric ARNP working under the clinical supervision of the Psychiatrist within 30 days of admission to the DJJ facility or program (for youths currently receiving psychotropic medications at the time of admission) or within 30 days of the initial prescription of psychotropic medication (for youths prescribed psychotropic medication subsequent to admission).
The psychiatric evaluation may be documented on the DJJ form entitled “Clinical Psychotropic Progress Note (CPPN) (all 3 pages) or in a form developed by the facility or program. The form utilized (CPPN) or facility/program form must be clearly identified as a “Psychiatric Evaluation.” However, if the psychiatric evaluation results in the prescription of psychotropic medications or changes to a youth’s existing psychotropic medication regimen, page 3 of the CPPN must be completed, regardless of the format used to document the psychiatric evaluation.

Review progress notes for documented notification to required parties when youth are admitted with psychotropic medication.

Review progress notes and CPPNs to determine if youth was seen within fourteen days of admission by a psychiatrist.

**Reference:**

- F.A.C. 63E-7.004 (7), Residential Services, Youth Intake
- F.A.C. 63E-7011 (3) (c) 4, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63N-1, Mental Health, Substance Abuse and Developmental Disability Services Delivery, Office of Health Services
4.34 Infection Control – Surveillance, Screening, and Management

The facility 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 (CDC) guidelines.

Guidelines/Requirements: The types or categories of diseases shall be addressed including the following:

- Common, infectious diseases of childhood (e.g., measles, mumps, 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.

There shall be documentation Universal Precautions were included in the comprehensive program education and prevention administered at each program.

Hepatitis B immunizations shall be provided to staff.

Determine if there were any instances in which the local county health department, CDC, and/or the Central Communications Center (CCC) should have been notified of an infectious disease and ensure such instances were reported as required.
Review the facility’s facility operating procedures (FOPs).

Review facility’s Exposure Control Plan and contractual agreement.

**Reference:**

- F.A.C. 64D-3, Control of Communicable Diseases and Conditions which may Significantly Affect Public Health
- F.A.C. 63E-7011 (3) (c) 5, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63F-11, Central Communications Center
- F.A.C. 63M-2, Health Services, Office of Health Services
4.35 **Infection Control – Education**

The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.

**Guidelines/Requirements:** Training related to each facility's specific exposure control plan shall be conducted at the time of hiring and annually thereafter.

Each youth shall receive Infection Control training, including but is not limited to, prevention of communicable diseases and prevention of blood borne pathogens.

This training shall be documented, and records retained in the youth Individual Health Care Record (IHCR) on the Health Education Record (HER) form (HS 013), to include the prevention of blood borne pathogens and prevention of communicable diseases. Employee training in the employee personnel record.

Review staff training records or confirm with the member of the team looking at the training indicators.

Review IHCR for each youth sampled to confirm documentation of required education.

**Reference:**

- F.A.C. 64D-3, Control of Communicable Diseases and Conditions which may Significantly Affect Public Health
- F.A.C. 63F-11, Central Communications Center
- F.A.C. 63M-2.050, 63M-2.070 Health Services, Office of Health Services
4.36 Infection Control – Exposure Control Plan

The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.

Guidelines/Requirements: An Exposure Control Plan shall be in place.

The Exposure Control Plan shall be written in accordance with OSHA standards (29 CFR 1910).

The plan shall be reviewed and signed annually by the administration of the facility and/or designees.

The Exposure Control Plan shall include Risk Assessment and Methods of Compliance.

A comprehensive process for needle stick post-exposure evaluation shall be in place.

The facility administrator, or program director, shall establish a separate file containing all documents for youth and employees who have experienced a facility/occupational exposure. All records shall be maintained confidentially for a ten-year period.

Any DJJ facility with three or more cases of any reportable infectious disease shall give an account of these cases to the local county health department and/or Centers for Disease Control and Prevention (as applicable). Specified infectious diseases should be reported by the Department within the required time frame in accordance with the Department of Health requirements. The list of reportable diseases is revised periodically and is detailed in Florida Administrative Code (F.A.C.) Chapter 64D-3.

A disease may be added to the list as a new pathogen emerges, or a disease may be deleted as its incidence declines. There is also a recent list of diseases and conditions required reporting by hospitals, physicians, and laboratories, which can be found at http://www.doh.state.fl.us/Disease_ctrl/epi/surv/reportable_diseases_08.pdf.
For more information and the Disease Report Form, go to the Epidemiology section at www.doh.state.fl.us or to local County Health Department websites. For information on health department reporting requirements nationally, go to http://wwwn.cdc.gov/nndss/document/2012_Case%20Definitions.pdf or http://www.cste.org.

Any incident involving contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, whichever number is less, within a facility or program shall be reported to the Central Communications Center (CCC) within two hours.

Review the facility’s facility operating procedures (FOP) and/or exposure control plan, as well as practices related to the FOP/exposure control plan.

Conduct an interview with the program director to determine the location(s) of the program’s exposure control plan.

Reference:

- F.A.C. 64D-3, Control of Communicable Diseases and Conditions which may Significantly Affect Public Health
- F.A.C. 63F-11, Central Communications Center
- F.A.C. 63M-2.050, Health Services, Office of Health Services
4.37 Prenatal Care – Physical Care of Pregnant Youth

The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” for all male programs.

Prenatal care shall begin immediately upon determination the youth is pregnant. Prenatal care shall be provided at the recommended intervals for the pregnant youth.

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

The licensed professional health care staff and trained non-licensed health care staff shall provide routine daily monitoring and observation for indications of pregnancy complications.

