STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Brevard Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
5225 Dewitt Avenue
Cocoa, Florida 32927

Review Date(s): August 7-10, 2018

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

The Bureau of Monitoring and Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Kamille Payne, Office of Program Accountability, Lead Reviewer (Standard 1)
Teresa Andersen, Office of Program Accountability, Deputy Supervisor (Standard 3, 4)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 4)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 3)
Dawn Perkins, Manatee Regional Juvenile Detention Center, Facility Training Coordinator (Standard 5)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Brevard Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Cocoa, FL County / Circuit 18
Review Date(s): August 7-10, 2018

MQI Program Code: 244
Contract Number: N/A
Number of Beds: 40
Lead Reviewer Code: 161

Methodology

This review was conducted in accordance with FDJJ-2000 (Contract Management and Program Monitoring and Quality Improvement Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Youth Management, (3) Mental Health and Substance Abuse Services, (4) Health Services, and (5) Safety and Security, which are included in the Detention Standards.

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- _____ # Case Managers
- 1 # Clinical Staff
- 1 # Food Service Personnel
- 5 # Healthcare Staff
- 1 # Maintenance Personnel
- 2 # Program Supervisors
- _____ # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☐ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☒ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☐ Supplemental Contracts
- ☐ Table of Organization
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- 11 # Health Records
- 8 # MH/SA Records
- 5 # Personnel Records
- 10 # Training Records/CORE
- 3 # Youth Records (Closed)
- 5 # Youth Records (Open)
- _____ # Other: _____

Surveys

- 5 # Youth
- 5 # Direct Care Staff
- _____ # Other: _____

Observations During Review

- ☒ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☐ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☐ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Staff Code of Conduct	Satisfactory
1.04	* Incident Reporting	Satisfactory
1.05	Protective Action Response (PAR)	Limited
1.06	* Pre-Service/Certification Requirements	Satisfactory
1.07	In-Service Training	Satisfactory
1.08	*Entering Alerts(JJIS) and Sharing of Alert Information	Satisfactory

* The Department has identified certain key critical indicators. These indicators represent critical areas that require 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 (detention, residential, probation).

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Admission	Satisfactory
2.02	Orientation	Satisfactory
2.03	Classification	Satisfactory
2.04	Classification of Gang Members	Satisfactory
2.05	Notification of JPO Circuit Gang Rep	Satisfactory
2.06	Admission of Youth Personal Property	Satisfactory
2.07	Storage of Youth Personal Property	Satisfactory
2.08	Release	Satisfactory
2.09	Release of Youth Personal Property	Satisfactory
2.10	Release of Meds, Aftercare Instructions	Satisfactory
2.11	Review of Youth in Secure Detention and Home Detention	Satisfactory
2.12	Daily Activity Schedule	Satisfactory
2.13	Adherence to Daily Schedule	Satisfactory
2.14	Educational Access	Satisfactory
2.15	Career Education	Satisfactory
2.16	Behavior Management System	Satisfactory
2.17	* Unauthorized Use of Punishment	Satisfactory
2.18	Grievances	Satisfactory
2.19	Trauma-Informed Care	Satisfactory

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Standard 3: Mental Health and Substance Abuse Services
Detention Rating Profile

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	* Licensed MH/SA Clinical Staff	Satisfactory
3.03	Non-Licensed MH/SA Clinical Staff	Satisfactory
3.04	MH/SA Admission Screening	Satisfactory
3.05	MH/SA Assessment/Evaluation	Satisfactory
3.06	MH/SA Treatment	Satisfactory
3.07	Treatment and Discharge Planning	Satisfactory
3.08	* Psychiatric Services	Satisfactory
3.09	* Suicide Prevention Plan	Satisfactory
3.10	* Suicide Prevention Services	Satisfactory
3.11	* Suicide Precaution Observation Logs	Satisfactory
3.12	* Suicide Prevention Training	Limited
3.13	* Mental Health Crisis Intervention Services	Satisfactory
3.14	*Emergency Care Plan	Satisfactory
3.15	*Crisis Assessments	Satisfactory
3.16	* Baker and Marchman Acts	Non-Applicable

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Suicide Risk Screening Instrument	Non-Applicable
4.10	Youth Orientation to Healthcare Services	Satisfactory
4.11	DHA/Designee Admission Notification	Satisfactory
4.12	Healthcare Admission Rescreening	Satisfactory
4.13	Health Related History	Satisfactory
4.14	Comprehensive Physical Assessment	Satisfactory
4.15	Female-Specific Screening/Examination	Satisfactory
4.16	Tuberculosis Screening	Satisfactory
4.17	Sexually Transmitted Infection Screening	Satisfactory
4.18	HIV Testing	Satisfactory
4.19	Sick Call Process - Requests/Complaints	Satisfactory
4.20	Sick Call Process - Visits/Encounters	Satisfactory
4.21	Restricted Housing	Satisfactory
4.22	Episodic/First Aid Care	Satisfactory
4.23	Emergency Care	Satisfactory
4.24	Off-Site Care/Referrals	Satisfactory
4.25	Chronic Conditions/Periodic Evaluations	Satisfactory
4.26	Medication Management - Verification	Satisfactory
4.27	Medication Management - Orders/Prescriptions	Satisfactory
4.28	Medication Management - Storage	Satisfactory
4.29	Medication and Sharps Inventory	Satisfactory
4.30	Medication Management - Controlled Medications	Satisfactory
4.31	Medication Administration Record	Satisfactory
4.32	Medication Administration By Licensed Staff	Satisfactory
4.33	Medications Provided By Non-Licensed Staff	Satisfactory
4.34	Psychotropic Medication Monitoring	Satisfactory
4.35	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.36	Infection Control - Education	Satisfactory
4.37	Infection Control - Exposure Control Plan	Satisfactory
4.38	Prenatal Care - Physical Care of Pregnant Youth	Satisfactory
4.39	Prenatal Care - Nutrition and Education of Youth	Satisfactory
4.40	Prenatal Staff Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	* Active Supervision of Youth	Satisfactory
5.02	* Ten-Minute Checks	Satisfactory
5.03	Census Counts and Tracking	Satisfactory
5.04	Logbook Maintenance	Satisfactory
5.05	Logbook Reviews	Satisfactory
5.06	Key Control	Satisfactory
5.07	Vehicles and Maintenance	Satisfactory
5.08	Tool Inventory and Management	Satisfactory
5.09	Kitchen Tools	Satisfactory
5.10	* Youth Access & Use of Tools, Cleaning Items	Satisfactory
5.11	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.12	* Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.14	Confinement Under Twenty-Four Hours	Limited
5.15	Confinement Over Twenty-Four Hours	Limited
5.16	Continuity of Operations Planning (COOP) Drills	Satisfactory
5.17	Escape Drills	Satisfactory
5.18	Fire Drills	Satisfactory

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Strengths and Innovative Approaches

- During the month of June 2018, the center held the 2nd Annual Bridging the Gap and Employee Appreciation Event. During this event, the administration from the center and Circuit 18 Probation collaborated to provide a day of education, appreciation, recognition, and fun for staff.

- The center strives to provide youth opportunities to connect to their community through center events, including celebrating Mother's Day in May 2018 with a luncheon for the youth and their parents in which youth could present their mothers, or in some cases their fathers, with a handmade card and having the Mirror Image Choir come into the center and perform for center youth in June 2018.

- The center provided opportunities for youth who had earned their level three status, including helping serve their favorite volunteers at Volunteer Appreciation Day or enjoying a dinner and treats for Halloween with program administration.

- The center hosted a major clean-up and refresh of the center in which staff volunteered to paint many of the inside areas of the center, install a chair rail, put in new carpet and ceiling tiles in one of the classrooms, and beautify the outside area with new plants and landscaping.

Standard 1: Management Accountability

Overview

The Brevard Regional Juvenile Detention Center is a hard-ware secure, state-operated detention center located in Cocoa, Florida. The center houses both male and female youth who are pending adjudication, disposition, or placement in a residential commitment program. The center has a capacity to hold forty youth amongst three living units which are connected by a commons area known as the “sunshine room”. On the first day of the annual compliance review, the program had a census of seventeen youth. While at the center, the youth are provided education, medical, and mental health services. Education is provided by the Brevard County School Board. In January 2018, the medical and mental health services at the center were taken over through a contract with Maxim Health Services, Inc. The center provides intake and orientation, behavior management, food services, transportation, security, and safety and emergency procedures for youth.

The center employs a superintendent, two assistant superintendents, two secretary specialists, one administrative assistant, one nurse manager, seven supervisors, twenty-five juvenile detention officers (JJDO), two food services workers, and one maintenance mechanic. At the time of the annual compliance review, the center had fifteen vacancies, including two food service workers, five JJDO I’s, and eight JJDO II’s. The center hired eighteen new JJDOs during the annual compliance review period and each is required to complete the detention officer training academy. The center provides additional pre-service and in-service training to staff through instructor-led and online courses in the Department’s Learning Management System (SkillPro). The center intermittently utilizes a rolling lockdown schedule due to a high number of vacancies in the center, in order to provide the safety and security necessary for youth and staff.

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
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. The background screening process is completed prior to hiring an employee or utilizing the services of a volunteer, mentor, or intern. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The center has a written policy and procedures regarding the background screening of all new staff. The center hired nineteen new staff since the last annual compliance review, eighteen were detention center staff and one was a contracted medical staff. A completed and eligible background screening was found in the Background Screening Unit (BSU) system for each of the eighteen detention staff and in Clearinghouse for the one contracted medical staff. Each staff’s background screening was rated as eligible prior to the staff start date. No exemptions were needed for newly hired staff. The center did not utilize any new volunteers during the annual compliance review period. The center teachers are employed by the Brevard County School Board, which is responsible for the teacher background screenings. The Annual Affidavit of Compliance with Level 2 Screening Standards was found for both the detention center and the school board and was submitted to the BSU for each on January 17, 2018.

1.02 Five-Year Rescreening	Satisfactory Compliance
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.	

The center has a written policy and procedures regarding the rescreening of all staff every five years of employment. The center had three staff eligible for a five-year background rescreening. Two of the staff were detention center staff and each had a completed and eligible background rescreening completed within the required timeframe in the Background Screening Unit. A third staff, a contracted mental health staff began splitting time between this detention and another detention center a year after being hired by the other detention center. A completed and eligible background screening was found for this staff in Clearinghouse; however, the screening was done within the required timeframe for the other detention center as they hired the staff member first.

1.03 Staff Code of Conduct	Satisfactory Compliance
Program staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, "horseplay", or personal relationships with youth. *Officers shall maintain the confidentiality afforded to all youth, and shall not release any information to the general public or the news media about any youth in detention or who has been in the custody of the department.* *Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.* *Officers shall not engage in or allow horseplay, either verbal or physical with and/or between any youth.* *Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.* *Management takes immediate action to investigate or address all allegations or violations of the code of conduct.*	

The center has a written policy and procedures regarding the provision for an abuse free environment, as well as, an established code of conduct which all officers are required to acknowledge and comply with. A signed code of conduct was found for all center staff. An interview with the superintendent confirmed the code of conduct is in place to ensure staff act appropriately in their supervision of youth and the steps taken if a staff member is suspected of improper conduct. Five staff were reviewed for violations of the code of conduct and commendations. Two staff of the five staff were applicable for violations of code of conduct. One staff was given a written reprimand and one was suspended for one day. All violation documentation was maintained in the staff's employment record. Three of the five staff were applicable for commendations. One staff was awarded detention employee of the quarter, one was awarded center training coordinator of the year, and the third was given a certification of appreciation. All commendation documentation was maintained in the staff's employment record.

A review of the center's Central Communications Center (CCC) reports, incident reports, and youth records found no additional improper conduct outside of the documented violations of the code of conduct in employee records. Five staff were interviewed, and each described the process for youth who wish to call the CCC or Florida Abuse Hotline. The staff reported they call the supervisor, allow the youth to make the call, step away to allow them privacy, and talk to the operator after the call to obtain the incident number and operator information. Three of the five staff reported never hearing their co-workers using profanity, one said they had heard profanity once, and one reported hearing profanity occasionally. All five of the staff reported they had never heard a co-worker threaten, intimidate, or humiliate the youth. Three of the five staff reported the working conditions were good and two reported the conditions were very good and further explained the culture at the center was positive and they felt supported by center administration. Five youth were interviewed, and each reported they felt safe at the program and had never been hindered from contacting the Florida Abuse Hotline or CCC. Four of the five youth reported the staff are respectful when they talk to youth and the one youth reported they don't, said it was only one staff member but would not provide additional information. Two youth said the staff never use profanity, one said they hear profanity from staff occasionally, and two youth said staff use profanity often. Further, three youth reported never hearing staff threaten or intimidate a youth, one reported they heard it once, and one reported it happens often; however, both youth who reported having seen or experienced this refused to provide additional information.

1.04 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
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.	

The center has a written policy and procedures in place regarding contact the Central Communications Center (CCC) to report any reportable incidents which occur at the center. The center had twenty-two reportable CCC incidents in the last six months. The superintendent was interviewed and verified the reporting process of staff reporting to the CCC within two hours of the incident occurring. Five CCC reports were reviewed, four were medical incidents and one was a complaint against staff. Four of the five incidents were called into the CCC within the required two-hour timeframe. One CCC report, which occurred May 10, 2018, was discovered at 1:45pm and was not reported to the CCC until 5:37pm; however, the center provided documentation both the superintendent and the assistant superintendent were involved in the incident, which occurred off-site, and by the time they returned to the center after the situation was managed, the two-hour timeframe had passed. The center further provided documentation a counseling memorandum and retraining was provided to the superintendent and assistant superintendent regarding the reporting of CCC incidents.

