



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Clearwater

on 03/29/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Review Team

Members

Ashley Davies, Forefront LLC, Lead Reviewer/Consultant

Angel Colón, Hillsborough County, Senior Case Manager

James Myles, Bethel Community, CEO

John Robertson, The Florida Network, Program Services Director

Ramona Salazar, DJJ, Regional Monitor

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input checked="" type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 0 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 13 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 8 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 6 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 4 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

2 Youth 4 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts | |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The agency implemented a tutoring program with the HEAT team through Pinellas County Schools.

In January, the agency had their COA recertification visit and scored so well that the re-accreditation did not have to go through the usual committee and they were given their new COA status within weeks of the visit.

The shelter Case Managers have begun providing SafePlace presentations and general outreach in the community to increase awareness and engagement with their programs.

The agency had about 10,000 outreach postcards donated. A high school student did a SafePlace2B video as part of a class project and it is now on the agency website.

The COO resigned in February 2017. This position was divided into two separate positions: Senior Director of Community Services and Senior Director of Residential Services. At the time of the review only one of those positions had been filled.

Standard 1: Management Accountability

Overview

Narrative

Family Resources, Inc. – North youth shelter, named SafePlace2B, and non-residential programs are located in Clearwater, Florida. Family Resources, Inc. provides services through a direct local service provider contract with the Florida Network of Youth and Family Services. The Family Resources agency primarily provides CINS/FINS services in Pinellas County and nearby surrounding counties. Family Resources also operates sister youth shelters, also called SafePlace2B, that are located in St. Petersburg and in Bradenton, Florida. These agencies service youth and families in Pinellas, Manatee and other surrounding counties.

Each location has a licensed clinician, Shelter Director, Residential and Non-Residential counselors, Residential staff members and Outreach staff. A centralized Human Resources and Fiscal department handles all personnel and financial matters. Each sites' clinician reviews and oversees all counseling and mental health services provided to youth and families delivered at their respective location. The agency assigns the daily operation and direct responsibility of each shelter to the Residential Director at each youth shelter.

All Family Resources residential shelters have implemented uniform operating protocols for all three service locations in the areas of operations and programming for both residential and non-residential services. Other uniform protocols for all three locations include training and professional development. The agency conducts screenings prior to the hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency training's combine staff members of each location to be trained on various core training topics. This report focuses on the services associated with the North Shelter.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

There is a facility operating procedure for background screening of employees and volunteers to include interns and mentors which was last reviewed in March 2017. Screenings are conducted for all department employees and contracted providers for any staff, volunteers, mentors, and interns with access to youth. All screening is completed prior to hiring an employee or utilizing services of a volunteer/mentor/intern. The procedure also outlines the process for five-year rescreens for every five years of employment. Lastly, the policy also ensure that the annual affidavit of good moral character is completed by January 31 of each year.

As required by law in Chapter 985.407 F.S. and DJJ, a background screening must include a complete criminal history check and fingerprinting utilizing level 2 standards for all staff and volunteers. The process includes submitting an entire BSU packet in order to complete the preliminary screening. The program is to ensure that all items needed are provided, signatures obtained and when applicable, notarized. The provider is responsible for all costs as it relates to obtaining screenings. Screenings will be completed on all employees, interns and volunteers every five years. An annual affidavit will be completed by the human resources department in January of each year on all staff who were working during the calendar year no later than January 31st.

There were thirteen staff hired since the last annual compliance review and there is one intern. All staff and intern had background screening completed prior to the date of hire or placement. All staff were screened as either eligible or eligible with charges. There were no staff eligible for a five-year rescreen during this annual review. The Annual Affidavit of Good Moral Character was submitted to the background screening unit on January 20, 2017 under Family Resources Inc., Pinellas as required annually by January 31.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

There is a facility operating procedure for provision of an abuse free environment to ensure the environment is safe and secure which was last reviewed in March 2017. The environment for youth and staff is non-threatening and free from any form of abuse or harassment. Staff are required to adhere to a code of conduct that forbids staff from using physical abuse, profanity, threats or intimidation. Youth shall not be deprived of any basic needs such as food, shelter, clothing medical care, sleep and security.

The procedure ensures that any person who knows or has reasonable cause to suspect abuse, neglect by a parent, legal custodian, caregiver or other person responsible for the child's welfare must report such knowledge or suspicion to the Florida Abuse Hotline. The policy and procedure provides instruction to staff with contact phone numbers and the information necessary to conduct the call. All reported incidents will document the call in the clients file. There is a procedure in place should the victim require temporary placement. The policy also ensures cooperatively with the Department of Children and Families when indicated.

There is a staff code of conduct which prohibits the use of physical and psychological abuse, profanity, threats and intimidation. Posting of the CCC hotline and the Abuse Registry are posted throughout the program. If required, management takes immediate action through a corrective action and/or staff training process as required. Residential and non-residential youth have access to filing a grievance/complaint with forms available for them to complete or they may ask for assistance from staff. The grievance boxes are locked and are accessed only by the supervisor. There are no reported incidents of abuse since the last annual compliance review.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

There is a facility operating procedure for incident reporting which was last revised in August 2016 and reviewed in March 2017. The reporting process is used to identify problems, document trends and provide any necessary corrective action needed to minimize risk. The policy outlines that management is to take immediate action to address founded incidents of abuse (physical or psychological), verbal intimidation, use of profanity, threats or excessive use of force. The risk management process includes identification of any significance in the number or severity of incident types not limited to use of force, youth on youth battery/assaults, and misconduct.