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

There is a documented plan for post-birth psychological and physical care.

Review the Individual Health Care Record (IHCR) of sampled youth when applicable. Closed IHCRs going back one year, if retained by the program, can be used if none of the youth sampled are applicable.

Review program’s facility operating procedures (FOPs).

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

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

Reference:

- F.A.C. 63M-2.010, Health Services, Office of Health Services
4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation

The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents.

The program provides education to pregnant and postpartum girls about infant care and lactation.

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” for all male programs.

The licensed health care professional staff shall provide routine monitoring of the pregnant female’s nutritional and weight status during the course of her pregnancy.

The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant adolescents.

Each pregnant girl 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; Parenting skills.

Biological fathers and fathers by relationship (marriage, boyfriends, etc.) are included in family planning and effective parenting education.

Review the individual health care record (IHCR) of sampled youth, when applicable. Closed IHCRs going back one year, if retained by the program, can be used if none of the youth sampled are applicable.

Review program’s facility operating procedures (FOPs) and related education plans/packets.

Additional healthcare records may be reviewed to ensure sample size is met.
Neonatal care is provided at recommended intervals.

The area where bottles are prepared is clean and well organized.

Infants have designated schedules for sleep and interaction with their mothers.

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

**Reference:**

- F.A.C. 63E-7008 (9) b, Residential Services, Facility and Food Services
- F.A.C. 63E-7011 (3) (c) 6, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63M-2.010, Health Services, Office of Health Services
4.39 Prenatal and Neonatal Staff Education

All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.

**Guidelines/Requirements:** This indicator shall be rated “Non-Applicable” for all programs unless the program has had a pregnant youth within the last year or since the last annual compliance review.

A licensed nurse must provide in-service education on girls’ health care annually to all non-health care staff involved in the supervision or treatment of girls.

This in-service training shall include training on monitoring, observation, and emergency care of the pregnant female and their infants (if applicable).

**Reference:**
- F.A.C. 63M-2.010, Health Services, Office of Health Services
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 Youth Supervision

Program staff shall maintain active supervision of youth, including interacting positively with youth, engaging in a full schedule of constructive activities, closely observing behavior of youth and changes in behavior, and consistently applying the program's behavior management system (BMS). Program staff can account for the whereabouts of youth under their supervision at all times.

Guidelines/Requirements: Observe staff during daily activities such as school, recreation, meals, breaks, and line movements to ensure staff is actively supervising youth.

Ask supervising staff how many youth they are supervising and observe to see if they have to count the youth or immediately know the count.

Ask staff to explain what the procedure is when they cannot reconcile the count.

Observations for this indicator are to be conducted each day of the annual compliance review by the regional monitors/reviewers. A rating should not be assigned until the final day.

The provider is adhering to the ratio requirements. Note: The provider shall provide appropriate levels of physical sight and sound presence of staff (the minimum ratio outlined in the contract) to provide immediate response to emergencies, active supervision of the youth, and suitable and timely response to the everyday needs of youth while maintaining safety and security within the program.

Review program policy and procedure to determine what the program considers active supervision.

Reference:

- F.A.C. 63E-7.013 (3)(a) 1-3, Residential Services, Supervision of Youth, Safety and Security
- Per Contract Requirement
5.02 Comprehensive and Consistent Implementation of the Behavior Management System and Staff Training

The program shall have a detailed written description of the collaborative behavior management system (BMS). The written description is conspicuously posted and provided in a resident handbook to allow easy access for youth, including rules governing conduct and positive and negative consequences for behavior including while in the classroom.

All staff shall be trained in the behavior management system (BMS) employed at the program.

Guidelines/Requirements: Consistent with its approach to treatment and delinquency intervention, a residential commitment program shall establish a BMS responsive to the unique characteristics of the program’s population. Only someone with training or experience in behavior management techniques or systems shall develop or modify a program’s BMS.

The program’s BMS shall foster accountability for behavior and compliance with the residential community’s rules and expectations. Evidence includes a posted BMS, or a resident handbook, accessible to youth, detailing the BMS, including the rules and the positive and negative consequences for actions.

Review the program’s documented BMS on file. Review the provider’s contract to ensure all appropriate parties were involved (including education) in the development, implementation, and on-going maintenance of the applicable BMS, if applicable.

Review documentation of youth orientation and training on the BMS.

Observe for postings of the BMS.

Interview staff and youth on their understanding of the BMS.

Conduct interview with program director to determine what BMS is utilized in the program.
Review youth interviews to determine if the program’s BMS is posted or outlined in the youth handbook and how the youth would rate the current system.

There shall be evidence staff consistently apply the BMS, including rewards and negative consequences. Negative consequences should be in direct relation to the severity or seriousness of inappropriate behavior exhibited. Evidence includes observations matching written policy, interviews with staff and youth confirming knowledge of the BMS, consequences for positive and negative behavior, and consistency of application.

The program uses a variety of rewards/incentives to encourage youth participation and completion of the program. The program provides opportunities for positive reinforcement and recognition of accomplishments and positive behaviors at a minimum ratio of four-to-one (4:1) positive to negative consequences.

Documentation of the BMS shall list a variety of rewards/incentives. Interviews with program staff and youth verify the use of a variety of types of rewards/incentives. Examples include: a range of token, tangible, and social rewards including earning privileges, certificates of completion, verbal praise, acknowledgement, points/tokens, and additional earned activities. The most readily available reward is recognition and acknowledgement of pro-social behavior. Starting with a specified number of points at the beginning of a day and taking points away for inappropriate behaviors, is a negative reinforcement tactic and not considered a reward or incentive. A phase system based on demonstration of pro-social behavior is a reward/incentive.