1.05 Protective Action Response (PAR)	Limited Compliance
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.	

The center abides by the statewide detention protective action response (PAR) plan. The center had a PAR rate of 1.05 for the fourth quarter, which is lower than the statewide detention PAR

rate of 9.29 and remains steady from the previous annual compliance review. The center had six PAR incidents during the annual compliance review period and five were reviewed. Four of the five PAR reports had all narratives completed by the end of the employee's work day. One staff's narrative appeared to be a day late; however, the center reported the narrative was completed on time and it was edited the next day. All of the PAR reports included narratives from each identified party involved; however, one report identified a second staff member in the narrative of the PAR report as being involved, but this staff was not identified on the report as officially involved and did not submit a report. None of the PAR reports was applicable for mechanical restraints. Each of the PAR reports had reviews completed by the supervisor, PAR instructor, and superintendent or designee. Four of the five reports documented all of the reviews were completed within seventy-two hours. One of the PAR reports showed the PAR instructor review was done thirty-seven days late; however, this was the same staff member who also completed the superintendent/designee review and the center reported the PAR instructor review was not saved when completed on the day of the incident. Post-PAR interviews were found for three of the five PAR reports. The center reported the other two post-PAR interviews were completed; however, the PAR report in the juvenile justice information system (JJIS) does not document the interview occurred, nor could the center provide additional documentation related to the interview in the youth's individual healthcare record (IHCR) which accompanied the youth to their commitment programs; therefore, the post-PAR interviews were not able to be verified as occurring. For the three post-PAR interviews which were completed, each was done within thirty minutes with the youth and the results were maintained in the youth's IHCR. Four of the five post-PAR interviews indicated the youth did not need a Medical Review or for the Central Communications Center (CCC) or Florida Abuse Hotline to be called. One post-PAR interview documented in the Facility Management System (FMS) of JJIS reported a Medical Review was necessary; however, the post-PAR interview in the IHCR does not indicate this was necessary and the supervisor involved in the incident reported this was a documentation error in JJIS.

A review of CCC reports, incident reports, and youth records found two CCC reports in which PARs were discussed but were not reported in JJIS. For one CCC incident, the center discussed the incident was not a PAR as it occurred in a center van which inhibits the ability of the staff to utilize PAR. For the other CCC the center reported after viewing the video footage of the incident, PAR was not utilized; however, the CCC was not contacted to edit either report. PAR monthly reports are generated and shared through JJIS and SharePoint. Five staff were interviewed and each reported staff encourage communication and try to talk with youth prior to engaging in PAR, which they reported using only as a last resort. An interview with the superintendent revealed it is a daily routine for the administration to check the FMS system and follow-up on any PAR incidents, as well as review logbooks and video daily to ensure all incidents are appropriate handled and reported.

1.06 Pre-Service/Certification Requirements (Critical)	**Satisfactory Compliance**
Detention staff are trained in accordance with Florida Administrative Code. Detention staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.	

The center trains all staff in accordance with the Florida Administrative Code and follows the statewide pre-service/certification plan for new detention employees. Five staff were reviewed for pre-service training/certification. Each staff completed all phase one and phase two training, including Protective Action Response (PAR), cardio pulmonary resuscitation (CPR)/first

aid/automated external defibrillator (AED) certification training, mental health and substance abuse, suicide prevention, Prison Rape Elimination Act (PREA), human trafficking, and the Department's Detention Center Facility Operations training which were all completed prior to contact with youth. Additionally, each staff completed the detention officer academy and was certified within 180-days of hire. All training was entered in the Department's Learning Management System (SkillPro).

1.07 In-Service Training	Satisfactory Compliance
All detention staff completes twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training. *Supervisory staff completes eight hours of training (as part of the twenty-four hours of in-service training) in the areas specified in Florida Administrative Code.*	

The center follows the statewide detention training plan for in-service staff and maintains a training calendar which is updated as changes occur. The superintendent was interviewed and verified the staff complete a mixture of face-to-face and online trainings as outlined on the center's training calendar. Five staff were reviewed for in-service training and each had well over the required twenty-four hours of training in the calendar year 2017. Each staff had documentation of completing a Protective Action Response (PAR) update, cardio pulmonary resuscitation/first aid/automated external defibrillator training and certification, suicide prevention training, and professionalism and ethics training. Two of the reviewed staff are supervisory staff. One staff completed eighteen hours of supervisory training in the areas of management, leadership, employee relations, communication skills and fiscal. The other staff completed eight hours of supervisory training in management, leadership, communication skills, and fiscal. All training was entered in the Department's Learning Management System (SkillPro).

1.08 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance
Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately. *Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the facility immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to that critical alert.*	

The center has a written policy and procedures in place regarding the sharing of alert information. Five staff were interviewed, and each verified the process for sharing alert information, which occurs during shift briefing, and reported it as an effective way to communicate alerts. The process was observed during the annual compliance review and the shift supervisor went through each alert with the staff and provided the on-duty staff with a copy of the alert list to carry on them during their shift. Shift reports for five randomly selected days further verified this process. Alerts are also appropriately placed in the logbook. Five youth alerts were reviewed, and each had their alert entered and downgraded by the appropriate person in the correct timeframe. The center's alerts are entered, updated, and downgraded by the corresponding administrative staff on an ongoing basis. All medical alerts are entered by medical staff, all mental health alerts are entered by the center's licensed clinicians, and all safety and security alerts are entered by program administration. Client management, medical, and safety and security alerts were reviewed, and all were appropriately documented. Two of the four alerts reviewed for mental health were appropriately documented, one suicide alert was closed while the youth was still on close supervision, and the other alert was entered late.

Standard 2: Assessment and Performance Plan

Overview

All youth admitted to the Brevard Regional Juvenile Detention Center (BRJDC) are screened by Juvenile Services Program, Inc. staff. It is the responsibility of the detention officer to conduct the search of the youth and secure the youth's personal property when the youth enters the facility. The detention center will take custody of the youth, at the direction of the detention screener. Once the detention center has custody of the youth, the juvenile justice detention officer (JJDO) conducts the admission, which consists of reviewing the intake documentation from the detention screener, completing the classification documentation in the Juvenile Justice Information System (JJIS), conducting orientation with the youth, reviewing the Prison Rape Elimination Act (PREA) video, and gathering the youth's personal property. The intake staff initiates the classification process for each youth, which includes gang classification. Personal property is stored in a secure location within the facility. The daily activity schedule includes access to education classes and groups. The behavior management system (BMS) is a level system where the youth can earn additional privileges by meeting center expectations. Educational and vocational services are provided by the Brevard County School District.

2.01 Admission	Satisfactory Compliance

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

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

Any youth identified as at risk of suicide shall be placed on Precautionary Observation until evaluated by the licensed mental health provider.

The center has facility operating procedures regarding the admission process for youth entering the center. Five youth records were reviewed and there was documentation the staff reviewed the arrest affidavit/custody order, detention risk assessment instrument (DRAI), and suicide risk screening instrument (SRSI) for each youth upon admission. In addition, the staff reviewed inactive (if applicable) and active records available regarding each youth. During admissions, the staff conduct a youth frisk strip, and/or electronic search, provide youth with a telephone call, provide youth with a meal, and complete medical, mental health and substance screenings. The review and completion of each admission requirement is listed on a booking checklist with staff signatures confirming the completion of each. In addition, each form had the staff signatures indicating completion or review. One admission was observed during the annual

compliance review. During the admission, the staff and youth reviewed required documentation and the youth was provided a meal and telephone call. The youth was searched prior to the review team's observation. The youth reported going through the process several times and is familiar with the steps of admission and reported the process as okay.

2.02 Orientation	Satisfactory Compliance
Program orientation process shall occur within twenty-four hours of a youth being admitted into detention and documented according to Facility Operating Procedures. During the orientation process, youth must be advised, both verbally and in writing, at a minimum, the following: 1. *Facility rules and regulations;* 2. *Grievance procedures;* 3. *Visitation;* 4. *Telephone calls;* 5. *Available medical, mental health and substance abuse services and how to access them;* 6. *How to access the Florida Abuse Hotline;* 7. *Expectations for behavior and related consequences;* 8. *Possible new law violations for destruction of property; and* 9. *Youth rights.*	

The center has facility operating procedures regarding the orientation process for youth. Five youth records were reviewed for completion of orientation and each of the five youth completed orientation within twenty-four hours of admission. The staff provided the orientation process both verbally and in writing. Each youth signed forms acknowledging the staff reviewed the rules/regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, substance abuse services, Florida Abuse Hotline/Central Communications Center reporting, behavior expectations/consequences, and possible new law violations for destruction of property. One orientation was observed during the annual compliance review in which the staff and youth reviewed all required elements. During the orientation, the youth watched a video on the expectations of being in the center. Each of the five youth interviewed reported the staff provided information on the center rules/regulations, daily schedule, education services, visitation, abuse reporting and the behavior management system upon admission.

2.03 Classification	Satisfactory Compliance

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

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

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

The center has facility operating procedures regarding the classification process. Five youth records were reviewed, and each record had documentation the staff reviewed all documentation. When the staff reviewed the documentation, the youth's sex, height, weight, age/level of aggressiveness, special needs, vulnerability to victimization and sexually aggressive behavior (VSAB), and security risk were taken into consideration before each youth was assigned to a room. All information was located on the Admission Wizard in the Juvenile Justice Information System (JJIS). Each of the five youth records documented youth were assigned to a room based on the classification information. None of the five youth were applicable for requiring alerts to be placed in JJIS.

2.04 Classification of Gang Members	Satisfactory Compliance

All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang.

Each facility shall identify a staff person to serve as a gang representative who shall review identified youth for suspected gang involvement or gang activity.

The center has facility operating procedures regarding classification of youth who have been identified as gang members. A review of open alerts was conducted and found the center does not currently have any youth classified as gang members in the center. Further, the superintendent reported no youth have been admitted and classified as gang members during the annual compliance review period. The superintendent is the assigned gang liaison for the center. The superintendent is informed of how to identify and address local gangs by working with the center's gang representatives (assigned juvenile probation officer) and local agencies. Staff are updated during staff meetings regarding the alert system, so youth can be appropriately classified during admission and closely supervised while in the facility in the event a youth is admitted who is classified as a gang member.

2.05 Notification of Juvenile Probation Officer Circuit Gang Representative	Satisfactory Compliance
Each center shall identify the Juvenile Probation Officer designated as the Circuit Gang Representative to communicate suspected gang activity. *A referral on a youth for suspected gang involvement shall be shared, via email, with the Juvenile Probation Officer designated as the Circuit Gang Representative indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.* *Detention staff should include in the email all pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."*	

The center has facility operating procedures regarding notification of law enforcement of youth admitted to the center who are affiliated with gangs. The center has not had any youth applicable for notification of law enforcement regarding gang involvement during the annual compliance review period. The center has a process in place should a youth be identified as gang involved at the center, in which the superintendent e-mails the juvenile probation officer (JPO) and the JPO's supervisor regarding any indication of gang activity. The probation gang representative then forwards any gang-related information (pictures, tattoos, drawings) to the local law enforcement agency.

2.06 Admission of Youth Personal Property	Satisfactory Compliance
The program takes possession of each youth's personal property during admission. In the presence of each youth, staff inventories all personal property in the youth's possession and records each surrendered item on the Property Receipt Form.	

The center has facility operating procedures regarding the process of handling youth property upon admission. Five youth were reviewed, and each youth record had documentation their personal property was inventoried by staff upon admission. Both personal and valuable property are documented on the same receipt form. Four of the five personal property receipt forms included the youth's signature. One of the five was missing the youth's signature; however, the youth did not refuse to sign, and the program concurred the signature was missing. All five youth personal property receipt forms included the staff signature and a list of all property the youth was admitted with. Each youth signed an acknowledgement regarding unclaimed property. Each youth personal property was assigned to a locker in which a copy of the receipt is placed inside, on the outside of the locker, and in the youth record. One of the five youth was admitted with valuable items and two additional examples were provided for review. All three valuable inventoried items were placed in a clear tamper proof bag, which included all required youth information. The valuable property inventory and property was placed in the drop safe for each youth, which is located in intake. The drop safe is under twenty-four-hour video surveillance. All information regarding the valuable property is logged in the drop safe logbook. One admission was observed during the review. During the admission, it was observed the youth signed the property inventory after reviewing the listed items for accuracy. The youth and staff placed the youth's property in the assigned locker with a copy of the receipt placed inside with the property and on the outside of the locker. Five youth were interviewed, and each reported the staff checked their personal property and had them sign the form advising the information was correct upon admission. An interview with the superintendent verified the youth's inventory is completed upon admission, and the personal property is stored in a locked

room in the intake area. Supervisory staff have access to the personal property room and only select staff have access to the valuable property drop safe.

2.07 Storage of Youth Personal Property	Satisfactory Compliance
The program safeguards each youth's personal property until it can be returned to the youth and/or legal guardian.	

During the annual compliance review, it was observed the youth personal property is located in the intake area of the center. Five youth inventories were reviewed and each of the youth's inventory forms were located inside and outside of each locker. Each locker has a pad lock and the lockers are located in a secure room with key access. Only the supervisory staff have access to the personal property. The center maintains a drop safe which contains the youth's valuable items and is kept under twenty-four-hour surveillance. Only the superintendent, assistant superintendent and the administrative assistant have access to the valuable property drop safe. Three youth were reviewed for valuable items and each youth's valuable property was logged in the safe logbook located next to the safe. The clear tamper proof property bags were used for each youth. The center did not have any Central Communications Center (CCC) reports regarding incidents related to youth property. One admission was observed during the review. It was observed the youth and staff placed the youth's property in an assigned locker with a copy of the receipt inside with property and on the outside of the locker.

2.08 Release	Satisfactory Compliance
When releasing youth from detention, the releasing officer shall verify the court's authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth. *All releases from the program are court-ordered, with the exception of deaths, escapes, and expirations of detention time period. In the absence of a written order, documentation of a verbal order in open court may be used for release.* *The on-duty JJDO Supervisor reviews all paperwork prior to release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.* *Questions concerning release are presented and addressed by the Superintendent, or designee, prior to release.* *The releasing officer shall verify the identification of the youth.*	

The center has facility operating procedures regarding the release of youth from the center. Three closed records were reviewed, and each record had documentation the supervisor reviewed all paperwork prior to each youth's release. The supervisor reviewed court orders, verified youth identification, and parent/guardian identification before release. Each youth changed into their own clothes upon their release. All three records contained a copy of the identification document of the person the youth was being released to. The supervisor provided the youth and parent/guardian of pending court dates. The staff ensures the youth and parent/guardian signed all paperwork before the youth was released from the center. A review of the Juvenile Justice Information System (JJIS) and each youth record confirmed the release dates matched. A review of the last six months of Central Communications Center (CCC)

reports was conducted and found the center did not have any CCC reports regarding unauthorized releases during the annual compliance review period. The superintendent verified the release process as including supervisory staff verify court orders, verify youth to be released, verify the person the youth is to be released to, and completion of required paperwork. A release was not able to be observed during the annual compliance review.