There is a facility operating procedure for the grievance process within the incident reporting policy which was last reviewed in March 2017. The grievance process outlines that any client has the right to initiate and bring to the attention of staff any complaints, grievances, or action of program staff or the youth's peer, or conditions/circumstances of care and treatment that are in violation of their rights. The grievance

process includes written documentation of the grievance, acknowledgement by youth in writing that a written response from the program was received and a final response that concludes the issue; all addressed within five working days. All grievances are maintained in an individual site file for a period of at least one year.

All employees who have direct knowledge of an incident that constitutes a risk to the organization or to its clients must complete an incident report independently. The procedure also outlines any incidents listed above and are outlined by description. There is an incident report routing process which includes the completion of the report, to whom provided and when. This includes a hard copy with signatures upon completion and review to the supervisor. The supervisor and the COO or other senior staff member conducts an investigation and a review of the incident and takes any necessary corrective action and noting such action. The agency risk manager also conducts review of the incident to determine whether immediate response is necessary based on the severity of the incident. Is so, the risk manager makes appropriate senior leadership notification. The incident reporting procedure is in accordance to the Department's Central Communication Center (CCC) guidelines and is reported no later than two hours of learning of the incident as required. The procedure provides a description of reportable incidents identified by the CCC.

The procedure ensures that all staff make every effort to resolve problems, complaints, and grievances with the utmost expediency. The procedure outlines a description of complaints that may include but not limited to the denial of youth rights or service shelter, safety, clothing, food, unfair treatment, physical healthcare, mental health and substance abuse services, education/vocation, physical exercises, religion, visitation, correspondence, telephone access, discipline, grievances and dissatisfaction with the quality of services or with established program policies or procedures.

Grievance forms shall be readily available and the process for filing a grievance is explained as part of the intake process. The procedure allows the client to use the informal or formal phase of the grievance process and at any stage, the client is given the opportunity to acknowledge on the grievance form that the grievance has been adequately resolved or proceed to the next level. The policy and procedure also provides staff direction that if at any point the client receiving services while in the program feels that they have been physically or sexually abused they may request immediate and private access to a telephone for the purpose of notifying the abuse registry.

A review of CCC reportable incidents and internal incidents from 9/29/2016 through 3/28/2017 was conducted. There is an internal report for all incidents and those reported to the CCC referenced the CCC incident number. Those not accepted by the CCC had documentation that the incident was not accepted by the agency and noted on the internal incident reporting form.

There were five incidents in the CCC database; all were reported within the 2-hour timeframe, with management review and corrective action completed as required. One of the five reported incidents occurred in June 2016, however disposition of the case was closed in February 2017. A review of internal incidents was also conducted and the procedure for notification, review and corrective action was also followed as outlined in policy. All four incidents within the time period reviewed were documented on the facility log book as required.

The contact phone numbers for the Abuse Registry and the CCC are posted throughout the program. Management does address and/or take immediate action if necessary and it is documented on the internal incident report form. There is a locked grievance box for both the residential and non-residential clients which is accessed by the residential supervisor as outlined in policy. All staff are required to receive training on child abuse and incident reporting procedures which includes the grievance process during program orientation.

There were no exceptions to this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a facility operating procedure for training requirements. The policy stipulates that the first year of employment is a critical period for staff development and training and requires all full time staff that work directly with youth to have 80 hours of training in the first year of employment. Subsequent years of employment staff are to maintain at least 40 hours of annual training to include but not limited to refresher training in the operation of fire safety/alarm equipment, CPR and First Aid and how to recognize and respond to youth who need mental health or crisis intervention. The procedure for training includes a list of required trainings for first year employees through program orientation, annual mandatory trainings and in-service training topics all outlined in policy. The policy was last reviewed in March 2017.

There is an individual training plan and training record for each staff that specifically outlines the required training areas to meet the standards set forth by the Department for all CINS/FINS providers. Directors and Supervisors maintain individual training files for each employee and are required to review with each employee to ensure training requirements are met. Employees are expected to take an active role in their staff development and training needs and interests through communication with their supervisor. Any additional training may be added for position specific functions. There is an annual training plan that runs from June to July that provides training topics, time, location and date for each month for required and optional training. The plan provides new and current employees training topics options throughout the year in order to meet the number of required training hours.

A review of four pre-service and four annual training files/plans was conducted based on the employees date of hire and training completion within that first year. Staff are required to complete required training within the first 120 days of employment. Of the four files reviewed, two staff did not complete the required training topics as outlined in policy within the first 120 days and they were both hired in August 2016. Two of the four staff are in the progress of completing the required training within the 120-day requirement as they were hired in January 2017. All four pre-service training files were reviewed for the training topics to be completed after the initial 120-day requirement and all four are still in progress for completion for the first year of required training.

A review of four training files/plans was conducted. All four completed at a minimum of forty hours and all exceeded. Two of the four did not complete fire safety equipment training which is required every two years. A review of the 2016 and 2015 training certificates and training plans did not have documented proof for the completion of this training; these two staff provide direct care to youth. One of those two staff did complete this training while the review team was on site on the last day of the review. Documentation was provided and placed in the staff training file.

Exceptions:

Two staff did not complete all required trainings within the first 120 days.

One staff did not complete fire safety equipment training which is required every two years.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure to address the requirements of the indicator. There is a facility operating procedure for analyzing and reporting information which was last reviewed in March 2017. The policy provides a process for each program in the agency to compose a monthly report with relevant

program data which is sent to the COO by the 10th of the following month. The COO reviews this report as well as the monthly NetMIS data reports for the following: Incident/accidents and grievances, annual report which highlights specific activities, trends, successes and/or recommendations, achievement of goals, consumer satisfaction data, and client outcomes. In addition, other analyzing and reporting information includes coordination, and case record (peer) reviews and reports as outlined in policy.