The application of rewards should outnumber negative consequences by at least a four-to-one (4:1) ratio. Evidence includes observation, written policy, and consistent responses from staff and youth concerning the appropriate ratio of rewards and negative consequences. The BMS should also include any special provisions outlined in the provider’s contract.
Interview the program director to determine how rewards are monitored, and how does the program ensure the rewards outnumber the consequences at a minimum of four-to-one (4:1).

Review youth interviews to determine what types of rewards the program provides youth.
Staff have received training in the specific BMS implemented at the program, not simply behavior management theory.

Review documentation of staff training in the program’s BMS. The BMS should include any special provisions outlined in the provider’s contract.

Interview staff to determine if they have received training in the BMS.

Conduct an interview with the program director to determine how consequences and/or punishments are monitored within the program.

Reference:

- F.A.C. 63E-7.005 (2), Residential Services, Youth Orientation
- F.A.C. 63E-7.009, Residential Services, Behavior Management
- Per Contract Requirements: Behavior Management System Requirements
- Educational Cooperative Agreement with applicable School District, as referenced in Florida Statute 1003.52 (14) Cooperative Agreements.
- F.A.C. 63E-7.009 (2) (j), Residential Services, Behavior Management
5.03 Behavior Management System Infractions and System Monitoring

The program’s behavior management system (BMS) is designed to maintain order and security, provide constructive discipline and a system of positive and negative consequences to encourage youth to meet expectations for behavior, provide opportunities for positive reinforcement and recognition for accomplishments and positive behaviors, promote dialogue and peaceful conflict resolution, and minimize separation of youth from the general population.

Supervisors shall monitor staff implementation of the behavior management system (BMS), and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.

Guidelines/Requirements: The program’s BMS shall include a process wherein staff explain to the youth the reason for any sanction imposed, the youth is given an opportunity to explain his or her behavior, and staff and the youth discuss the behavior’s impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior.

The program may use room restriction for major infractions as part of its BMS, temporarily restricting participation in routine activities by requiring the youth to remain in his or her sleeping quarters.

Room restriction shall not be used for a youth who is out of control or a suicide risk. A supervisor shall give prior approval for each use of room restriction. Room restriction shall not exceed four hours and the door to the room shall remain open to facilitate staff supervision. Staff shall engage, or attempt to engage, the youth in productive interactions at least every thirty minutes while on room restriction status. The program shall not deny a youth basic services, such as regular meals and physical or mental health services. Program staff shall use strategies, such as conflict resolution and constructive dialogue, to facilitate the youth’s reintegration into the general population when released from room restriction. For each use of room restriction, the program shall document the following:

- A description of the behavior resulting in room restriction.

<table>
<thead>
<tr>
<th>Yes □</th>
<th>No □</th>
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restriction;
- The date and time room restriction was implemented;
- The name of the staff person who recommended the use of room restriction and the name of the approving supervisor;
- The name of the staff person removing the youth from room restriction;
- The date and time of removal and a description of the youth’s behavior and attitude upon removal; and
- Follow-up actions taken or attempted to help re-integrate the youth back into the general population when released from room restriction.

A residential commitment program’s BMS shall not be used solely to increase a youth’s length of stay.

Examine written BMS and interview staff and youth to determine whether a process exists wherein staff and youth discuss sanctions imposed, consequences, and alternative acceptable behaviors.

Examine the program’s BMS to ensure it is not used solely to increase a youth’s length of stay, deny a youth basic rights or services, promote the use of group punishment, allow youth to sanction other youth, or include disciplinary confinement wherein a youth is isolated in a locked room as discipline for misbehavior.

Review youth interviews to determine the youth’s overall understanding of the program’s BMS to include how the program utilizes room restriction. The BMS should also include any special provisions outlined in the provider’s contract.

Review applicable documentation and video instances, if available, of the utilization of room restrictions to ensure all of the requirements are met.

Verify through interviews supervisors monitor staff use of the BMS and provide feedback to staff.

Review sample of position descriptions specifying required qualifications of staff whose job functions includes implementation of the program’s BMS.

Interview staff about the method and frequency with which they receive feedback. Feedback method may consist of written performance evaluations or annual evaluations specifically evaluating staff application of the BMS.
Review staff interviews to determine what type of rewards the program provides in the BMS.

Conduct interview with the program director to determine how the implementation of the BMS is monitored by the supervisor(s) to ensure it is administered fairly and consistently among all staff.

Review the provider’s contract to ensure all required parties were involved in the development, implementation, and ongoing maintenance of the applicable BMS

**Reference:**

- F.A.C. 63E-7.009, Residential Services, Behavior Management
- F.A.C. 63E-7.016 (4) (e-g), Residential Services, Program Administration
- F.A.C. 63E-7.013 (3), Residential Services, Safety and Security
- F.A.C. 63E-7.009 (2) (j), Residential Services, Behavior Management
- Per Contract Requirements: Behavior Management System Requirements
5.04 Ten-Minute Checks

A residential commitment program shall ensure staff observe youth 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 shall conduct the observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically.

— CRITICAL —

Guidelines/Requirements: All ten-minute checks shall be documented with a written document such as a head count sheet or a facility log, or with a method of electronic documentation. Documentation shall include the actual time of each check and the initials of the staff conducting the check in the case of paper check sheets or a method of determining the staff conducting the checks if checks are documented electronically.