2.09 Release of Youth Personal Property	Satisfactory Compliance
Upon the youth's release from detention and retrieval of personal property, the releasing officer, the youth, and the youth's parent or legal guardian shall review and sign the Property Receipt Form and account for all of the youth's personal property.	

The center has facility operating procedures regarding the process of the release of youth property. Three closed records were reviewed, and all three records had documentation the youth and the parent/guardian signed the property receipt at the time of release. A review of three additional examples in regard to property held for more than thirty days after release was conducted. The center maintained copies of the letter mailed to each family in which the center notified the family the youth's property required pick-up. An interview with the superintendent verified any property not picked up within thirty days after the youth's release is considered contraband. A registered notice of impending disposal of property is sent to the youth's last known address. After thirty days the property is donated to North Brevard Charities and cash left at the center after thirty days is obtained and sent to the Central Regional Office. A release was not able to be observed during the annual compliance review.

2.10 Release of Medication, Aftercare Instructions	Satisfactory Compliance
The program ensures there are provisions in place to ensure prescribed medication, along with medical instructions, accompanies detained youth upon release.	

The center has facility operating procedures regarding the process of release of medication. Three closed youth records were reviewed, and each record had documentation the person the youth was released to was verified through photo identification. Each youth was taking medication while in the program and was released with the medication. The medication release form for each youth listed all medication being released and was signed by the youth, the parent/guardian, and the facility staff signed the medication receipt, transfer, and disposition form.

2.11 Review of Youth in Secure and Home Detention	Satisfactory Compliance
Detention reviews are conducted by the program on a weekly basis to ensure proper management of youth placed in secure detention and appropriate sharing of information. The superintendent appoints an appropriate staff person to coordinate detention reviews.	

The center has secure and home detention audits (reviews) every Thursday morning. During the audits the detention administration, representatives from probation, mental health staff, medical staff, and community-based providers attend and share information. The attendees review each youth regarding court dates, releases, medical and mental health concerns, and behavior in detention. Each attendee reviews the Juvenile Justice Information System (JJIS) list of youth in secure and home detention. All information discussed at the meetings is recorded and maintained by the administrative assistant who enters the information into JJIS as evidenced by meeting minutes from the last six months. An observation of a home detention

and secure detention audit/review was conducted during the review. The review included all parties such as detention, probation, medical, and mental health staff, as well as education staff and community-based providers. During the meeting, each youth review was audited for court dates/orders, behavior issues, and medication compliance. An interview with the superintendent confirmed the weekly detention audits take place at the center on Thursdays in the conference room. Discussions involve the status of youth regarding confinements, medical issues, mental health issues, family involvement, court status, gang activity, release dates, commitment status, probation status, release status and Department of Children of Families (DCF) involvement and concerns.

2.12 Daily Activity Schedule	Satisfactory Compliance
Youth are provided the opportunity to participate in constructive activities that will benefit the youth and the program. The Superintendent or Designee develops a daily activity schedule, which is posted in each living area and outlines the days and times for each youth activity.	

The center has a daily schedule for the weekdays and weekends. Each schedule includes times for personal hygiene, meals, visitation, education, recreation, groups (gender specific, restorative justice, life and social skills), and indoor activities. The daily schedule was located throughout the center and observed during the annual compliance review center tour. The center provided gender-specific and restorative justice groups as documented in logbooks. All groups were documented in the facility management system (FMS). A curriculum was provided regarding the center's restorative justice groups. The center did not have a specific curriculum regarding gender-specific programming; however, gender-specific groups with appropriate topics were entered into the FMS and interviews with staff further explained additional opportunities for gender-specific programming provided. Five youth and five staff were interviewed, and each reported the facility has a daily activity schedule. Four of the five staff reported the center offers gender-specific programming and one reported the center does not offer gender-specific programming as the genders are treated the same.

2.13 Adherence to Daily Schedule	Satisfactory Compliance
Facility staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs. *The on-duty supervisor must approve any significant changes in the activity schedule and shall document the reason for the change(s) in the shift report.* *Any cancellation of visitation shall be approved by the superintendent.*	

During the annual compliance review, observations of the daily schedule activities were conducted on two separate days and it was found the center was following the posted activity schedule. The master control and dorm logbooks were reviewed for adherence to the daily schedule and verified the schedule is followed as posted. There was documentation in the shift reports and logbook anytime a change in the schedule was made. The staff also documented in the logbooks if the youth refused recreation. The entries for each activity were found in the logbooks. Five youth and five staff were interviewed, and each reported the schedule was being followed.

2.14 Educational Access	Satisfactory Compliance
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.	

The center has facility operating procedures regarding education provided to the youth. The Brevard County School Board provides education instruction at the center. The center provides twenty-five hours a week of instruction to the youth with minimal interruption or scheduled days without school. Youth have the opportunity to earn credits while they are at the facility through a variety of educational programs and formats including in-person instruction, Colorado Virtual School, and post-secondary educational opportunities. The activity schedule and logbooks were reviewed and confirmed the academic schedule is followed. During an interview with the lead teacher, it was reported the youth are in the classroom daily and on time and are provided opportunities to earn credit. It was further reported there have not been any interruptions to the youth education. Five youth were interviewed, and each reported the center offers educational classes including reading, social studies, science, and math, and the youth attend school Monday through Friday while in the center.

2.15 Career Education	Satisfactory Compliance
Staff shall develop and implement a career education competency development program.	

The center has defined career education programming which is appropriate based upon the youth's age, assessed educational abilities, goals of the youth, length of stay, and custody characteristics at the center. This is achieved by the completion of an on-line assessment tool called, Florida Shines. The center utilizes Type 1 career and life skills programming. The career educational programming includes instruction for youth on communication, interpersonal and decision-making skills.

2.16 Behavior Management System	Satisfactory Compliance
The program provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program's expectations. *Each facility shall implement and maintain a behavior management system to meet the needs of the youth and the facility. The system shall be approved by the regional director and shall include rewards for positive behavior and consequences for inappropriate behavior.* *The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.*	

The center has facility operating procedures which details the implementation of the behavior management system (BMS). The center's BMS is a three-tier system, ranging from level one to level three and includes rewards for positive behavior and consequences for negative behavior, and/or infractions. Each youth is oriented to the center's BMS during their admission to the center. The BMS expectations and rule were observed to be posted throughout the center for youth to review. The center provided documentation of staff giving rewards, such as canteen, and giving consequences according to the BMS. Five youth were interviewed and two rated the BMS as fair, two rated the BMS as good, and one rated the BMS as very good. Four of the five youth reported consequences were fair and one reported the consequences were not fair. The

superintendent confirmed the center uses the level system for their BMS. Five staff were interviewed, and each reported they believe the BMS is effective. All staff reported staff speak with youth to discuss the consequences being imposed, youth are able to explain their behavior, and staff discuss alternative behaviors with youth. Each of the five staff reported a youth's level can be taken as a consequence, and additionally one staff reported school can be taken away but only due to being on confinement. All five staff reported receiving feedback about on the implementation of the BMS on an as needed basis by their supervisor.

2.17 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance
The center's behavior management system restricts certain types of penalties on youth who demonstrate negative behaviors. *Group punishment shall not be used as a part of the facility's behavior management plan. However, corrective action taken with a group of youth is appropriate when the behavior of a group jeopardizes safety or security, and this should not be confused with group punishment.* *Corporal punishment shall not be used in detention facilities. All allegations of corporal punishment of any youth by facility staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center.* *The use of drugs to control the behavior of youth is prohibited. This does not preclude the proper administration of medication as prescribed by a licensed physician.*	

The use of group punishment and corporal punishment is prohibited according to the center's behavior management system (BMS) and facility operating procedures. All allegations of corporal punishment of any youth by center staff shall be reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). The center's BMS further restricts certain types of penalties on youth who demonstrate negative behaviors, including the use of drugs to control behavior; which does not include prescribed medications. Five staff were interviewed, and four reported meals, snacks, sleep or school are not taken away as a consequence, one reported school is taken because of confinement placement. Four staff reported never seeing a coworker take meals, snacks, clothing, education or medical care from youth because of negative behavior. Five youth were interviewed, and each youth reported levels are taken away as a consequence, one youth reported points are taken as a consequence, and three youth reported clothing/bedding can be taken away but only due to confinement or suicide precautions. All youth reported youth are never allowed to punish other youth. Four youth reported being sent to their room for punishment and having the door shut and locked; one reported they had never been sent to their room for punishment. Each youth reported staff do not use handcuffs or leg irons when youth are out of control to prevent them from hurting themselves or others.

2.18 Grievances	Satisfactory Compliance

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

1. *Informal phase, wherein the JJDO attempts to resolve the complaint or condition with the youth using effective communication skills;*
2. *Formal phase, wherein the youth submits a written grievance resulting in a response from a JJDO Supervisor by the end of the shift (if possible), or otherwise within twenty-four hours; and*
3. *Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.*

The center has facility operating procedures regarding the grievance process. Grievance forms, which are easily assessible to youth, were found stocked on each of the dorms. The center did not have any grievances during the annual compliance review period which was confirmed in the Facility Management System (FMS). An interview with the superintendent verified grievances are written by the youth on the grievance form and then entered into the Facility Management System (FMS) by staff and progresses from the informal stage through the formal phase and reviewed by administration, if needed. Five youth were interviewed and none of the youth reported filing a grievance while in the center. All five staff interviewed were able to explain the grievance process.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has facility operating procedures regarding trauma-informed care. Five pre-service and five in-service staff training records were reviewed, and each had documentation of training in trauma informed care. During the center tour, postings of different agencies who provide counseling to address both women and men needs was observed. The program is currently being repainted with soft colors. The superintendent verified the center promotes trauma informed care through training and staff response to the youth.

Standard 3: Mental Health and Substance Abuse Services

Overview

The center contracts with Maxim Health Services, Inc., who subcontracts with Camelot Community Care, Inc. to provide mental health and substance abuse services to the youth. There is a licensed mental health counselor (LMHC) who is assigned as the center's designated mental health clinician authority (DMHCA). The DMHCA is on-site at least forty hours a week, including four weekend hours, and is on-call twenty-four hours a day, seven days a week. The mental health provider also provides a licensed clinical social worker (LCSW) working about ten hours a week at the center. The clinical staff have office space in the secure area of the center. The mental health provider contracts with a licensed psychiatrist to provide psychiatric services for applicable youth. The psychiatrist is on-site on a weekly basis for a minimum of two hours to conduct initial diagnostic psychiatric interviews, psychiatric evaluations, and to provide medication management for applicable youth. The DMHCA communicates regularly with clinical staff, as well as the detention staff, to provide the appropriate mental health services to the youth.

3.01 Designated Mental Health Clinician Authority (DMHCA) [Contract Provider]	**Satisfactory Compliance**
A Designated Mental Health Clinician Authority (DMHCA) is required in each detention center. The DMHCA is responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services in the facility and shall promote consistent and effective services and allow the facility superintendent and staff a specific source of expertise and referral.	

The center has a written policy and procedures regarding the designated mental health clinician authority (DMHCA). The DMHCA is a licensed mental health counselor, with a clear and active license in the State of Florida; issued March 14, 2017 and expiring March 31, 2019. The DMHCA position is provided through a contract with Maxim Health Services, Inc. The DMHCA is on-site at least forty hours a week, including four weekend hours, and is on-call twenty-four hours a day, seven days a week. The job description for the DMHCA was reviewed and outlined the DMHCA shall develop and maintain a positive relationship with other entities working in the center, as well as the juvenile probation officers and the court, facilitate and attend treatment team meetings, screen and assess youth for possible suicidal ideations, implement strength evidenced based perspective with evidenced based theories, such as cognitive behavioral therapy and other appropriate substance abuse treatment services. The DMHCA was interviewed and reported she is responsible for the coordination and implementation of all the mental health and substance abuse services in the facility, as well as ensuring the other licensed mental health professionals implementing services as directed.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider] (Critical)	Satisfactory Compliance
The facility superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The center has a written policy and procedures regarding the licensed mental health clinical staff. The center contracts with a provider, Maxim Health Services, Inc., to deliver mental health services for the youth. In addition to the designated mental health clinician authority (DMHCA), the provider has a licensed clinical social worker (LCSW) working about ten hours a week at the center. The license of the LCSW is active and clear in the State of Florida; issued on March 16, 2017 and expiring March 31, 2019. The center also contracts with a licensed psychiatrist to provide services to applicable youth. The psychiatrist's license is also active and clear in the State of Florida and she is board certified in psychiatry.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider]	Satisfactory Compliance
The facility superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The center has a written policy and procedures regarding the non-licensed mental health and substance abuse clinical staff. The program does not currently employ any non-licensed mental health and substance abuse clinical staff and did not utilize any non-licensed staff during the annual compliance review period.

3.04 Mental Health and Substance Abuse Admission Screening [Detention Staff/Contract Provider]	Satisfactory Compliance
The mental health and substance 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. *Detention center superintendent has established procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Intervention.*	

The center has a written policy and procedures regarding the provision of mental health and substance abuse admission screenings, which was approved by the facility superintendent and designated mental health clinician authority (DMHCA) on July 19, 2017 and reviewed again on July 19, 2018. The policy includes a review of the youth's Positive Achievement Change Tool (PACT) Mental Health and Substance Abuse Report and Referral form, Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), the face sheet, and the Suicide Risk Screening Instrument (SRSI). A SRSI is completed by a detention officer and completed by the designated nursing or mental health clinical staff. A standardized process for referral of youth identified as in need of an Assessment of Suicide Risk (ASR) or further mental health and/or substance abuse evaluation to the detention mental health provider is included in the policy. If there is documentation for further assessment for suicide, a referral is automatically generated in the Department's Juvenile Justice Information System (JJIS).