All records receive a paperwork compliance review individualized for the required paperwork for that program and documentation of a record review is provided to the staff member responsible for that record. Individual staff members receive review documentation regarding a record they are responsible for. They are expected to use this information in their personal assessment of their skill level and training needs and to shape their future professional growth. The COO provides an aggregate report on the peer review activities for the directors and supervisors meeting on a quarterly basis.

The following reports were presented in support of this indicator: Risk management/Safety Committee meeting minutes, Netmis Average Length of Stay Report, Bed Days for CINS/FINS, DV Respite, and Probation Respite Bed Days, Knowledge Portal Discrepancy report (Med-Station) and CINS/FINS admissions. Review of incidents, accidents, and grievances are documented with annotated minutes of adjustment to procedure and practice as needed. The agency is COA accredited and adheres to the COA Performance and Quality Improvement structure of assigned multi-disciplinary teams assigned to assess and monitor specific agency processes, outcomes, and performance measures. Clinical Treatment Team meetings conduct regularly scheduled case file reviews to discuss methodology, approaches for individual clients, and evaluate the therapeutic process. Clinical Supervisor reviews and audits files for compliance and documents needed corrections and verifies service delivery.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

Agency internal policy adheres to the requirements of the Florida Network policy regarding transportation of youth.

Policy dictates that the program should avoid single client transport by a single agency staff person whenever possible to avoid risk to both the client and the staff person. In the event that single client transport cannot be avoided, the transporting personnel are to obtain prior approval from a director, and notify a supervisor when the trip is occurring. A trip plan must be documented with expected mileage and time estimates for travel. Personnel are then to notify the program when they arrive at their destination. Prior to approval of single client transport, a supervisor must consider the youth's past history, and current state of mind as well as the dynamic between individual staff and youth.

The agency practice is to pre-approve all clients for single client transport unless stated otherwise by program leadership. The transporting personnel do communicate their departure, destination, and arrival at destination for each documented occurrence of single client transport. The documents reviewed, including transportation log, contained all the elements as requested by the Florida Network indicator.

Exception:

The current practice does not demonstrate that all required factors are taken into consideration prior to approval such as youth/adult dynamic, client's current mental/emotional state, or client's past history.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy requiring participation in DJJ Circuit and Council meetings.

Procedure requires senior leadership to represent the agency in all standing meetings of DJJ circuits and councils.

Senior leadership share responsibility for attendance based on geographic location of the meeting. Participation was verified by eye witness testimony from Peer Reviewers in attendance who are familiar with the local meetings, and supported by documentation of email communication acknowledging participation of the agency. Documentation of minutes was not available due to turnover at the COO position and a lack of knowledge regarding the storage of the minutes.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Family Resources agency provides non-residential counseling services through its North Family Counseling Center located in Clearwater, Florida. The non-residential services include Truancy, Marriage and Family Counseling, and Family Counseling. There are two non-residential counselors and one licensed residential counselor. There is also one non-residential case manager and one residential case manager. Centralized Intake Services are evidenced throughout all charts reviewed. The Family Resources' non-residential program distributes a "Reference Guide for Clients" handbook to each parent/guardian or family. It clearly states the Rights and Responsibilities, Grievance Policy, Consent to Treatment, and Discharge Policy. The non-residential program also provides each family with the Florida Network's "A Guide to CINS/FINS Services for Parents". This provides the options and process through which parents can find the help needed for truant, runaway, and/or ungovernable youth.

Screenings are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. A case plan is developed for each client. In addition, home visits are conducted on a case-by-case basis to offer support to the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by Family Resources with shelter or residential care as a viable option for youth that need additional support services.

The non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, representative from the local school board, Department of Juvenile Justice attorney and other social services agencies gather together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist and resolve issues faced by the youth and their family.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The Agency has a written policy and procedures that addresses the key elements of Indicator 2.01. The policy was last reviewed in March 2017. The policy requires twenty-four hour, seven-days a week availability and access to CINS services for eligible youth. Screenings are to be completed within seven calendar days of the referral, but preferably immediately.

The agency's policy and procedures require the screener to conduct an eligibility screening upon first contact to determine client/family needs and appropriateness for either non-residential or shelter services. Review of presenting issues will determine placement in shelter, referral to non-residential services, or referral to other community agencies if not eligible for CINS services. Eligibility considerations include: ages between 10 and 17; delinquency status; no danger to self or others; not in need of detoxification; mental health status; no need for immediate medical care; and no history of arson, sexual or violent offenses. Eligible youth for shelter are placed the same day and parent is offered a family session the same day. If out-patient services are deemed most appropriate, the family is provided an appointment within seven days. At the time of admission intake, youth and parent are provided copies of: Rights & Responsibilities; Grievance Policy; service options; and FNYFS publication re: case staffing and CINS petition process.

There were ten youth files reviewed, five residential and five non-residential. All ten files included documentation of eligibility screening within seven days. All families received information regarding service options, rights and responsibilities, parent brochure, CINS petition process, and

grievance procedures.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that address the key elements of Indicator 2.02. The policy requires a needs assessment be initiated within 72 hours of admission to shelter and for non-residential clients, completed within two to three contacts of initial intake.