Observe ten-minute checks to ensure the checks are being conducted within the required frequency and in real time and to ensure the checks are met with fidelity (staff members are not to just walk by the rooms without pausing for a moment to actually observe the youth thoroughly enough to guarantee their safety).

Review of ten-minute checks by video is acceptable if the program has a camera system.

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 entered, as opposed to a check mark, and the staff conducting the checks is identified on the check sheet.

Review staff interviews to determine how often room checks are conducted (for non-suicidal youth) and what is the process of documenting the checks.

Reference:

- F.A.C. 63E-7.013 (3) (b), Residential Services, Supervision of Youth, Safety and Security
5.05 Census, Counts, and Tracking

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is practicable after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

Guidelines/Requirements: Review the program’s policy and procedure to determine if the youth’s census, count(s), and tracking are conducted as required. Review facility log and program logbooks (master control and modules) to determine if headcounts, youth movement, and daily census are documented as required.

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 computer program.

Observe counts being conducted.

Review staff interviews to determine when emergency counts are conducted. Review Continuity of Operations Plan (COOP), if necessary.

Reference:
- F.A.C. 63E-7.016 (14) (a), Residential Services, Program Administration
- F.A.C. 63E-7.013 (3) (a) 1-3, Residential Services, Safety and Security
5.06 Logbook Entries and Shift Report Review

The program maintains a chronological record of events, incidents, and activities in a central log-book maintained at master control, living unit logbooks, or both, in accordance with Florida Administrative Code. The program ensures direct care staff, including each supervisor, are briefed when coming on duty.

Guidelines/Requirements: Each logbook is a bound book with numbered pages. (Note: Bound books should not be falling apart or missing any pages.) At a minimum, each log-book entry should be legible and include the date and time of the event, the names of staff and youth involved, a brief description of the event, the name and signature of the person making the entry, and the date and time of the entry. No logbook entries are obliterated or removed; errors are struck through with a single line and initialed by the person correcting the error.

1. Living unit logbook review and master control log-book review (if applicable): If the program maintains a logbook at each living unit, each incoming staff reviews entries made during the previous two shifts in the logbook maintained in the living unit to which he or she is assigned. The staff documents his or her review in the logbook, including the date, time, and signature.

2. Shift report review: If the program does not maintain a logbook at each living unit, the program summarizes in a shift report the events, incidents, and activities documented in the program’s central logbook. A program supervisor verbally briefs incoming staff about the contents of the shift report, or incoming staff shall review the shift report. Each incoming staff signs and dates the shift report for the previous shift to document he/she has reviewed or has been verbally briefed about its contents. A copy of the shift report is maintained at each living unit for at least forty-eight hours.

Review the logbooks to ensure internal incidents reported to the Florida Abuse Hotline and/or the Central Communications Center (CCC) were documented.

Reference:

- F.A.C. 63E-7.016, Residential Services, Program
Administration
5.07 Key Control

The program has a system in place to govern the control and use of keys including the following:

- Key assignment and usage including restrictions on usage
- Inventory and tracking of keys
- Secure storage of keys not in use
- Procedures addressing missing or lost keys
- Reporting and replacement of damaged keys

Guidelines/Requirements: Review program policy on key control.
Observe the distribution and collection of keys whether conducted by master control or by supervisors and/or designee.

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.

Interview the master control operator, supervisor, or staff to determine the method for the daily tracking and reconciliation of keys.

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

Review policy and or interview the master control operator, a supervisor, or staff to determine if there is obvious knowledge of a procedure for addressing missing or lost keys and reporting and replacement of damaged keys.

Review staff interviews to determine the program’s key control process.

Conduct a random check of staff for personal keys to include administrative staff.

Reference:
- F.A.C. 63E-7.013 (9), Residential Services, Safety and Security
5.08 Contraband Procedure

The program shall develop and implement a system to prevent the introduction of contraband into the program.

A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.

The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case record. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth’s home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.

Guidelines/Requirements: The program has a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband.

The opportunities for youth to obtain contraband is greatest when they are outside the program or receive correspondence from the outside. It is critical staff maintains the safety and security of the program by performing searches to ensure no contraband is being brought into the program.

Review the program’s policies and procedures on contraband to ensure it aligns with the Department’s recommended guidelines for contraband, distributed August 2015. The program’s policies and procedures must include exemption to services provided.
Review the list of items determined to contraband and the associated consequences. The prohibited list must include personal cell phones and/or equipment and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area.

Review the facility log, incident reports, or search reports to determine frequency and quality of searches, and the results of each search.

Interview the director or supervisory personnel to determine how the discovery of contraband and illegal contraband is handled and disposed.

**Reference:**

- F.A.C. 63E-7.013 (10), Residential Services, Safety and Security
- F.A.C. 63E-7.004 (6), Residential Services, Youth Intake
- FDJJ Contraband Guidelines, Residential Services, August 2015
5.09 Searches and Full Body Visual Searches

The program shall perform searches to ensure no contraband is being introduced into the facility.

Guidelines/Requirements: Searches and full body visual searches are conducted, as prescribed, or otherwise permitted by Florida Administrative Code. This shall include any instance where a youth participated in any vocation or other activity involving the use or ability to obtain tools or other implements. Prior to conducting any search and full body visual searches, staff prepare the youth by explaining the purpose of the search and what it entails while assuring the youth of his or her safety. Staff avoids using unnecessary force and shall treat the youth with dignity and respect to minimize the youth's stress and embarrassment.