Five mental health records were reviewed. In three of five records reviewed a MAYSI-2, SRSI and PACT screening were completed during the admission process. The two remaining youth had been moved between centers due to court hearings and had been readmitted; therefore, the youth were not-applicable for an admission screening; however, the SRSI was still done for both youth. In one of the remaining two, the SRSI was completed during the readmission process. In the other record, the SRSI was completed one day after readmission. In all five records, the nursing and/or mental health staff completed the required sections in the SRSI; the entries included the summary and recommendations in the screening results. Each of the SRSIs were completed in JJIS. Three of the five youth screened were identified as at-risk for suicide and were placed on precautionary observation (PO) until an ASR could be completed. Two of the youth were identified at-risk due to results from the MAYSI-2 and contained a mental health referral. In the remaining one, the youth had been transferred from another center after court, not requiring the admission process to be completed; however, the staff knew the youth was usually placed on precautionary observation when entering the center and automatically placed him on PO and generated a referral to mental health. Once the mental health staff received the referral it was noticed the youth did not receive any screening prior to being placed on PO and the screening process was then initiated, one day after the admission. All screening was completed by trained staff. There was documentation to support the detention and clinical staff reviewed all instruments.

3.05 Mental Health and Substance Abuse Evaluation [Detention Staff/Contract Provider]	**Satisfactory Compliance**
The Probation and JAC intake/detention screening process ensures youth identified through preliminary screening as having mental health and substance abuse issues or problems receive in-depth mental health and/or substance abuse assessment shortly after intake to the juvenile justice system.	

The center has a written policy and procedures to address the provision of mental health and substance abuse evaluations. The policy requires youth who are identified as in need of further mental health assessment to be referred to a community provider. Five open and two closed mental health records were reviewed; none were referred to the center provider during the admission process. Five additional records were provided to the review team to demonstrate practice on mental health and substance abuse evaluations. One youth received a comprehensive evaluation conducted by the center provider, while the youth was at the center, due to a youth self-referral for services. Four youth were referred to a community provider during the screening process. One youth's evaluation had not been received at the time of the review as the due date was upcoming. The three other evaluations had been received and were reviewed by the center mental health staff prior to the thirty-one-day deadline.

3.06 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance

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

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

The center has a written policy and procedures to address the provision of mental health and substance abuse treatment. The policy requires youth in need of treatment to be assigned to a mini-treatment team, and when receiving mental health and/or substance abuse treatment in the center must have an initial or individualized mental health, substance abuse, or integrated mental health and substance abuse treatment plan. Five open and two closed mental health records were reviewed. Three of the youth were applicable for treatment and were assigned to a mini-treatment team. The mini-treatment team consisted of the mental health clinical staff, the youth, one staff from a different service area, the psychiatrist and where possible, the parent/guardian. For each youth an Authorization for Evaluation and Treatment (AET) and when needed, a consent for substance abuse treatment, were found in the youth records. Additionally, each youth had an initial and individual treatment plan within the required timeframe. Two of the three youth received individual counseling sessions and substance abuse treatment as prescribed on their treatment plan; the other youth did not, due to being released from the center before treatment could start. All treatment notes were documented on the Department's Mental Health/Substance Abuse (Form 018). The center provided documentation for two dates when a group was held during the annual compliance review period. On both dates the group did not contain more than five youth. The designated mental health clinician authority (DMHCA) stated they very rarely conduct groups and mainly focus on providing individual sessions to the youth in need. Five youth were interviewed and four considered the mental health and substance abuse services they were receiving at the center as very good or good, the remaining one youth rated them as poor. The DMHCA was interviewed and indicated individual counseling, family counseling (if requested), group counseling (if available), development of treatment plans, comprehensive assessments, and assessment of suicide risk are clinical services provided at the center.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance

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

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

The center has a written policy and procedures to address the provision of mental health and substance abuse treatment and discharge planning. Five open and four closed mental health records were reviewed. Four of the nine youth required mental health treatment. The center

completed an initial treatment plan for each applicable youth within seven days of the initiation of treatment. Each initial treatment plan included all required topics, including reason for referral for treatment, initial Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnosis, initial treatment methods, initial treatment goals, psychiatric medication, and applicable monitoring. The plan was developed on the Department's Initial Mental Health/Substance Abuse Treatment Plan (Form 015).. Three of the four plans were signed by the youth, a member of the youth's mini-treatment team, and a mental health/substance abuse professional. The center staff was only able to provide a copy of the fourth plan without signatures, due to the original plan having been sent with the youth to their commitment program. Three youth required individualized treatment plans. Each individualized treatment plan contained all required elements, including diagnosis, treatment focused symptoms, treatment goals, the youth's strengths, abilities and needs, and when required, psychiatric services, including medication and monitoring, and pharmacological interventions. Each individualized treatment plan was completed within thirty days of the youth's admission to the center and signed by a licensed clinician within ten days of completion. One plan was signed by the youth, and treatment team members. The center provided a copy of the other two plans without signatures, due to the original plan having been send with the youth to their commitment programs. There were progress notes in two of the three applicable records to document the youth received treatment services as prescribed by the individualized treatment plan. The third youth had been moved prior to receiving treatment services. One youth had been in the center long enough to require two individual treatment plan reviews. Each individual treatment plan review was completed within thirty days of the completion of the youth's individualized treatment plan and required modifications. The program provided copies of the individual treatment plan review documents without signatures due to the originals having been sent with the youth to their commitment program. The other youth received services but was not at the center long enough to require a treatment plan review.

The closed mental health records for three youth who received mental health services were reviewed. All had a mental health/substance abuse treatment discharge summary completed on form MH/SA 011. Two of the discharge summaries included documentation the youth, parent and juvenile probation officer (JPO) received a copy. The third discharge summary was a copy since all the original paperwork was sent with the youth to their commitment program; therefore, it could not be determined if the youth, the JPO and the parent/guardian received a copy. The center's common practice is to forward all original documentation to the youth's commitment program, when applicable.

3.08 Psychiatric Services [Contract Provider] (Critical)	**Satisfactory Compliance**
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.	

The center has a written policy and procedures to address the provision of psychiatric services for applicable youth. Mental health services are provided through a contract with a community provider; this contract includes the services of a psychiatrist. The psychiatrist's license is clear and active and holds certification from the American Board of Psychiatry. The contract requires the psychiatrist to visit the center on a weekly basis for a minimum of two hours. The center does not utilize the services of a psychiatric advanced registered nurse practitioner. Seven mental health records were reviewed. Three youth entered the center taking psychotropic medications. The medications for all three youth were continued by the psychiatrist and the

records contained an Authorization for Evaluation and Treatment (AET). The center's common practice is for the psychiatrist to complete an initial psychiatric interview and evaluation together. The psychiatrist completed an initial psychiatric interview and evaluation for all three youth; the evaluation was completed on the Clinical Psychotropic Progress Note (CPPN) within fourteen days of admission. All included all three pages of the CPPN. Each interview and evaluation included the identifying data, allergies, referral reason, mental status exam, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnosis, mental health and substance abuse history, medications and responses, past therapy, family psychiatric history, medical problems/surgeries, personal history, treatment planning and recommendations, prescribed medication, explanation of the need for psychotropic medication, and the frequency of medication management, side effects, the youth's adherence to medication, and telephonic contact with the youth's parent/guardian. The CPPN was signed by the psychiatrist. None of the youth were applicable for a new psychotropic medication prescription and the center had no youth being prescribed a new psychotropic medication during the annual compliance review period.

3.09 Suicide Prevention Plan [Detention Staff] (Critical)	**Satisfactory Compliance**
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 Rule 63N-1, Florida Administrative Code.	

The center has a written suicide prevention plan, which was approved by the designated mental health clinician authority (DMHCA) and superintendent on April 19, 2018 and reviewed by both on July 19, 2018. The plan includes all required elements, such as identification and assessment of youth at-risk of suicide, referral, communication, immediate staff response, notification, levels of supervision, suicide precautions, staff training, documentation and review process.

3.10 Suicide Prevention Services [Detention Staff/Contract Provider] (Critical)	**Satisfactory Compliance**
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings as having suicide risk factors or identified through assessment as a potential suicide risk. *Any youth exhibiting suicide risk behaviors must be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.* *All youths identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations must be placed on Suicide Precautions and receive an assessment of suicide risk.*	

The center has a written suicide prevention plan, which outlines the process for screening, supervising, monitoring, and housing of youth at risk for potential suicide risk. Youth exhibiting suicide risk are placed on precautionary or secure observation. The center's facility operating policy includes the established process for every serious suicide attempt of self-inflicted injury and a mortality review for completed suicide which includes all required elements. Five open and one closed mental health records were reviewed. Four of the youth required an Assessment of Suicide Risk (ASR), based on results of the Suicide Risk Screening Instrument (SRSI); three SRSI were conducted during admission, one was one day late. In all four instances, the youth was immediately placed on Precautionary Observation (PO) and a Juvenile

Justice Information System (JJIS) alert was initiated upon completion of the SRSI and identification of the youth as at-risk of suicide. In three records the alert was closed when the youth was stepped down to standard supervision; in the remaining one record the youth was placed on close supervision prior to being stepped down to standard supervision and the JJIS alert was closed while the youth was still on close supervision. In three of the records a referral for an ASR was conducted at the time of admission; the fourth did not have a referral. All four youth received an ASR within twenty-four hours of being identified at-risk of suicide, conducted by a licensed mental health professional, and the required Department form was utilized. Upon the completion of the ASR, three youth were placed on standard supervision and one on close supervision before being stepped down to standard supervision. There were PO logs completed for the time each youth was placed on constant supervision, including the safe housing area. The youth were permitted to participate in select activities in the designated areas, such as the dining hall, and classroom. One youth was placed on close supervision. The close supervision log documentation was completed for a span of three days and had seven instances where one five-minute close supervision check was not completed and one instance for a span of four and a half hours no checks were completed; no in or out was documented on the log. The staff indicated at those times the youth had been removed from the room and was completing another activity while consistently being supervised. The center provided documentation for the four and a half hour missed checks; the youth had been located in the sunshine room under constant supervision. In the four applicable youth records the center documented the administrative/supervisory staff providing instructions related to the suicide risk assessment findings/suicide precaution decisions on each ASR, not in the logbook. For each instance of PO, there was documentation in either the master control logbook or the unit logbook indicating the youth was placed on and released from precautionary observation, as well as close supervision. The center had no examples to provide concerning youth on PO being placed in secure observation.

Five staff were interviewed, and each indicated, after being questioned on what to do if a youth would express suicidal thoughts, it is the responsibility of staff to notify the mental health authority. Three staff said they would document supervision of the youth and conduct constant sight and sound supervision of the youth, and one indicated they would search the youth and room for sharp objects. Three of the five staff also mentioned they would notify the supervisor. Five youth were interviewed and four indicated they had been placed on PO while at the facility and were watched, at all times.

3.11 Suicide Precaution Observation Logs [Detention Staff/Contract Provider] (Critical)	**Satisfactory Compliance**
Youth placed on suicide precautions must be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth's behavior at intervals of no more than thirty minutes.	

The center has a written suicide prevention plan, which outlines the process for screening, supervising, monitoring, and housing of youth at risk for potential suicide risk. Youth exhibiting suicide risk are placed on precautionary or secure observation. Five mental health records were reviewed. Three of the youth were placed on precautionary observation (PO) after admission to the center. In all three the suicide PO logs were completed for the duration the youth was on PO, including the identification of safe housing locations, and documented on the Department's Mental Health/Substance Abuse (Form 006). The logs were completed in real time with youth behavior documented in intervals not exceeding thirty-minutes. All logs were reviewed and

signed by each shift supervisor and daily by the mental health clinical staff. None of the three youth exhibited any warning signs while on PO warranting an immediate notification to the superintendent and designated mental health clinician authority (DMHCA). Five youth were interviewed and four indicated they had been placed on PO while being detained at this facility and had been watched the entire time.

3.12 Suicide Prevention Training [Detention Staff] (Critical)	Limited Compliance
All staff who work with youth must be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.	

The center has written policy and procedures for suicide prevention training, which includes staff training requirements. Five pre-service and five in-service staff training records were reviewed and each had documentation of completing six hours of suicide prevention training, which included both instructor-led and online suicide prevention training in the Department's Learning Management System (SkillPro). A review of the mock suicide drill documentation for the last twelve months indicated the center completed multiple drills on each shift for each quarter. The reviewed mock suicide drills included methods for contacting other center staff by radio, calling for back-up support, medical personnel, and emergency medical services (9-1-1), and provision of life saving measures such as cardio pulmonary resuscitation (CPR), and use of the suicide response kit per established protocol. Sign-in sheets documented each applicable staff except for two participated in a drill at least semi-annually; however, the center reported a staff signing the sign-in sheet does not necessarily mean they participated in the drill. The current center practice is for the supervisor to review a drill with staff who were not present the next time they come on shift and they then sign the same sign-in sheet as the staff who did participate; therefore, it cannot be discerned which staff actually met the requirement for semi-annual participation in a mock suicide drill. Five staff were interviewed regarding the center's suicide response kits and each indicated the suicide response kits are in master control, three indicated there is also one in the medical and two indicated there is one in the training room.

3.13 Mental Health Crisis Intervention Services [Detention Staff] (Critical)	Satisfactory Compliance
Every program must respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the facility. The program must be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others, which would require suicide precautions or emergency treatment.	

The center has a written mental health crisis intervention plan which was approved by the designated mental health clinician authority (DMHCA) and superintendent on July 19, 2017 and reviewed by both on July 19, 2018. The plan addresses the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation, and review, as required.

3.14 Emergency Care Plan [Detention Staff] (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health or substance abuse emergencies occurring in facility, requires emergency care provided in accordance with the facility's emergency care plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated Crisis Intervention and Emergency Services Plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.	

The center has a written emergency care plan which was approved by the designated mental health clinician authority (DMHCA) and superintendent on July 19, 2017 and reviewed by both on July 19, 2018. The plan addresses immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and/or substance abuse evaluation and treatment, documentation, training, and review.

3.15 Crisis Assessments [Contract Provider] (Critical)	Satisfactory Compliance
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 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 superintendent or designee must be notified of the crisis situation and need for Crisis Assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk (ASR) instead of a Crisis Assessment.	