Needs assessments are completed by Master's level or Bachelor's level staff and signed by a Supervisor. When a suicide risk assessment is required as a result of screening, the licensed clinical supervisor must sign their name or complete and sign.

There were ten youth files reviewed, five residential and five non-residential. All five residential files had a needs assessment initiated within 72 hours. All five non-residential files had a needs assessment completed within the first two to three contacts. All ten needs assessments were completed by a Bachelor or Master's level staff and all were reviewed by a supervisor. One of the ten files showed the youth had an elevated risk of suicide based upon the screening and the youth was referred for a suicide risk assessment. The assessment was completed by a licensed mental health staff.

There were no exceptions to this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures that addresses the key elements of the indicator. The policy was reviewed and approved in March 2017. The policy requires a Case Plan to be developed both for shelter and non-residential clients based upon screening and needs assessment data.

The agency policy requires case plans to be completed within seven days following completion of the needs assessment. The case plan is to include: needs of youth/family; time frames; measurable goals; persons responsible; service locations; and services to be provided.

There were ten youth files reviewed, five residential and five non-residential. All ten files documented case plans were developed within seven days of the needs assessment. All ten case plans were individualized and documented prioritized needs and goals. All ten case plans included: service type, frequency, and location; persons responsible; target dates; and all signatures, including youth, parent, and staff with supervisor reviews. Nine out of the ten case plans documented completion dates.

Four of the ten files required either a 30, 60, or 90 day review. One of the files documented all reviews. The other three files were all missing one required review.

Exceptions:

One case plan did not document completion dates.

Three files were missing either a 30, 60, or 90 day review.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has written policy and procedures that addresses the key elements of Indicator 2.04. The policy was reviewed and approved in March 2017.

Agency procedure requires each youth assigned to either shelter or non-residential be assigned a case manager to follow the case and ensure delivery of services through direct delivery or provision of referral. Referrals include but are not limited to: court involvement, case staffing committee referral, and family support.

There were ten youth files reviewed, five residential and five non-residential. All ten files documented: assignment of counselor/case manager; identification and coordination of referrals; service plan implementation; monitoring progress for case plan; and case termination notes.

Out of the ten files reviewed, three required thirty day follow-ups. The follow-ups were completed as required.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of Indicator 2.05. The policy was last reviewed and approved in March 2017.

The agency offers counseling, both to their shelter clients and non-residential clients and their families. Individual case files are maintained for all counseling services, including individual/family counseling and daily group counseling for shelter clients. Family counselors in the shelter make every attempt to provide two family sessions with a goal of family reunification. Counseling services are based upon family/youth needs and goals and in accordance with an agreed upon case plan.

There were ten youth files reviewed, five residential and five non-residential. All ten files contained a needs assessment, case plan, and counseling progress notes that reflected continuity with family needs and planned goals.

All ten files had evidence of clinical reviews of case records.

There were no exceptions to this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for the Adjudication/Petition Process. The policy was last reviewed in March 2017.

In the event the CINS/FINS Counselor is unable to assist in resolving the problem or the family or youth have not demonstrated substantial progress in achieving goals specified in the service plan, the case is referred to the Case Staffing Committee. The Case Staffing Committee shall recommend needed services and treatment for the Case Manager to implement with the child and family. It shall receive reports from the Case Manager on progress or problems in implementing or successfully fulfilling recommendations.

The Case Staffing Committee shall include a representative from the Department of Juvenile Justice contracted CINS/FINS provider; and a representative from the youth's school district. The Case Staffing Committee may include: the youth, parent/guardian, a representative from the State Attorney's Office, the alternative sanctions coordinator, representatives from areas of health, mental health, educational, and social services, a supervisor of the departments contract provider, a representative from law enforcement, and any person recommended by the youth, family, or Family Resources. The Case Staffing Committee shall meet on a monthly basis.

There were three files reviewed for the Adjudication/Petition Process. None of the files were initiated by the parent. All three files were initiated by truancy court. All families and Case Staffing Committee were notified no less than five working days prior to the staffing. The case staffing included: a local school district representative, a representative from the agency, a representative from the State Attorney's Office, and a mental health/substance abuse representative. In all three files the youth and family were provided a new service plan. A written report was provided to the parent/guardian within seven days of the case staffing, outlining recommendations, in all three cases. There was documentation in two of the three cases that the case manager completed a review summary prior to the court hearing. The case manager was in the process of completing this in the third file reviewed.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Youth Records. The policy was last reviewed in March 2017.

All youth records shall be housed in a physically secure area or within locking cabinets, under the control of the supervisor. This area must be an area approved for each facility. Records may be removed for staff access. All records are to be returned to the secured areas at the end of the work day. Records will be transported in a locked, opaque container that is marked confidential.

There were ten youth files reviewed, five residential and five non-residential. All ten files were marked confidential. Non-residential files are stored in a locked room, in a locked file cabinet on the non-residential wing of the facility. The residential files are stored in a locked room, in locked files cabinets, on the residential side of the facility. The agency has an opaque container, that locks, that is used for transporting files when needed. All ten files reviewed were neat and organized in a consistent manner.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

Family Resources, Inc. provides residential CINS/FINS services through a contract with the Florida Network of Youth and Family Services. The North SafePlace2B shelter is located in Clearwater, Florida. At the time of this Quality Improvement review, the program was staffed with a Residential Supervisor, Shelter Counselor, a Case Manager, sixteen Youth Development Specialists, a Cook, and a Nurse.