A search is conducted through the youth's clothing by staff who is of the same sex as the youth being searched. Electronic search equipment may be used to supplement a full body visual search. A full body visual search is conducted visually, without touching the unclothed youth, in a private area/room with two staff present, both of the same sex as the youth. If two staff of the same sex are not available, one staff of the same sex conducts the full body visual search while the staff of the opposite sex is positioned to observe the staff conducting the search but cannot view the youth.

Observe searches to determine the thoroughness of the search and observe and listen to the instructions given by staff and the overall demeanor the staff has when explaining the reason and extent of the search.

Observe the search is conducted by the appropriate number of staff and the staff is the appropriate sex or are positioned properly when both staff are not the same sex of the youth being searched in the case of searches.

Observe youth searches during group movement, before and after transports, after education and vocational instruction, and following access/or ability to obtain tools or other implements, during admission, and before and after visitation, if possible.
Searches and full body visual searches should be based on the Protection Action Response (PAR) training manual. Searches should be observed and compared to the searches as outlined in the training module in the PAR manual.

Review youth interviews to determine when searches and full body visual searches occur.

Review staff interviews to determine the process for conducting searches and full body visual searches and under what circumstances are searches being conducted.

**Reference:**

- F.A.C. 63E-7.013 (10)(a-b), Residential Services, Safety and Security
- Protective Action Response Manual
5.10 Vehicles and Maintenance

All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner.

The program ensures any vehicle used by the program to transport youth is properly maintained, and maintains documentation on the use and maintenance of each vehicle. Each vehicle being used for transport of youth shall pass an annual safety inspection. Each vehicle used to transport youth 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. Youth and staff wear seat belts during transportation, and youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.

Guidelines/Requirements: Each vehicle being used for transport of youth shall pass an annual safety inspection. Each vehicle used to transport youth 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. Youth and staff wear seat belts during transportation, and youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.

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

Observe each vehicle used to transport youth and determine if 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, but at a minimum, interview transportation staff and youth and get an understanding of the consistency of seatbelt usage.

Reference:

- F.A.C. 63E-7.013 (18), Residential Services, Safety and Security
5.11 Transportation of Youth

Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.

Guidelines/Requirements: The program provides the minimum ratio of one staff for every five youth during transportation. (Driver can be included in the staff to youth ratio). Transporters are provided a cellular phone or radio for use in the event of vehicle problems or other emergencies. Staff do not transport youth in any personal vehicle unless the program director approves such action based on extenuating circumstances.

Secure high-risk and secure maximum-risk programs provide secure transportation for all youth. Non-secure programs provide secure transportation for any youth determined to be a security risk, a risk to self or others, or demonstrating he or she cannot be transported by less restrictive methods. If five or fewer youth are being transported, the program provides a minimum of two staff, with one being the same sex as the youth transported; transporting more than ten youth requires one additional staff for every five youth. Mechanical restraints are used in accordance with Florida Administrative Code. The vehicle has rear doors that cannot be opened from the inside. The vehicle is equipped with a safety screen separating the driver’s compartment from the passengers’ compartment, or a staff person occupies the passengers’ compartment.

The program shall ensure a current driver’s license for any staff member operating a program vehicle. The program shall ensure compliance of all requirements outlined by the Department relating to the transportation of youth, and driver eligibility.

Youth and staff wear seat belts during transportation, and youth shall not be attached to any part of the vehicle by any means other than the proper use of a seat belt.

Staff shall not leave youth unsupervised in a vehicle.

Youth shall not be permitted to drive program or staff vehicles.

Staff shall lock personal and program vehicles when not in use.
Observe a transport to determine if the staff to youth ratio is within departmental requirements. If no transports are conducted during the annual compliance review, interview staff and youth to get an understanding of routine staff to youth ratios maintained during transports.

Interview staff to ensure they are provided a communication device for use during transports, and they do not use personal vehicles unless approved by the program director.

Inspect vehicles to ensure doors to the youth passenger area cannot be opened from the inside and the vehicles have a safety screen separating the driver's compartment.

Conduct a random check of personal vehicles and facility vehicles to ensure they are kept locked when not in use.

**Reference:**

- F.A.C. 63E-7.013 (18), Residential Services, Safety and Security
- FDJJ 1920, Operating a Vehicle for the Purpose of Transporting Youth
5.12 **Weekly Safety and Security Audits**

A residential commitment program shall maintain a safe and secure physical plant, grounds and perimeter.

**Guidelines/Requirements:** The program shall complete weekly safety and security audits. The program shall develop a policy and procedure that outlines the audit/inspection process to include, at a minimum, the following:

- Who is responsible for conducting the weekly security audits and safety inspections;
- The development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, or inspection; and,
- Internal system to verify the deficiencies are corrected and existing systems are improved or new systems are instituted as needed to maintain compliance.

Review programs policy and procedure to ensure it meets all the requirements of F.A.C. 63E-7.013 (5).

Review sample weekly safety and security audit documents to ensure they were completed every seven days.

Interview program director to ensure there is a clear process regarding the identification, tracking, deficiencies are being addressed by the program.

**Reference:**
- F.A.C. 63E-7.013 (5), Residential Services, Safe and Secure Facility
5.13 Tool Inventory and Management

The facility shall have a tool management system ensuring youth do not use tools or equipment as weapons or security breaches.

Guidelines/Requirements: Tools shall be marked or identified in a way facilitating issuance of tools and timely identification of missing tools. Tools shall be inventoried prior to being issued for work and at the conclusion of the work activity. Staff shall report any discrepancy to the program director or designee for immediate follow-up action.