The program has a policy and procedures in place regarding crisis assessments. The center has a mental health crisis intervention plan, which was approved by the designated mental health clinician authority (DMHCA) and the superintendent on July 19, 2017 and reviewed by both on July 19, 2018. The plan contains the reason for assessment, mental status examination and interview, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notification to parent/guardian of follow-up treatment. The center did not conduct any crisis assessments during the annual compliance review period.

3.16 Baker and Marchman Acts [Detention Staff/Contract Provider] (Critical)	Non-Applicable
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.	

The program did not have a Baker Act or Marchman Act the annual compliance review period; therefore; this indicator rates as non-applicable.

Standard 4: Health Services

Overview

The Department of Juvenile Justice has a contract with Maxim Health Services, Inc. to provide comprehensive health services including medical, mental health, substance abuse, and psychiatric services at the Brevard Regional Juvenile Detention Center. The provider maintains a designated health authority (DHA) for one hour a week, one advanced registered nurse practitioner (ARNP) for sixteen hours a week, one full-time registered nurse (RN) serving as the clinic manager, two licensed practical nurses (LPN) covering fifty-six hours a week, and a medical records clerk. The two LPNs and one RN provide nursing coverage seven days a week for a minimum of twelve hours a day. The medical staff duties include: conducting sick call, administration of medications, admission screenings, and completing referrals to outside providers/scheduling off-site care visits. Off-site referrals are utilized for dental care, obstetrics, and gynecological issues. Human immunodeficiency virus (HIV) pre/post-test counseling and testing services are provided on-site by an outside provider.

4.01 Designated Health Authority/Designee [Contract Provider] (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for the medical care of all youth at the facility.	

The Designated Health Authority (DHA) is a licensed physician who is board certified in internal medicine. The advanced registered nurse practitioner (ARNP) holds a license and is certified by the Pediatric Nursing Certification Board as a pediatric nurse practitioner. The program provided for review an active/clear license with the Florida Department of Health, Bureau of Medical Quality Assurance for both the DHA and ARNP. An interview with the DHA regarding their role revealed the DHA is responsible for medical facility operating procedures, nursing protocols, and non-healthcare protocols to be reviewed and signed annually. The DHA also performs the Comprehensive Physical Assessments (CPAs), periodic evaluations, and sick call visits performed on an as needed basis during the weekly visits. The DHA is available when not on-site twenty-four hours a day, seven days a week for consultation with nursing staff, non-healthcare staff, and the advanced registered nurse practitioner (ARNP). The DHA has designated the ARNP to provide clinical services twice a week, eight hours a visit for a total of sixteen hours a week. The DHA indicated the Maxim physician on-call provides coverage during scheduled absences. The ARNP has a collaborative practice protocol agreement with the DHA on file with the program. An interview with the ARNP revealed she provides focused medical evaluations, conducts episodic visits, follow-up from outside medical care, sick call visits, reviews laboratory and X-RAY results and determines plan of care, provides treatment of chronic medical conditions, writes prescriptions for treatment and for youth admitted with medication (other than psychotropic), and educates youth on health conditions and preventive health care. A review of the medical sign-in log indicated the DHA was on-site each week in the last six months. Each of the visits were within eight days of the previous visit. The medical sign-in log also confirmed the ARNP is consistently on-site Tuesdays and Thursdays from 8:00 a.m. to 4:00 p.m.

4.02 Facility Operating Procedures [Contract Provider]	Satisfactory Compliance
There shall be Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.	

The program maintains the standard detention facility operating procedures (FOP) for medical services signed by the superintendent July 15, 2018 and the designated health authority (DHA) July 17, 2018. Documentation review and staff interviews revealed the psychiatrist had not signed the FOPs regarding psychiatric care and psychotropic medication management, nor was there documentation the psychiatrist participated in the drafting and review of applicable procedures. The FOPs were signed by the psychiatrist during the review week. Each of the nursing staff completed an annual review and signed the cover page on all FOPs, treatment protocols, and standing procedures the first week of August 2018. There are no newly employed healthcare personnel to be reviewed. The center has a policy in place stating all newly employed healthcare personnel must receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by a registered nurse (RN) or designated healthcare professional.

4.03 Authority for Evaluation and Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance
Each center shall ensure the completion of the Authority for Evaluation and Treatment (AET) or Limited Consent for Evaluation and Treatment authorizing specific treatment for youth in the custody of the Department.	

The center has a written policy and procedures regarding the authorization of treatment for youth. All five reviewed youth records contained an Authorization for Evaluation and Treatment (AET) completed prior to providing medical care. Each of the five AETs were completed within the previous 12 months. Two of the AETs were current with original signatures; three were copies. Two of the copies were marked as a copy. One of the three AETs was clearly a copy of the original but was not marked as such. None of the records were applicable for Department of Children and Families (DCF) Limited Consent for Evaluation and Treatment. The program provided two examples of youth who were admitted with a Limited Consent for Evaluation and Treatment (Form HS 057), each of which was signed by the DCF caseworker. Both of the youth were on continual supervision by the Department since the Limited Consent was signed. Neither of the applicable youth were prescribed psychotropic medications.

4.04 Parental Notification [Contract Provider]	Satisfactory Compliance
The center shall inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed.	

Five youth individual healthcare records were reviewed and two were applicable for notification to the parent/guardian of some change to the medical condition/care of the youth. One of the reviewed records concerned a youth who was eighteen and not applicable for parent/guardian notification. Two of the five reviewed records contained notification to the parent/guardian of practitioner-ordered over the counter (OTC) medication not covered by the Authorization for Evaluation and Treatment (AET). One additional youth recorded contained a notification to the parent/guardian of off-site medical care provided. Each of the reviewed notifications utilized the required Department's Parental Notification of Health-Related Care: General and Medication Management. (Form 021 or HS 020).

4.05 Notification – Clinical Psychotropic Progress Note (CPPN) [Contract Provider]	Satisfactory Compliance
The Department's requirement to inform the parent or guardian and obtain consent for the prescription of new psychotropic medications, discontinuances or psychotropic medication adjustments.	

The center has a written policy and procedures regarding parental/guardian notification of psychotropic medication monitoring utilizing clinical psychotropic progress note (CPPN). A review of one applicable record revealed documentation the parent/guardian was called by phone for permission to start the psychotropic medication. The documentation indicated the psychiatrist attempted the phone contact without success. The documentation indicates the nurse was able to make notification and obtain verbal permission to start the medication in the presence of a witness. Documentation also included the CPPN return receipt request which was sent to the parent/guardian. The center had no additional youth applicable for parent/guardian notification regarding initiation, change to or discontinuation of psychotropic medication. The center had no applicable Department of Child and Family (DCF) youth on psychotropic medication.

4.06 Immunizations [Contract Provider]	Satisfactory Compliance
Each 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).	

The center has a written policy and procedures in place regarding the procedures for the administration of required and ordered vaccinations. The contract indicates the program is responsible for ascertaining routine immunization status (through a thorough review of immunization and school records) and administration of needed immunizations (including first hepatitis B virus and Influenza, if applicable) per written order of the designated health authority (DHA) and guidelines of the Centers for Disease Control and Prevention. Further, all immunizations must be up-to-date. The facility operating procedures indicate the program has thirty days to get needed immunizations. All five youth records contained an immunization record, each of which included a dated signature of the advanced registered nurse practitioner (ARNP). None of the records indicated immunizations were needed. Interviews with medical staff indicated youth needing immunizations are taken to the county health department following receipt of permission from the parent/guardian.

4.07 Healthcare Admission Screening Form (Medical and Mental Health Screening Form) (screening entered into JJIS/FMS)	Satisfactory Compliance
Youth are screened upon admission for healthcare concerns that may need a referral for further assessment by healthcare staff.	

The center has a written policy and procedures regarding the completion of health care admission screenings. Five youth records were reviewed, and each contained the medical and mental health screening form entered into the Juvenile Justice Information System (JJIS) Admission Wizard. Each screening was completed by the juvenile justice detention officer/supervisor (JJDO/JJDOS) and reviewed by the licensed healthcare professional within twenty-four hours of admission. Interviews with administrative staff indicated the juvenile justice detention officer (JJDO) completes the healthcare admission screenings for all youth. Interviews

with nursing staff further verify the JJDOs complete the initial screening and then the nursing staff see a newly admitted youth within twenty-four hours of admission to review the admission screening. If nursing staff is on-site when the youth is admitted, they will complete the screening form.

4.08 Medical Alerts [Contract Provider]	Satisfactory Compliance
The Department's requirement to alert staff of medical issues that may affect the security and safety of the youth in the facility.	

The center has written policy and procedures to ensure an alert system is utilized to alert staff when mental health, medical or security issues exist which may affect the security and safety of the youth in the center. A review of five youth records revealed each youth had at least one entry on the alert log. Each youth record documented alerts on the admission chronological nursing form and verification of alerts. A comparison of the alerts on the Juvenile Justice Information System (JJIS), the youth record, and the program alert log revealed all alerts were consistently entered or updated on JJIS in a timely manner. Nursing staff are solely responsible for entering and removing medical alerts in JJIS. Five staff were interviewed regarding the process of receiving information regarding youth medical alerts. All five interviewed staff indicated they received medical alert information during shift meetings. One staff additionally indicated staff are informed of medical alerts in the logbook. Three staff indicated this process was good, while two staff indicated the process was very good. Interviews with administrative staff indicated the juvenile justice detention officer (JJDO) makes sure all critical and special alerts are listed in JJIS upon admission. The medical staff will then review the alerts and ensure each alert is correctly tracked and managed. The responses and updates by the medical staff are documented in Juvenile Justice Information System (JJIS) alerts section, as they pertain to each critical alert.

4.09 Suicide Risk Screening Instrument [Contract Provider]	Non-Applicable
A Suicide Risk Screening Instrument shall be completed within twenty-four hours of admission and filed in the Individual Health Care Record.	

The Suicide Risk Screening Instrument was completed within twenty-four hours of admission, reviewed by the mental health staff, and filed in the youth's mental health record; therefore, this indicator rates as non-applicable.

4.10 Youth Orientation to Healthcare Services [Contract Provider]	Satisfactory Compliance
All youth are to be oriented to the general process of healthcare delivery services at the facility.	

The center has a written policy and procedures regarding healthcare orientation for youth. All five youth records documented orientation was completed during the admission healthcare screening. The program provided a binder of the subjects included in the orientation and documented in the health education record section. The binder included education for youth on all required topics. The right to refuse care is a line item in the health education record and documented in all five records; however, there was no section in the binder identifying the subject or inclusion of the topic of how the refusal of healthcare is documented. The center also maintains a list of updated healthcare contacts which was found to be accurate.

4.11 Designated Health Authority/Designee Admission Notification [Contract Provider]	Satisfactory Compliance
The DHA or designee is notified when youth ad-mitted require emergency care or routine notification in accordance with Department requirements.	

The center has a written policy and procedures in place to ensure the designated health authority (DHA) is notified of all youth admitted to the center with chronic health conditions or for youth in need of emergency care. Two of the five reviewed youth records were applicable for notification and both contained documentation the DHA was contacted by telephone or in person upon admission within the time frame. Interviews with nursing staff revealed, for youth admitted with serious or chronic conditions, the nurse doing the assessment or upon notification and verification of youth with chronic serious condition will notify the DHA. Referrals to the DHA are documented on the sick call list in the clinic and episodic progress notes.

4.12 Healthcare Admission Rescreening [Contract Provider]	Satisfactory Compliance
A Healthcare Admission Rescreening is to be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

The center has a written policy and procedures in place regarding healthcare admission rescreening. A review of youth Face Sheets in the Juvenile Justice Information System (JJIS) revealed two youth were applicable for rescreening. Both applicable youth were rescreened upon return to the facility. In both cases, the juvenile justice detention officer (JJDO) completed the screening, which was reviewed by the licensed healthcare professional. Documentation was maintained in each youth's individual healthcare record. There were no additional instances of youth rescreening available for review.

4.13 Health-Related History [Contract Provider]	Satisfactory Compliance
The standard Department Health-Related History (HRH) form shall be completed for all youth admitted into the physical custody of a DJJ facility.	

The center has a written policy and procedures regarding the completion of the health-related history (HRH). Five records were reviewed, and each included either a current HRH which was updated or a new HRH. Each HRH was completed by a licensed healthcare professional. Each HRH was completed prior to or at the same time as the Comprehensive Physical Assessment (CPA). Each HRH was reviewed by the physician or ARNP and documented on the CPA.

4.14 Comprehensive Physical Assessment [Contract Provider]	Satisfactory Compliance
The Comprehensive Physical Assessment (CPA) form shall be completed for all youth admitted in-to the physical custody of a DJJ facility.	

The center has a written policy and procedures regarding completion of the Comprehensive Physical Assessment (CPA) form. Five youth records were reviewed and four contained a current CPA which was reviewed in the electronic healthcare record by the advanced registered nurse practitioner (ARNP). One youth record contained a new CPA completed within seven days of admission by the physician or ARNP. None of the CPAs documented a condition requiring the Department of Juvenile Justice (DJJ) problem list to be updated.

4.15 Female-Specific Screening/Examination [Contract Provider]	Satisfactory Compliance
The Department requires all adolescent girls receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

The center has a written policy and procedures regarding the female specific examinations. One of the five records included applicable screenings. Three additional records were reviewed for pregnancy which were also applicable for female specific screening. All four applicable reviewed records contained documentation youth received female specific screenings upon admission. Each record included the youth providing a urine specimen for screening; however, the individual healthcare record of each applicable youth did not include documentation the youth provided verbal consent for qualitative urine pregnancy screening test. One applicable youth record included documentation of doctor's orders for a gynecological examination. The applicable youth was eighteen years of age and able to provide consent. Five youth were interviewed regarding receipt of prenatal, obstetrical, or gynecological services when needed at the center. One applicable youth indicated she had received these services.

4.16 Tuberculosis Screening [Contract Provider]	Satisfactory Compliance
All youth are required to be screened for Tuberculosis (TB), and accurate documentation of results shall be maintained by each facility.	