The Residential Supervisor oversees the day-to-day operations of the youth shelter. The residential program's Counselor is an LMHC. The shelter provides a "Client Handbook" to each youth upon admittance. Beyond that, each parent sits with the youth while staff goes through the handbook so both youth and parent will know what the expectations are while the youth is in the shelter. Parents and/or guardians also receive at that time a brochure, "Strong Families Are the Cornerstone of Our Community". All forms are signed by parent/guardians and youth showing an understanding of them. It identifies and explains many family services offered by Family Resources.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The facility has a detailed written description that addresses the key components of the Shelter Environment that meets the requirements of The Florida Network of Youth and Family Services Indicator 3.01; which was revised in March 2017 and signed by the CEO.

The agency's policy and procedures addresses the environment of the shelter with daily structured, daily programming, admission and discharged procedures. The facility's Residential Supervisor or their designee conducts weekly inspections of the facility by using a checklist to attend the areas that are in need of attending regarding the facility overall such as cracking plasters, paints, graffiti, malfunctioning appliances, broken windows, insect infestation, inappropriate storage, worn electrical cords, etc. Staff inspects the sleeping rooms on a weekly basis to determine whether they have appropriate lighting, bed covers, pillows, curtains or blinds. The facility also has a locker where each youth is able to keep their personal belongings if requested. Staff is responsible in preparing the daily schedule that is to include education, recreation, specialized treatment services, life and social skills training, reading and leisure activities that includes television but only as part of the behavior management system or for educational purposes.

The facility is presented very clean and the grounds are very well kept. All health and safety inspections are current. The furniture is in great condition, no graffiti on the walls, doors, or windows. Each room appears to be very clean with individual bed, clean mattress, pillows, and sufficient blankets. The facility is also very secured with limited access, both in and out, controlled by facility staff. As of March 2017, there has been ten (10) emergency drills, eighteen (18) fire drills, thirteen (13) tornado drills and five (5) suicide drills. The facility has a detailed color-coded daily schedule for the youth with meaningful structured activities which consist of education, recreation, life and social skills. There are also opportunities for the youth to engage in educational activities and complete their homework while school is in session.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that meets the requirements of Indicator 3.02 regarding the program orientation for the agency.

The agency has implemented a detailed procedure regarding the program orientation. Within twenty four (24) hours of admission, staff provides the following procedures to the youth: identification of key staff and their roles, tours of the facility, emergency evacuation procedures, room assignment, disaster preparedness, suicide prevention, policies on contraband, grievance procedures, FL Abuse Hotline contact information, telephone and mail procedures, medical care, review of consequences if youth violate rules of the program, dress code and expectations to youth hygiene practices which are consistent with the FDJJ Policy 8.07. A Youth Orientation Checklist is completed and signed by the youth and staff within twenty four (24) hours of their admission date. Each youth is provided with a Youth Handbook which details the program.

Each file reviewed by the Reviewer listed the expectations of the orientation requirements which are well documented and contained all required signatures and dates within the 24 hour time-frame. Each file had all appropriate signatures and materials provided such as contraband items, disciplinary actions, dress codes, medical and mental health services, procedures for visitations, map of the facility, room assignment and any alerts regarding suicide prevention. Based on the findings by the Reviewer it appears that each youth has been well informed and educated with the facilities program procedures and expectations. Staff that was interviewed by the Reviewer was very knowledgeable of the materials and process for the program orientation. All youth being admitted into the program receives a tour of the shelter and are introduced to available staff along with their functions. A Citizenship Scavenger Hunt is provided to the youth as a tool to have the youth engaged and learn about the program rules and expectations which is reviewed and signed by a staff member.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that was last reviewed in March 2017 and approved by the CEO of Family Resources Inc. SafePlace2B Youth. The policy is clear and complies with the expectations for protection of the youth. It also ensures the most appropriate sleeping room assignments and arrangements.

The agency Youth Room Assignment procedure is well documented where the staff interviews the youth to make the most appropriate room assignment. The determination of the room assignment is based on the youth's age, sex, height, weight, level of maturity, gang affiliation, prior delinquency background, level of aggression, past involvement in assaultive or aggressive behavior both sexual and physical which are for the protection of their residential youth. The youth accommodations are approved by the Residential Supervisor. Any special accommodations is documented in the youth file or milieu and approved by the Residential Supervisor after the admission and the approval by phone from a Supervisor is documented if necessary.

During the review process of five (5) files of residential youth, it was revealed that the staff makes the most appropriate room assignments based on the program procedures. The conditions of the rooms appear to be very clean and organized, there is ample space within their assigned rooms for comfort, privacy, and

security. Each file reviewed was color-coded with a system alert sticker on the outside for an indication that there is a potential serious medical condition. Each shift change, the staff logs in the progress notes as an alert to the staff for any concerns or any regular debriefing information until the youth is discharged from the facility.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy that addresses the key elements of maintaining a permanent log book to record the daily activities, events, incidents, emergency situations and unusual incidents as part of the QI indicator. The policy was last approved in March 2017 and signed by the CEO.

The agency's logbook procedures meets all requirements of Indicator 3.04. The procedure is maintained by staff. The log is reviewed and signed by all staff upon arrival to departing the assigned shift. All entries are to be written in ink with staff signatures, date and time. Any errors are struck through a single line and initial and date the correction. Significant events that impact the security and safety of the program are highlighted as well as new shift, admissions, discharges, emergency drills, alert changes and temperature and heat index. The Residential Supervisor reviews and signs the permanent log weekly.