Tools shall be stored securely when not in use and inventoried at least monthly. Tools with sharp edges or points and a high potential to be used as a weapon are inventoried daily, except on days when they are not in use. If the program consistently implements a system whereby tools are securely stored in a sealed container or closet, or if the seal has not been broken at the time an inventory is being conducted, the sealed tools may be exempt from inventory. Prohibited tools include machetes, bowie knives, or other long blade knives. Staff and youth are trained on the intended and safe use of tools.

Inspect the tool room to determine the level of security when tools are not in use. Inspect tools to ensure they are marked with identifying marks.

Review the inventory used to document issuance and return of tools.

Compare the monthly inventory of tools without a high potential to be utilized as a weapon and the daily inventory of tools with a high potential to be used as a weapon against the actual tools at the program and determine if there are any tools on the inventories missing from the program and whether there are any tools at the program not listed on the inventory.

Review training documentation the staff and youth are trained on the intended and safe use of tools. Review youth interviews to determine if youth utilize any tools, and if “Yes,” what types of tools.

Reference:

- F.A.C. 63E-7.013 (12), Residential Services, Safety and Security
5.14 Youth Tool Handling and Supervision

There shall be procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth, other youth, and staff.

Guidelines/Requirements: There is a minimum ratio of one staff for every five youth during activities involving tools, except in the case of disciplinary work projects involving tools, which require a minimum ratio of one staff for every three youth. If the program is designed to focus on vocational training, the contract or monitoring plan may specify other staff-to-youth ratios when tools are used for vocational training.

The program has procedures for issuing tools to youth and staff, including an assessment to determine a youth’s risk to self and others. Youth are searched at the completion of each work project or activity involving the use of tools.

Review policy, if available, to determine the established ratios, tool distribution and collection, and search criteria used during work projects.

Observe ratios, search procedures, and tool distribution and collection during a work project, if possible, but at a minimum, interview staff and youth to determine if the program is aware of the requirements.

Review risk assessments for any youth using tools.

Conduct staff interviews to determine what tools are youth permitted to utilize.

Reference:

- F.A.C. 63E-7.013 (12) (a) (b), Residential Services, Safety and Security
5.15 Outside Contractors

The program shall establish guidelines required for outside contractors, which includes information about tool control and restrictions.

Guidelines/Requirements: Procedures address when an outside repairman or worker enters the program to perform a work project requiring the use of tools. The program restricts tools to those necessary, checks tools upon the worker’s arrival and departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follows up if any tool is missing. Personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. The program’s policy and procedure should outline who is responsible for providing approval/permissions if such items are required.

Review procedures addressing outside repairmen or workers who enter the program.

Review any sign-in sheets or instruction sheets provided to outside repairmen or workers.

Review project invoices submitted to the program by the vendor. Determine if the date the project was being worked on and/or completed matches the sign-in sheets of the outside repairmen or workers.

Reference:

- F.A.C. 63E-7.013 (12) (k), Residential Services, Safety and Security
- FDJJ Contraband Guidelines, Residential Services, August 2015
5.16 Fire, Safety, and Evacuation Drills

The program shall conduct fire, safety and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster.

Guidelines/Requirements: Drills must be consistent with the program’s disaster plan or Continuity of Operations Plan (COOP). Another source specifying how drills might be conducted are the facility operating procedures. The documentation for all drills shall contain the following information: type of drill, date and time of the drill, participants, brief scenario and findings/recommendations.

- Using an actual emergency as a “drill” is allowable, as long as follow-up protocol is conducted;
- Using a drill involving multiple emergency situations and classifying as “dual or multiple” drills is allowable;
- The program shall conduct practice events or drills and shall be prepared for immediate implementation or mobilization of the plans whenever an emergency or disaster situation necessitates.

If an actual emergency was used as a drill or a single drill was determined to be used as a dual or multiple event drill, ask the program to provide the debriefing documentation verifying the separate events.

Conduct interview with the program director to determine how often, and what types of drills are conducted within the program.

Review youth interviews to determine if youth have been instructed on the fire evacuation process. Review staff interviews to determine what types of drills staff participate within the program.

Reference:

- F.A.C. 63E-7.013 (20), Residential Services, Safety and Security
- F.A.C. 63E-7.005 (2) (k), Residential Services, Youth Orientation
- Program’s Disaster or Continuity of Operations Plan (COOP) approved by the applicable Regional Director for Residential Services
5.17 Disaster and Continuity of Operations Planning

The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.

Guidelines/Requirements: Ask the program to show you a copy of their Emergency Disaster Preparedness Plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The following requirements should also be verified:

- Documentation confirming the plan has been reviewed, approved and signed by the regional director by June 30 of each fiscal year;
- The plan addresses alternative housing plans approved by the applicable Department Regional Director;
- Older plans approved are valid as long as the following annexes are updated annually: Delegations of Authority, New Cooperative Agreements, Vendor Contact List, and Emergency and Staff Contact Numbers, and County Cooperation Checklist;
- Documentation is present confirming the plan was submitted to the Department’s Residential Services COOP Coordinator for approval with an email confirmation.

Conduct an interview with the program director to determine where the COOP plan is posted and all staff have access.

Reference:

- F.A.C. 63E-7.013 (20), Residential Services, Safety and Security
- COOP Annexes: Annex1, Delegations of Authority; Annex 2, Cooperative Agreements; Annex 8, Emergency and Staff Contact Numbers; and Annex 16, Vendor Contact List
5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials

The program director or designee shall maintain strict control of flammable, poisonous and toxic items and materials and a complete inventory of all such items.