The center has a written policy and procedures regarding tuberculosis screening test (TST) and treatment. A review of five youth records revealed two had a verified TST documented in each youth's healthcare record upon admission. Three youth without a TST received the TST upon admission with follow-up. None of the five youth required further evaluation prior to entering the population and none of the youth required isolation. The center provided records for review of two youth applicable for a positive TST. Each of the youth received a follow-up chest X-ray. Neither of the two youth required medication or isolation, however, procedures are in place to provide those services. Nursing staff interviews indicate the process for tuberculosis screening includes screening youth yearly unless otherwise noted. In addition, an X-ray is ordered for any youth refusing TST.

4.17 Sexually Transmitted Infection Screening [Contract Provider]	Satisfactory Compliance
The facility shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

The center has a written policy and procedures regarding screening for sexually transmitted infections (STI). A review of five youth records revealed four applicable youth were screened for STIs. One of the four applicable youth was referred for further evaluation to the designated health authority (DHA). In all four applicable records the Department's Infectious and Communicable Diseases form (HS 018) was found and included lab results. Nursing staff interviews revealed all newly admitted youth are screened for sexually transmitted infections by providing urine samples which are sent to Lab Corp. All youth are asked if they would like or need to be tested. Those who refuse the test are documented. If screening indicates a need for further evaluation, applicable youth are referred to the DHA or advance registered nurse practitioner (ARNP) and applicable orders are given. All sexually transmitted infections screening, evaluation, testing and referrals are documented in the individual healthcare record on the Infectious disease form.

4.18 HIV Testing [Contract Provider]	Satisfactory Compliance
The facility shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

The center has a written policy and procedures regarding testing for human immunodeficiency virus (HIV). A review of five youth records revealed each youth was provided an opportunity to receive HIV counseling, testing and treatment referral if necessary. Four of the five youth consented to counseling and testing documented on the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form (HS 015). Two of the records contain documentation in the health education record each youth received pre and posttest counseling. Each of the two records contained results filed in a confidential manner. One of the four youth requested counseling and testing but has not had time yet to receive the services. One of the youth requested the counseling and testing but was in confinement when the HIV counselor provided services to youth in the center. Staff interviews indicated counseling and testing was completed in a confidential area. The program utilizes the services of Project Response which has a certificate for provision of HIV/Acquired Immune deficiency (AIDS) prevention counseling, testing and linkage services from the Department of Health expiration date of November 15, 2018. Services were provided every two weeks from June 21, 2018 to the present. Most of the months (February, April, May, and July 2018) in the last six months the center received services twice in the month; however, there was a gap in service of five weeks from March 1 to April 5, 2018. There were two other times there was a gap in service for three weeks. Five youth were interviewed regarding HIV/AIDS testing and each indicated they can ask for an HIV/AIDS test. Interviews with nursing staff revealed they offer youth the opportunity to consent for HIV testing during admission. If the youth consents, the youth name is placed on the list of youth to be tested, and the completed form is placed in the youth record. After the test, completed by the community provider, the youth is given sealed results and a sealed copy is maintained in the youth record and is marked confidential. Each youth seen by the provider agency is documented in a log.

4.19 Sick Call Process – Requests/Complaints [Detention Staff/Contract Provider]	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

The center has a written policy and procedures in place regarding the sick call process. The program conducts sick call daily from 8:00 a.m. to 10:00 a.m. and as needed. A review of five youth records revealed three youth had placed a sick call request. Each sick call was filed in the youth's individual healthcare record. A review of the sick call log revealed there were no applicable similar sick call complaints submitted three or more times within a two-week period; however, the program has procedures in place to make a referral to the physician if this should occur. Although none of the sick call complaints were of severe pain, several sick calls were referred to the advanced registered nurse practitioner (ARNP). There were no incidents in which a youth complained of severe pain with which the staff was unfamiliar. Five youth were interviewed regarding sick call availability and each indicated they are seen for sick call within one day of making a sick call request. Interviews of nursing staff revealed the registered nurse (RN) or licensed practical nurse (LPN) routinely conducts sick call. If the LPN conducts sick call the RN reviews the documentation daily. All sick calls are documented in the sick call log which is kept in medical. In addition, the designated health authority (DHA) or ARNP conducts sick call when on-site.

4.20 Sick Call Process – Visits/Encounters [Contract Provider]	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters as required by the Department.	

A review of five youth records revealed three of the youth had entered sick call requests. Each sick call request reviewed was generated electronically in the Juvenile Justice Information System (JJIS). The clinic prints out each sick call request and utilizes it to document the youth signature upon receipt of professional care. One of the three sick call requests was conducted by the licensed practical nurse (LPN) and the documentation was reviewed by the registered nurse (RN) within the required time frame. All other sick calls were completed by the RN or the advanced registered nurse practitioner (ARNP). The clinic maintains a sick call/referral log which documents all sick calls including a specific page for each day of the week in case there were no sick calls. The review team observed sick calls on two separate days of the review week. In each case detention staff escorted the youth to the clinic where youth were seen in a private area within sight of the juvenile justice detention officer (JJDO). Licensed professional nurses conducted the sick call utilizing the approved nursing protocol including taking vital signs. In both cases the youth was referred to the ARNP who was present during the sick call. The program has procedures in place to provide care if licensed nurses are not on duty, including supervisors being notified of sick call requests immediately. Five youth were interviewed regarding sick call availability and each indicated they are seen for sick call within one day of making a sick call request. Five staff were interviewed regarding who conducts sick call and each indicated the nurse conducts sick call. One staff additionally indicated supervisory staff receive sick call requests after hours and call nursing staff for guidance on the youth's care.

4.21 Restricted Housing [Contract Provider]	Satisfactory Compliance
All youth in Restricted Housing/Confinement shall have timely access to medical care, as required by the Department.	

The center has a written policy and procedures regarding the provision of healthcare for youth in restricted housing (confinement, seclusion, room restriction, and/or secure observation). One of the five reviewed youth records included documentation the youth was in restricted housing. The individual record included documentation of healthcare nursing visits to the youth in restricted housing including distribution of medicine and health and welfare checks. The program provided two additional records of youth in restricted housing. Each of the two youth received medical services during the time they were in confinement, including medication administration. Medical services were documented in the individual health record for each youth. Interviews with nursing staff revealed all confined youth are checked on at least once per shift and receive medical care as needed.

4.22 Episodic/First Aid Care [Contract Provider]	Satisfactory Compliance
The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.	

The center has a policy and procedures relating to episodic care and first aid interventions. The program maintains a combination episodic/emergency care log. A review of three episodic care events revealed each youth individual healthcare record documented the progress note, clearly identifying the event as episodic/first aid. The progress notes for episodic care included the date/time of the care, nature of the complaint, findings, treatment rendered, signature of staff

providing care with credentials and if applicable, any referrals. All episodic care incidents were provided by licensed healthcare professionals. Each reviewed treatment note included instructions to the youth and plans for follow-up. In each of the two applicable cases the youth's parent/guardian notification was documented.

During the review week, six first aid kits were reviewed, including kits in four vehicles, the training room, and master control. Most of the kits included the required items and most of the items with an expiration date were current. On the outside of each kit there was documentation the nurse conducted monthly checks of each first aid kit. The kits should include eye rinse solution; however, none of the kits included this item. Two of the six kits had expired hand sanitizer. Nursing staff interviews revealed first aid kits are located in master control, the classrooms, the living units, and the vehicles. All first aid kits are inspected monthly or as needed. The center has two automated external defibrillators (AED), one in master control and one in medical. The AED procedures are located with each device. The nurse checks the AED batteries and pads for operability. The center maintains a list of emergency telephone numbers in medical and master control. Detention staff conduct mock emergency drills in conjunction with the nursing staff. If non-healthcare staff provides first aid/emergency care to youth they document the care in the episodic care log with notes to the nurse and in the master control logbook. The nursing staff review the episodic and emergency room log daily. All doctor's or hospital orders are signed/dated by the reviewing nurse and reviewed and signed by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP).

4.23 Emergency Care [Contract Provider]	**Satisfactory Compliance**
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

The center has a written policy and procedures establishing a process for providing emergency care or responding to an emergency situation. Two automated external defibrillators (AEDs) were reviewed. Master control and the nursing office each have an AED. The AED unit verbally provides instruction as well as a brochure in the AED box. The nurse conducts monthly checks of the AEDs. The AED batteries and pads were up to date. Near each AED an extra battery and pads with an expiration date for 2020 were found. The nurse documents on the battery and pads when it was installed. The nurse conducted a check of each AED in front of the review team during the annual compliance review. A list of emergency numbers was located on living units and master control for youth and staff to have access. Five pre-service and five in-service staff training records were reviewed, and each contained documentation the staff completed training in first aid, cardio pulmonary resuscitation (CPR), and use of the AED. Additionally, all five in-service staff completed training on use of EpiPen auto injector even though it is only required for supervisory staff.

A review of emergency medical drills, which included applicable mock suicide drills, since January 2018 was conducted. Per the facility operating procedure, medical drills are to be conducted on a quarterly basis on each shift (January – March, April – June, and July – August). All shifts had emergency medical drills during each quarter since January 2018. For Bravo and Charlie living units there was documentation cardio-pulmonary resuscitation (CPR) and AED were used in drills. The drills did include the elements of 9-1-1 being called and the staff response. It should be noted the staff are using the knife for life during drills. The documentation of emergency medical or mock suicide drills on the Alpha living unit did not include the use of CPR/AED. Also, the reviewed drills did not document the actual time 9-1-1 was called or staff response time. The documentation did not indicate staff are taking the first

aid kit with them when a medical drill is called. Five staff were interviewed regarding the capacity to call 9-1-1 and each indicated they could call 9-1-1 if they felt it was necessary.

4.24 Off-Site Care/Referrals [Contract Provider]	Satisfactory Compliance
The facility shall provide for timely referrals and coordination of medical services to an off-site healthcare provider (emergent and non-emergent), and document such services, as required by the Department.	

The center has a written policy and procedures regarding off-site care/referrals. Two of the five youth records included documentation of off-site care received during the youth's stay in detention. The program provided an additional record of a youth who received off-site care. All three records contained the off-site care form with discharge documents including a review by the DHA or designee and center nursing staff. Each of the three also included follow-up instructions and appointments. Each of the incidents were documented in the program sick call log. In each of the three cases, youth received timely follow-up and care.

4.25 Chronic Conditions/Periodic Evaluations [Contract Provider]	Satisfactory Compliance
The facility shall ensure youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up.	

The center has a written policy and procedures to ensure youth who have chronic illnesses receive regularly scheduled evaluations and necessary follow-up. The center maintains the Department's Chronic Physical Health Conditions Roster form (HS 004) for each month of the review period. None of the five youth records reviewed were applicable. The center provided five additional records for review and each youth was logged into the chronic conditions log and received an initial focused evaluation documented in their individual healthcare record. One of the youth was in the center long enough to receive the ninety-day evaluation, which was completed within the required timeframe and performed by the designated health authority (DHA). One youth was discharged and returned and received an additional focused evaluation for the chronic condition. Four of the youth had conditions already on the problem checklist. Nursing staff interviews verified the center maintains a chronic conditions log, which is monitored regularly.

4.26 Medication Management – Verification [Contract Provider]	Satisfactory Compliance
A youth's medication regimen shall be ascertained upon admission to the facility.	

The center has a written policy and procedures for medication verification. A review of five youth records revealed two youth received medication which required verification. The process was documented in each case record. One youth's medication was verified by the parent/guardian while the other included documented phone calls to the pharmacy. In each case the designated health authority (DHA) and/or psychiatrist provided an order to continue the medication. The center provided an additional youth record applicable for medication verification. The center verified the medication with the pharmacy and the parent/guardian, documenting it on the Department's Medication Receipt, Transfer & Disposition form (HS 053). Nursing staff interviews revealed the process to verify medications upon youth admission includes review of the medicine label, calling the pharmacy and calling the parent/guardian for verification.

4.27 Medication Management – Orders/Prescriptions [Contract Provider]	Satisfactory Compliance
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

A review of five youth records revealed three youth were admitted on medications. In each case the initial medication administration record (MAR) matched the medication list. Each of the youth had a current valid order and received a doctor's order to continue the medication from the designated health authority (DHA) or psychiatrist. In four of the five reviewed records youth received over-the-counter (OTC) medications. In each applicable youth, the medications were dispensed as ordered and administration was clearly documented on the youth's MAR.

4.28 Medication Management – Storage [Contract Provider]	Satisfactory Compliance
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

The center has a written policy and procedures regarding the disposal of medication, which indicates the registered nurse shall be responsible for the disposal and further states the requirement to maintain documentation of all disposed medication. The center's medication disposal log was reviewed and indicated there were two disposals of medication within the last six months. Through observation of the center's medical unit, it was determined all medications are stored in a separate, secure area and are not accessible to youth. Each form of medication is kept separately, and refrigerated medication is kept in a locked refrigerator designated to only store medications. The center maintains a list of detention supervisors who are trained in self-administration of medication. Detention supervisors, who are trained, have access to the medications in order to administer to youth in the event medical staff are not onsite. Detention supervisors must obtain a medical unit key from master control on an as needed basis.

4.29 Medication Management – Medication and Sharps Inventory [Contract Provider]	Satisfactory Compliance
All medications and sharps shall be inventoried, as per Department requirements.	

The center has a written policy and procedures regarding the inventory of medications and sharps (syringes, needles, scissors, and suture removal kits), which includes procedures for any discrepancies noted in the inventories. Through observation of the medical unit, it was determined all sharps are secured in a locked cabinet. A review of the sharps perpetual and weekly inventory validated the center has completed the required inventories for the last six months. The center maintains a perpetual daily running inventory of medication utilization for all prescription and over-the-counter (OTC) medications. The center maintains a weekly inventory count of all opened OTC medications. There were no discrepancies with the inventories upon review of the last six months of documentation. Three randomly selected sharps, prescribed medications and OTC medication were observed and compared to the counts on the inventories with no discrepancies found. While no discrepancies have occurred during the annual compliance review period, the center has a process in place to notify the designated health authority (DHA) and superintendent and contact the Central Communications Center (CCC) in the event a discrepancy would occur.