After reviewing the logbook, it appears that the agency has met all QI Indicators. Staff are documenting clear with ink and no erasures or white out areas. Logbook reflects the track of dates, times, and events that occur within the residential program. Important entries are highlighted and coded as Pink for new shift/day/month and year; yellow for child in the shelter; and blue for out of the shelter. Purple is coded for alert changes; orange for emergency, fire, and tornado drill; and green is coded as the entries of the temperature & heat index. The Residential Supervisor reviews the logbook weekly as required and makes entries of the date it was reviewed, makes corrections, recommendations, and follows up as necessary. During the review, there was an entry by the Residential Supervisor requesting the staff not to be on their cellular devices during their shift. Seven (7) days later the Residential Supervisor followed up with another entry indicating that staff continues the usage of cellular devices during their shift and it was viewed on the surveillance cameras by the Residential Supervisor which reflects a good practice of monitoring.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a detailed description of the Behavioral Management System (BMS) which meets the QI 3.05 Indicator and was last reviewed in March 2017 and signed by the CEO.

The Behavioral Management System (BMS) procedures for the agency are written with a detail description that encourages accountability and provides positive reinforcement for compliance with the program's rules and expectations. The agency does not include seclusion, restraint or other restrictive interventions.

The staff determines the level of performance of each item and designates a child as being on Orientation, Citizenship, Leadership or Ownership. All staff is trained on the (BMS) as well as Supervisors to include the point-based and level-based interventions.

During the interview with a Case Manager, the procedure and practice of the (BMS) was described well and in detailed. Youth is provided with a Youth Handbook upon intake. A Youth Citizenship Scavenger Hunt is provided to the youth in order to get educated with the rules and expectations of the residential program. The program has a level system that includes Orientation, Citizenship, Leadership, and Ownership. During the Orientation level, the youth reviews the policies, expectations and safety information. A behavior grading sheet is being documented on a daily basis by the residential staff with a checkmark for compliance and a (0) for non-compliance.

In order to acquire the Leadership level, youth will meet expectations and follow all residential program rules. Once a youth is in Leadership level, the youth will have access to choose one of the following: chose of chores, earn extra shelter dollar for the shelter store, play video game during free time, stay up thirty (30) minutes later in common area. If youth is on the Citizenship level, they can attend the recreational outings, vote on television (TV) programs during free time and make phone calls during the hours of 7pm-9pm with family members or approved adults only.

The Ownership level is a result of negative or inappropriate behavior by the youth. The expectations on this level are for the youth to follow shelter rules, and complete intervention assignments provided by counselor/case manager. The shelter store permits the youth to purchase items with shelter dollars (written on paper) once per week which is on Thursdays. Items in the shelter store rotate frequently and staff on duty assigns the dollar amount to the item. Each level has well defined expectations and privileges.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency utilizes the Florida Network Policy 3.06 Staffing and Supervision for their internal policy corresponding to the supervision of youth.

Their policy adheres to the minimum required ratios governing all shifts within the shelter. The policy also states that each shift will have staff matching the genders represented in the program. The written policy also dictates that a staff schedule will be posted in a visible location and that a roster of available on-call is maintained to provide for additional supervision or substitute coverage of shifts. The policy requires that overnight staff conduct bed checks of all clients at fifteen minute intervals or more frequently if designated by a counselor or case manager.

The agency follows the stated procedure. They do have difficulty finding male direct care staff, and therefore have two female staff on overnights. They provided documentation of posted job notices exclusively seeking qualified male staff. They have an abundance of male staff at a different agency program in Manatee County and attempt to recruit them for service in this program. Efforts to meet gender requirements are ongoing.

Video records were reviewed for three distinct dates over the last three weeks. Records were not available for the past thirty days due to memory shortage-- a problem which was rectified by the security contractor while review team was on-site. Video system can now retain six terabytes instead of two, which increases retention capacity for a minimum of four weeks and a maximum of six weeks depending on the activity

level during the recorded time-period.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

[Rating Narrative](#)

Agency has a policy addressing all requirements regarding special populations. Policy is current and was reviewed and approved in March 2017.

The program provides for increased levels of supervision as required for placement under DV Respite, Probation Respite, Staff Secure, and DMST youth. Policy dictates that plans of service must be specific to the presenting needs and precipitating factors for the referral.

Program has served two youth under Domestic Violence Respite program during the period since the last review. Both case files indicate that the youth were referred from the JAC and were approved by the Florida Network. Case plans and chronological notes indicate both youth were monitored for behavioral triggers related to their incidences of domestic violence and received excellent clinical treatment by the licensed counselor. Both youth were discharged to home detention with referral for continued non-residential family counseling.

The agency did not service any Probation Respite, Staff Secure or DMST youth during the review period.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency utilizes the Florida Network QI Indicator 3.08 as a policy governing the use of a video monitoring system.

The stated policy provides for a written notice to be posted in plain view on the premises notifying all of the presence of a video monitoring system. The policy requires all general areas in which youth and staff congregate inside the building and on the grounds. All cameras must be visible, with no cameras placed in bathrooms or sleeping areas. The system must capture and retain video at a resolution to recognize individuals. The system must record, date, time, and store video for a minimum of thirty days. Video monitoring system is required to have a battery back-up function. Supervisory review of video coverage is required every 14 days with documentation of shifts reviewed, and observations made regarding practice witnessed. The system must have the ability to transmit and share coverage with third parties as requested.

The program maintains a video monitoring system supported by a third-party contractor, Fort Knox Security Inc. Prior to March 29, 2017 the system did not have adequate memory to store video for the

required thirty days. On average, the coverage was available for the prior two to three weeks. After increasing storage to four terabytes, the system can now retain coverage for a minimum of four weeks and a maximum of six weeks.