Guidelines/Requirements: All flammable, poisonous, and toxic materials shall be stored in secure areas inaccessible to youth.

Flammable material is defined as liquids with a flash point below 100 degrees Fahrenheit. Toxic material is defined as substances, through chemical reaction or mixture, producing possible injury or harm to the body by entering through the skin, digestive tract, or respiratory tract.

Review the flammable, poisonous, and toxic items and materials inventory and compare it to the actual flammable, poisonous, and toxic items and materials at the program and determine if the inventory has items on it that cannot be accounted for and whether there are items on site that are not on the inventory.

Compare the Safety Data Sheets (SDS)/safety datasheets to the flammable, poisonous, and toxic items and materials and determine if there is an SDS for all materials.

Review the program’s facility operating procedures on the storage and inventory of flammable, poisonous, and toxic items.

Observe the storage area to determine who has access and what types of items are stored.

Reference:

- F.A.C. 63E-7.013 (14), Residential Services, Safety and Security
5.19 **Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials**

The program shall maintain strict control of flammable, poisonous, and toxic items and materials.

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

**Guidelines/Requirements:** Substances that do not contain one or more of the above properties, but are labeled “Keep out of reach of children” or “May be harmful if swallowed,” may not meet the above definitions, but should be kept under strict control.

Review the program’s facility operating procedures.

If possible, observe daily cleaning activities.

Review youth interviews to determine youth access to toxic items and if youth are permitted to utilize hazardous cleaning items.

**Reference:**

- F.A.C. 63E-7.013 (14) (c), Residential Services, Safety and Security
5.20 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.

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, producing 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 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.

Hazardous material shall be disposed of in accordance with the manufacturers’ 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 with 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 shutdown 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 facility operating procedure 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. The operating procedures should also include disposal of hazardous items and toxic substances or chemicals in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 (amended 1-1-2004).

Review the program’s disposal log to determine when, how often, and by what means the material was disposed.

Conduct interview with the program director to determine what is the program’s disposal practice for flammable, toxic, caustic, and poisonous items.

Reference:

- F.A.C. 63E-7.013 (14) (d), Residential Services, Safety and Services
5.21 Recreation and Leisure Activities

The program shall provide a variety of recreation and leisure activities.

Guidelines/Requirements: The program promotes the active participation of youth through opportunities to make choices, assume meaningful roles, including team membership and leadership roles, and give input into the rules and operation of the residential community.

Activities are planned to expose youth to a variety of recreation and leisure choices, exploration of interests, constructive use of leisure time, and social and cognitive skill development, as well as to promote creativity, teamwork, healthy competition, mental stimulation, and physical fitness.

Review the provider’s contract related to the staffing and recreational activities. Ensure the therapeutic activity provided is incorporated into the youths’ individualized performance and/or treatment plan.

Review the program’s activity schedule to determine the program is providing a range of supervised and structured indoor and outdoor recreation and leisure activities for youth.

Review the program’s logbook to determine the activities are provided as outlined on the program’s activity schedule.

Review how the program provides activities based on the developmental level and needs of the youth in the program.

Interview the youth to determine if the youth are provided with at least one hour of large muscle activity daily.

Interview the youth to determine if they are provided with varying degrees of mental and physical exertion throughout the day (e.g., board games, creative arts, sports, and physical fitness activities).

Observe the youth participating in the activities to determine if the program is taking precautionary measures to prevent overexertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury.
Review staff interviews to determine how youth are provided one hour of large muscle activity daily (indoor or outdoor).

If the program contract requires a recreational therapist, review the program’s staffing roster as well as the therapist’s credentials, schedule, and services provided to youth to ensure all requirements are being met and the recreational program is a part of each youth’s individualized performance plan or treatment plan.

**Reference:**

- F.A.C. 63E-7.011(2) (d) 5c, Residential Services, Delinquency Intervention and Treatment Services
- F.A.C. 63E-7.016 (14), Residential Services
- Per Contract Requirements
5.22 Elements of the Water Safety Plan, Staff Training, and Swim Test

Programs choosing to participate in water related activities shall develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. The plan shall also ensure staff are appropriately trained for each specific type of water activity.

Programs allowing youth to participate in water related activities shall have a water safety plan addressing, at a minimum, safety issues, emergency procedures, and the rules to be followed during water related activities, as follows:

- Determination of the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues, and physical stature and conditioning;
- Type of water, such as pool or open water;
- Water conditions, such as clarity, turbulence, and bottom conditions;
- Type of activity, such as swimming, boating, canoeing, rafting, snorkeling, scuba diving, and shoreline and offshore activities to include fishing from a bank or pier, fishing while wading, or picnicking close to a body of water.
- Lifeguard-to-youth ratio and positioning of lifeguards;
- Other staff supervision; and
- Safety equipment needed for the activity, such as personal flotation devices when youth are in a boat, canoe, or raft, and availability of a life-line during shoreline and offshore activities.

Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.

Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.
CRITICAL

Guidelines/Requirements: Programs shall have a policy in place regarding participation in water-related activities. This indicator shall be rated “Non-Applicable” for programs with a policy specifically stating they do not participate in water-related activities.

When water activities are offered, the safety of youth and staff should be a priority concern at all times. The ability to respond in an emergency is critical when youth are engaged in water activities.