4.30 Medication Management – Controlled Medications [Contract Provider]	Satisfactory Compliance
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

Observations were conducted and found all controlled medication is stored in a locked box in the locked medication cart and kept in the medical unit. There is a shift-to-shift count of all controlled medication, which is documented on each youth's individual Controlled Medication Inventory Record. For each shift-to-shift count, two medical staff initial, verifying the count. In addition, the remaining number of pills/dosages were documented on each youth's individual Controlled Medication Inventory Record. The inventories were reviewed for the past six months and no discrepancies were found. Three randomly selected controlled medications were selected, counted, and compared to the counts on the inventories with no discrepancies.

4.31 Medication Management – Medication Administration Record [Contract Provider]	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

A review of five youth medical records, validated four youth were applicable for receiving medication while at the center and contained medication administration records (MAR). Each of the four youth's MARs contained the required elements. Of the four, only two youth records contained refusals, and each refusal was documented appropriately on the MAR and also on the Refusal of Treatment Form maintained in the youth's individual healthcare record (IHCR). There were no lapses or errors in medication administration. Each MAR for each youth clearly indicated the start and stop date of the medication and documented the youth received the medication as ordered. Each MAR documented both the staff and youth initial each time medication was administered, regardless of who administered the medication, medical or non-medical staff. Each MAR confirmed the nursing staff documents weekly side effect monitoring. Of the four medical records reviewed, none were applicable for non-medical staff assisting in the self-administration of medication; therefore, not requiring daily documentation of side effects. Of the four youth IHCRs reviewed, only one youth had medication upon admission, which matched the medication list. This youth's medication was continued and was documented in the youth's IHCR on the Department's Practitioner Order form.

4.32 Medication Management – Medication Administration by Licensed Staff [Contract Provider]	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

During the annual compliance review, a sick call was observed for one youth in which medication was administered and was conducted by the registered nurse (RN). During the medication administration process, the RN was not conducting unrelated center activities and was solely focused on the youth. The medical unit, where sick call and med pass are conducted, was clean and well organized. Detention staff escorted the youth to medical and remained in the hallway, in visual sight of the youth at all times, while allowing privacy for the youth. Five Rights of Medication Administration was verified during the sick call for this youth. The RN was able to review the youth's allergies and alert status on the youth's medication administration record (MAR) and asked the youth if she was experiencing any issues or concerns. Both the RN and youth initialed the MAR during the sick call. The medication

administered to the youth was not a parenteral medication. All parenteral medication is administered by medical staff. When youth refuse medication, the center utilizes the Department's Refusal of Treatment Form. Five youth were interviewed regarding who gives them medication and four youth indicated the nurse gives the medication, while the other youth indicated they did not take medication.

4.33 Medication Management – Medication Provided by Non-Licensed Staff [Detention Staff/Contract Provider]	Satisfactory Compliance
Trained, non-healthcare 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.	

The center has a written policy and procedures addressing medications provided by non-licensed staff. The juvenile detention officers are trained, by the registered nurse (RN), to administer medication to youth when medical staff are not on-site. The medical staff maintains a list of trained non-medical staff; which notes the name of the staff and title of each staff and their date of training. Each detention staff member on the list was trained on self-administration of medication on July 20, 2018 by the RN. Additionally, five staff in-service training records were reviewed, and each had documentation of medication administration training in 2017 as well. Of the five youth medical records reviewed, only four were applicable for medication administration. Of the four medical records reviewed, the current medication administration records (MARs) did not reflect non-licensed medical staff provided medication. Five youth were interviewed regarding persons who give them medication. Four indicated the nurse provides their medication; one youth indicated they did not take medication. Five staff were interviewed and each indicated they have not administered medication to youth. Nursing staff interviews revealed non-healthcare staff provide prescription or over the counter (OTC) medication following training by the nurse or registered nurse manager and only in the event nursing staff is not on-site; however, there were no examples of medication administration by a non-licensed staff during the annual compliance review period.

4.34 Medication Management – Psychotropic Medication Monitoring [Contract Provider]	Satisfactory Compliance
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety and as required by the Department.	

Three of the five reviewed records documented youth were taking psychotropic medication upon admission. In each case, the designated health authority (DHA) and the psychiatrist were notified, and youth was continued on medication until the psychiatrist conducted the initial diagnostic interview. The initial interview was conducted within the required time frame and documented on the Department form. In two of the cases the medication was discontinued by the psychiatrist prior to the thirty-day medication monitoring. One youth received his monthly psychotropic medication monitoring, which was documented on the required Department form. No additional youth were applicable for thirty-day psychotropic medication monitoring. The program does not have any standing, emergency treatment, or PRN "pro re nata" orders for psychotropic medication.

4.35 Infection Control – Surveillance, Screening, and Management [Contract Provider]	Satisfactory Compliance
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.	

The center has a site-specific infection, biohazard, and exposure control plan in place which received an annual review by the designated health authority (DHA) on October 1, 2017 and superintendent on October 2, 2017. A review of the infection control plan revealed procedures and reporting requirements for all the required elements. A review of logbooks, Central Control Communications (CCC) reports, and staff interviews indicated the program had no occasions of infectious diseases which required reporting to the local health department during the annual compliance review period. None of the five youth records were applicable for notification of sexually transmitted diseases (STD) to the county health department. A review of the program log for notification of STD positive results revealed the program reports were consistently completed in a timely manner. The center provided documentation universal precautions are followed by all staff and Hepatitis B immunization is made available for staff. A review of consent forms signed by staff and shot records confirmed the immunization are being made available to staff. A copy of the exposure control plan is available to all staff and maintained in master control.

4.36 Infection Control – Education [Contract Provider]	Satisfactory Compliance
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.	

The center has a written policy and procedures to provide for infection control education. A review of five youth health education records revealed each youth received the required infection control training within seven days of admission, including handwashing techniques, universal precautions, and Center for Disease Control and Prevention (CDC) guidelines for infection control. Each youth's education was documented on the Health Education Record form HS 013. A review of five pre-service and five in-service staff training records revealed each staff also received training in infection control.

4.37 Infection Control – Exposure Control Plan [Contract Provider]	Satisfactory Compliance
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.	

The center has a site-specific Infection, Biohazard and Exposure Control Plan which was reviewed by the designated health authority (DHA) and superintendent on October 1 and 2, 2017 respectively. The program maintains a list of all job classifications and their tasks and procedures in which staff have the potential for occupational exposure. The program had documentation of engineering and work practice controls which include procedures for proper disposal of needles and other sharps and procedures for handling of contaminated laundry, and a system of medical record keeping for staff with occupational exposure. The review team observed clear signage marking bio-hazardous waste container locations and hazardous waste clean-up tools.

4.38 Prenatal Care – Physical Care of Pregnant Youth [Contract Provider]	Satisfactory Compliance
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth will be provided additional testing and services, as recommended.	

The center has a written policy and procedures to ensure appropriate treatment and consideration is given for youth admitted to the center who are pregnant. None of the five records reviewed were applicable for physical care of pregnant youth. The program provided three additional records for review. Each of the youth began to receive care immediately upon determination of the youth's pregnancy at the center. Each of the three youth had a focused medical evaluation every thirty days and a pregnancy plan of care was completed by the physician. All three youth were started on prenatal vitamins and weekly weight and blood pressure checks upon admission. A review of the medication administration record (MAR) for the three youth revealed documentation of the vitamins, weight, and blood pressure checks. Two youth were discharged prior to requiring or receiving additional prenatal care. The third youth received monthly off-site obstetrics care which was reviewed by the advanced registered nurse practitioner (ARNP) and designated health authority (DHA) upon return. Interviews with nursing staff revealed the services provided to pregnant youth includes administration of prenatal vitamins, weekly blood pressure and weight checks, provision of two mattresses, an obstetrical education packet which all required topics covered, and an obstetrical/gynecological (OB/GYN) prenatal appointment, as needed.

4.39 Prenatal Care – Nutrition and Education of Youth [Contract Provider]	Satisfactory Compliance
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, postpartum, and parenting education including topics directly related to healthcare issues and medical risk for pregnant adolescents.	

The center has a written policy and procedures to ensure appropriate treatment and consideration is given for youth admitted who are pregnant. Three youth records were provided by the center and reviewed. Each youth's individual healthcare record (IHCR) included a pregnancy education packet which covered all required areas and documentation all required pregnancy education occurred. Each of the three youth received a plan including a diet plan specifically designed for pregnancy, which included prenatal vitamins. A review of the Medication Administration Record (MAR) of the three youth revealed each youth was receiving prenatal vitamins.

4.40 Prenatal Staff Education [Contract Provider]	Satisfactory Compliance
All non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education.	

A review of five pre-service and five in-service staff training records revealed each staff had received prenatal education provided by a licensed nurse. The in-service training includes the emergency care, monitoring, and observation of pregnant youth.

Standard 5: Safety and Security

Overview

The juvenile detention officers (JJDOs) and other detention staff at Brevard Regional Juvenile Detention Center are responsible for the supervision of youth and safety and security at the center. The JJDOs are scheduled amongst three shifts and the JJDO supervisors conduct a shift briefing at the beginning of each shift to share pertinent information and distribute JJDO assignments and keys. The center has three living units, two for males and one for females, which are connected to a common area known as the sunshine room where additional programming can occur. The center has a video surveillance system with cameras throughout the center. During the annual compliance review all cameras were operational with the exception of two which are both located outside of the secure area for youth. Ten-minute checks are conducted while youth are in their sleeping rooms through the use of an electronic wand system which tracks checks for each room. The assistant superintendents are responsible for oversight of camera and electronic wand activity.

The center maintains both master control and living unit logbooks which document all activities and incidents at the program. Master control staff is accountable for key control at the center. Transportation to court, medical appointments, and any other off-site location is provided by center staff in Department-issue vehicles, which are regularly maintained. The center's maintenance mechanic is responsible for upkeep of the vehicles and facility, and control of the center's tools and chemicals. The center conducts drills for different emergency events on all shifts, including monthly fire drills as part of the center's fire protection plan.

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

Youth are in sight of at least one Juvenile Justice Detention Officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).

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

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

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

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

The center has a written policy and procedures regarding the supervision of youth. The center provides on-going, active supervision of youth. Youth are in sight of at least one detention officer at all times, except for when placed in sleeping rooms, or in a secure placement. During the annual compliance review period, four separate days of on-site observations were made.

Observations of youth supervision were made during a variety of activities which included education, dining, recreation, confinement, structured leisure time in the living unit, and line movements. During these activities staff were present and positioned to engage youth constructively and provide on-going active supervision. Tracking of youth daily census is collected and documented within the master control logbook and within the Department's Juvenile Justice Information System (JJIS), as well as on a white board in each unit to document what room each youth is assigned to. Youth were accounted for and accompanied by staff at all times during the observations. Master control authorized all observed movement of youth prior to the youth being moved. Movement and counts were documented in both master control and module logbooks. Five staff were interviewed, and each reported they feel there is enough staff at the center to provide for the safety and security of the youth and staff. Each of the staff also discussed the process which occurs if the count of youth is ever incorrect, all movement is ceased until Master Control rectifies the count with the staff.

5.02 Ten-Minute Checks (Critical)	**Satisfactory Compliance**
Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. *Staff conducts observations in a manner ensuring the safety and security of each youth and documents real-time observation manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.* *There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.* *If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.*	

The center has a written policy and procedures to ensure the safety and security of each youth placed in a room, whether for sleeping, confinement, or medical isolation. The center utilizes an electronic recording system to capture ten-minute visual checks. The facility has a system in place utilizing the Guard 1 wand system. During the annual compliance review it was determined the system was only displaying the location and not the activity or summary report schedule; therefore, the print-outs of the electronically-recorded ten-minute checks were not able to be reviewed. The center actively worked to remedy the issue while the review team was on-site; however, the issue would not be able to be resolved until the week after the annual compliance review. To verify ten-minute checks were being done appropriately and within the proper timeframe, a review of five days of the video coverage was completed. The video displayed staff completing ten-minute room checks in real time. Observations reflected there were no obstructions over the room windows or areas where direct line of sight is necessary for staff to visually see into youth rooms. All checks were consistently done within the ten-minute requirement and all checks were conducted appropriately with staff ensuring the safety of each youth. Five staff were interviewed and each reported room checks are conducted every ten-minutes when youth are placed in their room for showers or shift change, sleeping, or non-punishment reasons.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a written policy and procedures in place to track all youth placed in the center. The center practice is to conduct counts of youth at the beginning and end of each shift, at the top of each hour, and twice randomly each shift. This practice was verified through interviews with five staff. The staff also verified the process if counts are incorrect. Observations of staff demonstrated this practice through consistent counts being called and reconciled by Master Control through the annual compliance review. Logbook entries consistently reflected youth movement, youth counts, youth admissions, and youth releases. Master control maintains and tracks the census daily with a daily movement sheet and the Department's Juvenile Justice Information System (JJIS).

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

Log entries regarding Medical, Special Needs, and Mental Health alerts, or other issues impacting facility safety and security shall be highlighted.

The center has a written policy and procedures regarding logbook maintenance. The center maintains separate logbooks in master control and each living module. The master control logbook captures incidents reported to the Central Communications Center (CCC), drills, incidents involving youth, counts, alerts, suicide precautions, calls to the Florida Abuse Hotline, law enforcement officers entering the center, and all other important information. A review of the past six months revealed each logbook is bound and has numbered pages. All entries included the date and time of the entry. All entries impacting the safety and security of the center,

including special needs and mental health alerts, were highlighted. Some errors in the logbooks were traced over rather than staff using a single line to cross out when an error was made. The master control logbook included Protective Action Response (PAR) incidents, drills, population counts at the beginning and end of each shift, population counts throughout the shift as counts changed, following emergency situations, admissions and releases, youth placed in confinement, and names of youth placed on precautionary and secure observations.

5.05 Logbook Reviews	Satisfactory Compliance
The superintendent or designee reviews all logbooks on a weekly basis. *The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.* *The Juvenile Justice Detention Officer (JJDO) Supervisor(s) reviews logbooks maintained in each living area daily.* *The JJDO(s) reviews the logbook maintained in his/her assigned living area when he/she accepts responsibility for the living area at shift change.*	

The center has a written policy and procedures in place addressing logbook reviews. Documentation reviewed for the past six months confirmed the superintendent or designee reviewed all logbooks on a weekly basis. Detention officers review the logbook maintained in the module when accepting responsibility for the living area at shift change. At the end of each shift there is a shift summary documented. Status checks were documented by the shift supervisors in the module logbooks. Logbook documentation reflected the superintendent, assistant superintendent, or person in charge of the center conducted a tour of the youth living module areas at least once during each shift.