A supervisor regularly reviews the coverage and documents particular shifts reviewed in the logbook and provides observations and insights based on the footage reviewed. Documentation reviewed demonstrated a thorough analysis of the activity reported and feedback was provided in the logbook regarding activities witnessed. The video system has the ability to download and store particular footage as an MP4 video file.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Family Resources agency provides screening, counseling and mental health assessment services. The residential Counselor is a Licensed Mental Health Counselor (LMHC). The Family Resources agency has staff members that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. The agency also uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in the residential youth shelter.

The Family Resources agency assists in the delivery of medication to all youth admitted to the residential youth shelter. The agency operates a detailed medication distribution system and utilizes the Pyxis Med-Station 4000 Medication Cabinet. The agency provides medication distribution training, CPR, first aid, fire safety, emergency drills and exercises, and training on suicide prevention, observation and intervention techniques to all direct care staff members. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place called Healthcare Admission Screening. The policy was last reviewed in March 2017.

The admission process will include an in-depth health screening through the completion of the CINS Intake Assessment Form. If there is any concern that a physical condition merits screening or it is apparent that there is a major health care issue, the youth will be immediately referred to their physician, emergency room, or the public health care department. In the event a youth is admitted with a chronic medical condition, staff will contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medication, general precautions, and how to proceed in the case of an emergency.

There were five open residential files reviewed. All five files documented the CINS Intake Assessment Form was completed at admission. None of the youth had any chronic or acute health conditions. There were three youth taking medications and the medications were documented. One youth had allergies to medications and those were documented as well. The CINS Intake Assessment Form was signed by a supervisor, in all five files, on the day it was completed. The form was also reviewed and signed by the RN, in all five files, within twenty-four hours of admission.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a Comprehensive Master Plan for Suicide Prevention and Response in place. The plan was last reviewed in March 2017.

The plan states that each youth will be screened for suicide risk by the six suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to questions two and three, the youth is considered to be at high risk of suicide and must be placed on One-to-One supervision and referred for Baker Act. If the

youth answers “yes” to questions 1, 4, 5, or 6 on the Intake Form then the youth is determined to be at moderate risk for suicide. The youth will be placed on sight and sound supervision until a full suicide risk assessment is completed. The assessment will be done within twenty-four hours during the weekdays or within seventy-two hours if over the weekend.

There are four different levels of supervision used in the shelter. One-to-One Supervision is the most intense level of supervision and is used while waiting for the removal of the youth from the program for the purpose of Baker Act. Constant Sight and Sound Supervision is used for youth who are identified as being at moderate risk of suicide but are not expressing current suicidal thoughts or threats. Elevated Support is a step-down alert. The youth was previously identified as a suicide risk but is no longer considered at-risk for suicide. Standard Supervision is for youth whose screening of suicide risk did not indicate the need for further assessment and they may be placed in general population.

There were four files reviewed for youth placed on suicide precautions. Three of the four youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. Two of those three youth were seen immediately by a counselor and a Suicide Risk Assessment was completed and the youth were placed on elevated supervision. The third youth was placed on constant sight and sound supervision until seen and assessed by a counselor. The fourth youth was placed on suicide precautions after admission due to staff observations.

All Suicide Risk Assessments were either completed by a licensed counselor or documented consultation with the licensed counselor. The youth were removed from suicide precautions after consultation with the licensed counselor. The two youth placed on constant sight and sound supervision documented thirty minute observations the entire time.

Documentation was found in the logbook of youth on suicide precautions and also changes in supervision levels.

There were no exceptions to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Medication Management and Distribution. The policy was last reviewed on July 1, 2016.

There are procedures in place for the verification of medication at admission by a staff member. Medications must be verified using one of the four methods outlined in the CINS/FINS Policy and Procedure Manual. There are procedures in place for the utilization of the Pyxis Med-Station 4000 including: storage, access, and inventory. There are processes in place for the delivery or assisting in the self-administration of medications. There were procedures in place for medication distribution for youth away from the shelter and the discharge of youth with medication. There were no procedures for disposal of medications.

The agency has a Registered Nurse (RN) who is on-site Monday through Friday from approximately 7am to 9am and then again from 5pm to 8pm. The RN will distribute all the morning and evening medications when on-site.

The agency provided a list of seventeen staff who are trained to supervise the self-administration of medications. There are three Super Users listed and the RN is one of them.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. There is a Skills Checklist completed with the RN and newly hired staff during the training process. The checklist is signed by the staff and RN and dated when completed. The staff are then given a “test youth” on medication and are required to complete the whole process as if it were a newly admitted youth. All staff must complete this training with the RN before they are authorized to distribute medications. Once

the staff has completed the training the RN will observe the staff give the medications for the first time if needed. The RN also completes on-going trainings with staff on various health related topics. The RN completes health education groups with the youth. The youth are given print-outs from TeenHealth.org on different health related topics such as alcohol, drug use, hygiene, etc. and the RN will go over these print-outs after dinner.

All medication is stored in the Pyxis Med-Station. Regular prescription/non-controlled medications are stored in drawer two. Controlled medications are stored in the third drawer of the Med-Station. Drawer four is used for over-sized medications. Medications are verified at admission usually by the RN; however, if the RN is not present for the admission the staff will call the pharmacy to verify the medication. Drawer one was empty at the time of the review.