The program provides a sufficient number of lifeguards who are certified consistent with American Red Cross or nationally accepted standards for the type of water in which the activity is taking place. Shoreline and offshore activities do not require lifeguards, but do require staff trained in emergency procedures. Scuba diving, snorkeling, or skin/free diving activities are conducted by an instructor appropriately certified by the National Association of Underwater Instructors (NAUI) or the Professional Association of Diving Instructors (PADI).

The program shall have each youth complete a swim test prior to participation in water-related programming to determine the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues and physical stature and conditioning.

If the program chooses to participate in water-related activities, review documentation of swim tests and ensure they are conducted by instructors certified consistent with the type of water activity used during the swim test.

Review the water safety plan to ensure it addresses the requirements of the residential administrative rule.

Review youth interviews to determine if youth participate in any water activities.

Conduct youth interviews to determine if youth received a swim test since they were admitted.
Ask the regional monitor/reviewer assigned to Standard One (Indicator 1.09) to review the logbook for any aquatic activities taking place.

**Review instructor certifications to ensure they are current and are certified consistent with the type of water activity they supervise.**

**Reference:**

- F.A.C. 63E-7.013 (22), Residential Services, Safety and Security
- F.A.C. 63E-7.013 (22) (a) 1, Residential Services, Safety and Security
5.23 Visitation and Communication

The program allows visitation and communication for youth while in the program.

Guidelines/Requirements: Review the program’s policies and procedures, provider’s contract, visitation schedule, and logs in order to verify opportunities are made available to youth.

If necessary, the program considers requests for alternative visitation arrangements with parent/guardian. Youth are given the opportunity to communicate with family members by mail and/or telephone as specified by the program’s written procedures. Note: If the program has demonstrated an innovative practice, please include in the annual compliance report.

Observe the program’s posted visitation schedule.

Review the program’s policies relating to visitation, youth mail, and use of telephone. Review the following: visitation log, telephone log, youth mail/correspondence log(s), and youth interview results.

Review youth interviews to determine if each youth is provided the opportunity to communicate with his/her family via visitation, mail, or telephone.

Reference:

- F.A.C. 63E-7.006 (2), Residential Services, Quality of Life and Youth Grievance Process
- F.A.C. 63E-7.013 (11) (a-h), Residential Services, Safety and Security
- F.A.C. 63E-7.005 (2) (g), Residential Services, Youth Orientation
5.24 Search and Inspection of Controlled Observation Room

The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” if the program does not utilize Controlled Observation.

Practice demonstrating youth are not placed in Controlled Observation until the youth is frisk searched (not strip searched), and the room is inspected and meets size and construction requirements.

Review documentation of staff conducting youth searches and room inspections prior to placing a youth on Controlled Observation.

Reference:

- F.A.C. 63E-7.013 (16), Residential Services, Safety and Security
5.25 Controlled Observation

**Programs shall only place youth in Controlled Observation when non-physical interventions would not be effective.**

**Guidelines/Requirements:** This indicator shall be rated “Non-Applicable” if the program does not utilize Controlled Observation.

Delegated supervisors authorize each use of Controlled Observation unless the delay of seeking prior approval would further jeopardize safety and security. Youth demonstrating acute psychological distress behaviors, such as panic, paranoia, hallucinations, or self-harming or suicidal behaviors are not placed in Controlled Observation.

If feasible, authorization should be obtained prior to placing the youth in Controlled Observation. If this is not possible, the supervisor shall be immediately notified of the placement, or notified of the placement as soon as it is reasonably safe to do so. The supervisor shall then authorize continued placement or the youth shall be removed from Controlled Observation.

Staff discuss with the youth the reasons for placement in Controlled Observation and the expected behavior for removal from placement.

Review documentation placement of a youth in Controlled Observation is authorized by a supervisor with delegated authority or higher level staff.

Review documentation the youth was placed in Controlled Observation because of an emergency safety situation where there was imminent risk of the youth physically harming himself, herself, staff, or others or the youth was engaged in major property destruction and was likely to compromise the security of the program or jeopardize the youth's safety or the safety of others.

Review the Health Status Checklist to determine if it was completed upon the youth's placement. **(Note:** A healthcare professional or a staff person of the same sex as the youth shall conduct the visual check unless a same-sex staff person is unavailable in the vicinity, in which case a staff person of the opposite sex may conduct the visual check.)
Review the Controlled Observation report to determine if the youth was placed and remained in Controlled Observation longer than two hours, and if so, the program director or designee granted two-hour extensions (up to twenty-four hours).

Reference:
- F.A.C. 63E-7.013 (16), Residential Services, Safety and Security
5.26 Controlled Observation Safety Checks and Release Procedures

The program shall conduct safety checks for youth on Controlled Observation.

The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.

Guidelines/Requirements: This indicator shall be rated “Non-Applicable” if the program does not utilize Controlled Observation.

Review the Controlled Observation Safety Checks Form to ensure staff conducted safety checks and observed the youth’s behavior at least every fifteen minutes, or provided continuous sight and sound supervision when the youth demonstrated behaviors that posed a high risk of self-injury.

Review documentation the program director or supervisor with delegated authority approved the youth's release based on the youth's verbal and physical behavior that he or she was no longer an imminent threat of harm to self or others.

Ensure the Controlled Observation Report was reviewed by the program director or assistant program director within fourteen days to determine if placement was warranted and handled appropriately.

Review documentation or the process used by staff to make a determination whether or not an in-house alert was warranted when the youth was released from Controlled Observation.

Reference:

- F.A.C. 63E-7.013 (16) (h.i), Residential Services, Safety and Security