5.06 Key Control	Satisfactory Compliance
Each facility is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2016-2017 Detention indicators.)*	

The center has a written policy and procedures to account for facility keys. The keys are stored in a locked box located in master control, which the master control operators distribute and collect. All keys are on a tamper-resistant ring and marked for identification. An inventory of all keys is kept and includes all required information and matches observations of the center keys. A work order is sent to the maintenance mechanic if there is a broken key. A completed work

order was provided for review to demonstrate the center's practice. During the annual compliance review, key issuance and collections were observed during a shift change meeting. The master control operator collected the personal keys of the oncoming staff. The supervisors then retrieve the shift keys for their staff from Master Control and distribute the assigned keys to each staff on shift. Each staff is assigned the same keys each time they are on shift and the key distribution is documented in the key control logbook which logs which staff is assigned to the key, and time the key was issued and/or returned. The center has initiated a system where a key must be issued for a key. The staff's personal keys are placed in the box where secured keys are maintained. Visitors receive a chit and their personal keys are placed on a pegboard. A random review was done of three staff in which each verified they did not have personal keys on them and the center keys they had matched the key control log. The superintendent maintains a master key log with all keys and the capabilities. Five staff were interviewed, and each staff reported they received training on the center's key control policy and procedures and each were knowledgeable of what program keys were considered restricted. The restriction of keys such as administration, inventory, and youth medical, mental health, and case management records, was verified by a supervisor. The center has not had any missing or lost keys in the past six months.

5.07 Vehicles and Maintenance	**Satisfactory Compliance**
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. *Youth and staff are not permitted to use tobacco products.* *Program vehicles are locked when not in use.*	

The center has a written policy and procedures regarding vehicles. The facility has seven vehicles, but only five are used for youth transport. The five vehicles on site used to transport youth were in good operating condition and contained all required safety items. Throughout the annual compliance review, the vehicles were checked to ensure they were secure when not in use. The center completes an inspection for the year. The documentation supported regular maintenance was completed on all the vehicles. Additionally, there was documentation to support staff check the vehicles prior to each transportation including a contraband check, and checking the vehicle for contraband upon return, which is documented in a logbook. During the annual compliance review, a transport of youth going to court was observed. The officer conducted a pre-inspection of the vehicle, checking tire pressure, gas, windshield wipers, oil, seat belts, emergency equipment, lights, horn, and under carriage to assess for safety issues and concerns. The staff also completed a contraband check prior to allowing youth on the vehicle. The youth were fastened in their seatbelts prior to the vehicle leaving. The vehicle was in good repair, had the appropriate number of seat belts, and all the necessary required emergency equipment for transport of youth. Emergency equipment included a first aid kit, flares/flashlights, emergency roadside kit, fire extinguisher, biohazard spill bag, and window punch/seat belt cutter. Upon return to the center, the staff conducted a contraband check once the youth had been secured back inside the building.

5.08 Tool Inventory and Management	Satisfactory Compliance
The program ensures all tools and equipment related to maintenance are properly maintained, stored, and inventoried.	

The center has a written policy and procedures for tool control and inventory. The maintenance office is keyed with limited access to only administrative staff and the maintenance mechanic. The facility tools are kept on a shadow board within the maintenance office. The maintenance department has not had to replace any tools during the annual compliance review period. The maintenance mechanic was able to describe the process of replacing old, damaged tools when needed. The maintenance mechanic maintains a sign-in log for outside contractors and the maintenance mechanic is responsible to escort repair personnel when in the center. The maintenance mechanic stated all tools and supplies used are documented on the inventory and are then replaced back on the shadow board and checked back into inventory when they are no longer needed. Areas where work is being conducted with tools are placed out of service to youth while repair personnel are on-site. There were no discrepancies noted between the tools on the shadow board and the tool inventory. The inventory is completed and reviewed as required. All tools were noted as being numbered and etched as property of the Department.

5.09 Kitchen Tools	Satisfactory Compliance
Kitchen knives and other hazardous kitchen sharps are stored in a locked cabinet, drawer, or toolbox containing an inventory list. *All storage areas, including cabinets and drawers, are secured when not in use.* *Kitchen staff conducts an itemized inventory of all equipment, including kitchen knives and other hazardous kitchen implements, upon reporting for duty.* *All equipment is accounted for prior to the departure of the kitchen staff. Any discrepancy must be reported to the Superintendent or designee.*	

The center has a written policy and procedures in place addressing kitchen tools. Observations conducted during the annual compliance review confirmed all kitchen tools and utensils were securely locked and inaccessible to youth. An interview with the food service personnel revealed no youth are authorized in the kitchen area. All kitchen knives and sharps are stored in locked cabinets containing an inventory. Documentation revealed the kitchen staff conducts an itemized inventory of all equipment including knives and utensils prior to each shift. An inventory of kitchen tools was conducted and compared to the actual kitchen tools on-site to determine accuracy and is signed off by the supervisor and administration. A completed inventory matched all tools and utensils. The kitchen supervisor was interviewed and explained the process in place in the instance a kitchen tool is broken or missing; however, the center did not have any incidents of broken or missing kitchen tools during the annual compliance review period.

5.10 Youth Access & Use of Tools, Cleaning Items (Critical)	Satisfactory Compliance
Youth are forbidden to use or access any tools, including kitchen or medical equipment. *Youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision.*	

The center has a written policy and procedures regarding youth access to tools. Interviews with kitchen staff and maintenance staff revealed youth do not have access to the areas where tools are stored, nor are youth ever permitted to handle their tools and sharps equipment. Five youth and five staff were interviewed, and each reported the youth do not have access to any tools or chemicals. Youth are allowed to utilize mops and brooms, but staff follow procedures to only allow use of mops and brooms to two youth at a time, under staff supervision.

5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items. *All flammable, toxic, caustic, and poisonous items shall be inventoried and secured when not in use. The use of hazardous material shall be consistent with the manufacturers' instruction and all safety precautions shall be followed.* *All flammable, toxic, caustic, and poisonous items shall have the Material Safety Data Sheets (MSDS) on hand in the facility. Toxic or caustic materials shall not be allowed to enter into the facility unless an MSDS is on file in an MSDS logbook and posted near items. A master copy of the MSDS logbook shall be maintained in an accessible binder for all personnel to review at all times.* *No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.*	

The center has a written policy and procedures in place for handling toxic materials, as well as a center safety plan. All flammable, toxic, caustic, and poisonous items are kept outside of the secure area in the maintenance area, until brought into the center by the maintenance mechanic. Chemicals are kept in his office which has restricted access for maintenance and administrative staff. Additional chemicals are located in the auto dispenser located in the janitorial closet which is not accessible to any youth and only select staff. An inventory is kept of all chemicals located in the maintenance office. A review of the safety data sheets (SDS) book, located in the maintenance office, found a sheet for all chemicals present.

5.12 Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel. *Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's bio hazardous material, bodily fluids, or human waste.*	

The center has a policy and procedures in place prohibiting youth access to or the handling of flammable, toxic, caustic, and poisonous items. During the annual compliance review, the review team did not observe any incidents of chemicals being left out or youth having access to any chemicals. Five youth and five staff were interviewed, and each stated youth are not allowed to use any type of cleaning agent such as bleach, laundry soap, window, or toilet cleaners. Further, youth are only allowed to clean by wiping cleaning chemicals the staff spray for them and are never allowed to control the cleaning supplies. Further, one of the staff explained the only cleaning supplies the youth are even allowed to wipe are non-toxic cleaning agents.

5.13 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The Maintenance Mechanic or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste shall be responsible for disposing of hazardous items and toxic materials in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 (amended 1-1-2004).	

The center has a written safety plan addressing proper use, storage and disposal of toxic, caustic, and poisonous items. The center has a grease trap for the kitchen. Mop sinks are located throughout the center. The maintenance mechanic has a red disposal canister for hazardous liquid waste and utilizes the county's recycling center to dispose of all other hazardous waste. An interview with the maintenance mechanic confirmed flammable, toxic, caustic, and poisonous items and materials are disposed of according to the center's policy and procedures; however, the center has not disposed of any such materials within the last six months.

5.14 Confinement Under Twenty-Four Hours	Limited Compliance
Staff shall use behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self.	

The center has a written policy and procedures regarding the use of confinement under twenty-four hours. The center had 257 confinements under twenty-hours hours during the annual compliance review period, of which twenty-five were reviewed. All confinement room windows and cameras were free of obstructions and did not contain non-fixed items. The youth were all afforded appropriate living conditions while in confinement, including education, hygiene, school, and meals. Each of the confinements reviewed had documentation the rooms were searched prior to the confinement. Seventeen of the confinement reports were completed as required and within one hour of the confinement start time. Seven of the reports did not have a completed confinement report and one was done an hour late. Twenty-two supervisory

approvals were documented on time, one was an hour late. The additional two reports had confinement start times of seven hours and twenty-four hours past the incident time; therefore, it was unable to be discerned when the supervisory approval should have occurred. Twenty-one of the reports documented all supervisory reviews were completed at intervals of no more than three hours. Four of the reports contained a total of six late checks ranging from twenty minutes to two hours late. Fourteen of the reports had consistent documentation of the need for continued confinement; however, eleven had multiple supervisory reviews in which there is no justification for further confinement. Twenty-three of the reports had superintendent/designee reviews within forty-eight hours of the end of confinement, one was three days late and one was two days late. Thirteen confinements occurred during school hours and eight of the applicable reports documented youth were provided educational materials and the youth's absence was discussed with the school. Five of the reports did not include documentation indicating education was offered nor was the school informed of the confinement. Five youth and five staff were interviewed, and each indicated education, hygiene, school, and meals are never taken away from youth in confinement.

5.15 Confinement Over Twenty-Four Hours	Limited Compliance
Confinement beyond twenty-four hours must be approved by the Superintendent or designee. *The Superintendent shall approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Reasons for extended confinement must be clearly documented on the confinement report.* *The JJDOS(s) shall continue to evaluate and document the youth's status every three hours. Current youth behavior and/or conversation with the youth shall be documented on the confinement report as evidence for the need to continue or terminate confinement.* *The length of confinement shall not exceed three days unless the release of the youth into the general population would jeopardize the safety and security of the facility as documented by the Superintendent. No youth shall be held in confinement beyond three days without a confinement hearing conducted by an employee of the Department who holds a management or supervisory position.*	

The center has a written policy and procedures regarding the use of confinement over twenty-four hours. The center had 115 confinements over twenty-four hours during the annual compliance review period, of which ten were reviewed. Each confinement was logged into the Juvenile Justice Information System (JJIS) system as required. Each confinement report documented the confinement room was searched prior to placing the youth in the room to begin the confinement. Each of the ten confinements reviewed were approved by a superintendent within eight hours for the confinement to last up to twenty-four hours. Of the ten confinements, five were found with approval to extend beyond twenty-four hours and one was ended at twenty-five hours due to not having approval for an extension. Three confinements lasted beyond forty-eight hours; however, none of the three had approval from the regional director to extend beyond forty-eight hours. One of the confinements last beyond seventy-two hours; however, no approval was found for this confinement, which lasted beyond eighty-six hours, to extend beyond seventy-two hours. There was also no confinement hearing held for this confinement, which is required for all youth held in confinement longer than three days. Three of the ten confinement reports documented all supervisory reviews as being conducted at a minimum of three-hour intervals. The other seven reports included a total of eleven late supervisory checks, ranging from twenty-six minutes late to six hours late. Three of the ten reports had consistent

documentation of the need for continued confinement. The other seven reports each had multiple supervisory reviews which did not document the need for continued confinement.

5.16 Continuity of Operations Planning (COOP) Drills	Satisfactory Compliance
COOP drills shall be conducted and documented, at minimum, twice a year, with one drill being completed prior to the hurricane season, which begins June 1st.	

The center has a comprehensive continuity of operations plan (COOP) to address multiple types of disasters. The center completed a weather drill before the beginning of hurricane season on January 24, 2018. An additional weather drill was conducted on April 30, 2018. Drills were conducted by all shifts. The drills were documented in the master control logbook. Each drill had an accompanying narrative and sign-in sheet. Five staff were interviewed, and each verified they were a part of a weather or disaster drill in the last six months.

5.17 Escape Drills	Satisfactory Compliance
The center shall develop, implement, and maintain an escape prevention plan incorporating the Department's established policies and procedure regarding escapes. *The facility shall conduct and document quarterly mock escape drills.*	

The center has a written policy and procedures regarding escape drills. The center's escape prevention plan is incorporated into facility operating procedures and includes all required elements. Escape drills are documented on a drill reporting form, with a staff sign-in roster, a description of the scenario, and the actions taken attached. Drills are conducted on a quarterly basis on all three shifts and were noted in the master control logbook. Five staff were reviewed for in-service training and each had documentation they had completed escape prevention training during the annual compliance review period. Additionally, five staff were interviewed and each reported participating in an escape drill during the previous six month time period.

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

The center has a policy and procedures in place to respond to emergencies, including those requiring the detention center to evacuate or relocate. The emergency drill reporting form is utilized to document fire drills. All drills were documented in the master control log. The center conducted fire drills on a monthly basis on each shift. A review of the fire drills in the master control log book showed drills were consistently documented. The center's evacuation plans are documented throughout the center indicating primary and secondary evacuation points. Five staff were interviewed, and each indicated they had recently participated in a fire drill. Five youth were interviewed, and each indicated they had been instructed on what to do in case of a fire.

Program Name: Brevard Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Cocoa, FL County / Circuit
Review Date(s): August 7-10, 2018

MQI Program Code: 244
Contract Number: N/A
Number of Beds: 40
Lead Reviewer Code: 161

Overall Rating Summary

The following limited and/or failed indicators require immediate corrective action.

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	
3.12 Suicide Prevention Training	
5.14 Confinement Under Twenty-Four Hours	
5.15 Confinement Over Twenty-Four Hours	