There have been fifteen discrepancies in the last thirty days. The discrepancies are generally closed out within twenty-four hours unless it is over a weekend and the RN is not on-site. The staff notifies the RN each time there is a discrepancy, if the RN is not on-site then they will call. The RN maintains a notebook of all discrepancies. The printout from the Pyxis Med-Station detailing the discrepancy is stapled in the notebook and the RN documents the date, time, solution, and signature next to the print-out. The Residential Supervisor also signs off on the discrepancies. Most discrepancies reviewed were staff inputting incorrect beginning counts. The RN reported there have not been any discrepancies involving missing medications.

Trained direct care staff complete an inventory every shift of all the controlled substances. This is completed by two staff members and is documented on the youth's Medication Distribution Log (MDL). A perpetual inventory is maintained on the youth's MDL each time a medication is given. Non-controlled medications are inventoried by maintaining a perpetual inventory each it is given and inventoried one time each week by the RN. The shelter does not maintain any over-the-counter medications that would require an inventory.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. The RN maintains a log documenting the temperature of the refrigerator at least once per week.

The shelter has sharps located in a locked box in a cabinet in the staff work area of the dorm. The shelter maintains eight pairs of scissors and disposable razors that are restocked as needed. These sharps were inventoried each shift for the past six months. A perpetual inventory is also maintained each time one of the sharps is used.

The RN currently runs several reports from the Knowledge Portal. The reports include: All Orders by Medication, All Discrepancies, a Console and Activity Log report, and a Patient Audit. These reports are maintained in a binder and reviewed by the RN at least monthly.

The shelter has a process in place for refills of medications when they get low. The RN will call the youth's parent once the medication has approximately seven days remaining and request them to bring in a refill. The RN will continue to call the youth's parent if the medication is not received in a timely manner.

The shelter has two alert boards located in the dayroom and the medication room. The board located in the dayroom documents which youth are on medication and the board in the medication room documents the youth's name, the medication, and the times to be given. The RN will complete a form for all staff to review if there is a new youth admitted on medication, anytime a medication is added to an existing youth, or if a youth has an odd medication time frame. This form is then reviewed with all staff on each shift during shift change.

There were five youth in the shelter currently on medications. The Medication Administration Log was reviewed for these five youth. All medications were verified at admission either by the RN or the pharmacy. The Consent for Self-Administration of Medication and Verification of Prescription Medication form was found for each documenting all medications the youth was taking. All the MDL's reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, times to be given, common side effects, reason, and the full printed name of each staff administering medication, as well as, the youth. A picture of the youth is located in front of the MDL in the

Medication Administration Log. All MDLs reviewed on site document that perpetual inventory counts with running balances are being maintained on each medication. All MDLs reviewed for the youth also documented that all medications were given at prescribed times. All inventories of the medications were documented on the MDLs. Controlled substances were generally inventoried each shift by two staff members. There were instances of these medications not being inventoried on second shift due to there not being two trained staff members present for the inventory. All non-controlled prescription medications were inventoried once per week by the RN and documented on the MDLs. Perpetual inventories were maintained on the MDLs for all medications.

The shelter also maintains a binder with print-outs of side effects for every medication in the shelter. As new medications come in, the RN will add the print-outs to the binder if they are not already in there.

There was one CCC report in the last six months relating to a medication error. The error was due to a malfunction of the Pyxis Med-Station. The Med-Station would not open so that staff could dispense the medication. The RN and Care Fusion were contacted and the problem was fixed and the youth was able to receive the medication; however, it was outside the one hour window. No staff were reprimanded in this instance due to the problem being with the Med-Station and not with staff forgetting to give the medication.

Exceptions:

The policy does not have procedures for disposal of medications left at the facility.

There were instances where shift-to-shift inventories of controlled medications were not completed on second shift.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for Medical and Mental Health Alert Process last reviewed and updated in March 2017.

There is one alert board located in the dayroom for staff to review and also an alert board in the nurse's station. The alert system consists of color-coded dots with each colored dot representing a different alert. There are eight different colors used for alerts: red indicates the youth is on constant sight and sound supervision, yellow is elevated support, green is a mental health alert, blue is substance abuse, purple is sharps restriction, black indicates a medical issue, orange indicates the youth is on medication, and pink indicates allergies and/or special diet. The applicable color-coded dot is placed on youth's file for each alert the youth is on. The color-coded dot is also placed next to the youth's name on the alert board.

A total of six open files were reviewed for adherence to this indicator. All files reviewed had an alert that was appropriate to their screening and assessment results. All alerts documented in the youth's file corresponded with the alerts documented on the alert board. Any food allergies or dietary alerts are also documented in the kitchen. All alerts were documented in the logbook as well.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on Episodic/Emergency Care that was last reviewed in March 2017.

All staff have current training in CPR/First Aid and the use of emergency equipment (knife-for-life, wire

cutters, first aid kit). There are first aid kits located in the shelter and the vehicles. Also there is a closet located in the dining room with bulk supplies of first aid items. The contents of all first aid kits are checked weekly by the RN. The knife-for-life and wire cutters are located in a cabinet located behind the staff work area in the shelter. A seatbelt cutter and window punch is located on the keychain for the vehicles.

The shelter maintains an Episodic (First Aid/Emergency) Care Log. There have been five instances of episodic care-- three of which required the youth to be taken off-site to the hospital. Those three were reported to the CCC. All five instances were documented in the Episodic Care Log. All incidents documented the parent/guardian and Residential Supervisor were notified. An internal incident report was completed for all incidents, as well as, a CCC report if required. Follow-up instructions/care were also documented.

The shelter has completed five mock drills in the last six months: one was a broken leg, two were burns, and two were cuts.

There were no exceptions to this indicator.