



Florida Network of Youth and Family Services Quality Improvement Program Report

Family Resources St. Petersburg

September 28 – 29, 2016

Compliance Monitoring Services Provided by





CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
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 & 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 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 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%



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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%

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.30%

Percent of indicators rated Limited: 3.70%

Percent of indicators rated Failed: 0.00%

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; limited, unintentional, and/or 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.

Review Team

Members

Ashley Davies, Lead Reviewer, Consultant-Forefront LLC

Kelley Scott, Youth and Family Alternatives, CINS/FINS Non-Residential Supervisor

Julie Edison, Hillsborough County, Manager of Residential Services

Toni Del Regno, DJJ, Regional Monitor



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Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2016).

Persons Interviewed

- | | | |
|--|--------------------------------|--|
| <input checked="" type="checkbox"/> Program Director | 2 # Case Managers | 1 # Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 # Clinical Staff | 1 # Program Supervisors |
| <input type="checkbox"/> DHA or designee | _____ # Food Service Personnel | _____ # Other (listed by title): _____ |
| <input type="checkbox"/> DMHA or designee | 1 # Healthcare Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" 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 type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 5 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 8 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 # Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 # Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | _____ # Other: _____ |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|------------------|------------------------------|-------------------------|
| 6 # Youth | 4 # Direct Care Staff | 0 # Other: _____ |
|------------------|------------------------------|-------------------------|

Observations During Review

- | | | |
|---|--|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input 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"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input checked="" type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input checked="" type="checkbox"/> Medical Clinic | <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



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Strengths and Innovative Approaches

Narrative

The agency has added a new position, Director of Quality & Integrity.

The shelter has added a position, Facilities Coordinator, who oversees maintenance concerns, purchasing, vehicles, and vehicle maintenance.

The agency secured grants from Northeast Exchange and the County to put in new flooring, furniture, appliances, and fencing throughout the shelter. They are calling this renovation to the shelter their Drab to Fab campaign.

The LGBTQ program that was located in the St. Pete shelter has been moved to the agencies Clearwater shelter.

The shelter has implemented an evidenced based curriculum called Safe2B You & Me. It is a healthy relationship education provided to shelter youth once a week. This program is also in 98% of the high schools in Pinellas County.

The agencies Case Managers are certified in delivering the Why Try curriculum.

The shelter partnered with the American Legion over the summer for swimming activities which included life guarding and lunch.

The sheltered partnered with the Pinellas County Schools' HEAT team (a team that works with homeless students and families) to provide tutoring during the school year and Summer Bridge.

The shelter received donations from the Ford Motor Credit Corporation that included pictures, cutlery, books, and clothing.

The shelter received a donation of flip flops for the youth from the Parrot Head Club.



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Standard 1: Management Accountability

Overview

Narrative

The Family Resources, Inc. SafePlace2B program provides shelter and non-residential services for youth and their families in Pinellas County and Manatee County.

Residential shelter staff includes a Residential Supervisor, nineteen Youth Development Specialists, three Residential Counselors, one Case Manager, one Truancy Case Manager, two Street Outreach Specialists, one Administrative Assistant, and one cook. All residential shelter staff and non-residential staff are overseen by an on-site Program Director. The Department of Children and Families has licensed Safe Place 2B as an emergency runaway shelter.

The agency operates a total of three youth shelters and the company handles all personnel functions through its Human Resources division located at its central office in Pinellas Park, Florida. This office processes all state and local background screenings. The provider agency conducts orientation training to all shelter personnel through its Residential Supervisor. The majority of core training is also provided by inter-agency training delivered by the agency, as well as, outside and on-line training resources. Each employee has a separate training file containing a training plan and copies of documentation for training received. Annual training is tracked according to the employee's date of hire. The program provides training through a combination of web-based and in-person instructor-led courses.



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1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

All employees, interns, mentors and volunteers with access to youth undergo a criminal history background screening to ensure that they are not a danger to youth. The background screening must be completed prior to employment or position change. All staff and volunteers and interns working in the program are screened through a formal law enforcement criminal history and receive an eligible rating prior to an offer of employment. A re-screening is completed every five years after the date of initial screening. An Annual Affidavit of Compliance with Good Moral Character will be completed by the Human Resources Department by January 31 of each year on all staff who were actually working during the calendar year.

As required by law in Chapter 985.407, Florida Statutes and the Department of Juvenile Justice policies, a background screening must include a complete criminal history check including fingerprinting. The following procedures shall be maintained by the prospective new employee, volunteer, intern: Completion of a background screening packet, and make sure all items requested are supplied, all forms signed and, where applicable, notarized.

The program has hired six new employees since the last compliance review in January 2016. Background screenings were reviewed for each new employee. Each of the reviewed screenings were completed prior to the date of hire. All six employees were rated eligible for hire, so no exemptions were required. The program has recently engaged one intern from the University of South Florida who provides counseling services. A review of her background screening verifies screening was completed prior to the intern's access to youth in the program. The program does not currently utilize volunteer services. One employee was applicable for a five-year background rescreening. A review of the rescreening documentation verified the rescreening was completed two months prior to the five-year anniversary date.

Documentation was reviewed confirming the completion/submission of the Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 4, 2016, prior to the deadline date of January 31, 2016, as required by Department of Juvenile Justice Policy.

Exceptions

There were no exceptions noted regarding this indicator during this review.



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1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has written policies in place ensuring the youth in the program experience an environment in which they feel safe, secure and free from threats, harassment, and/or any form of abuse. This policy addresses the staff Code of Conduct, the reporting of any kind of abuse, neglect, or abandonment to the Florida Abuse Hotline, the implementation of a grievance system to ensure youth in the program are able to grieve actions of staff and conditions or circumstances related to the violation or denial of basic rights and the requirement that management responds immediately to address any incidents involving any type of abuse, verbal intimidation of youth, the use of profanity by staff in the presence of youth, as well as, any instance of the excessive use of force.

The program requires all staff to sign a Code of Conduct documenting their awareness of the Code and the expectations of them during their course of employment. The program provides staff training regarding the reporting of suspected abuse, neglect, abandonment by parent/guardians and provides the number to the Florida Abuse Hotline to the staff via postings on the facility walls. The program also ensures youth are aware of their right to contact the Abuse Hotline and the telephone numbers to the hotline are strategically placed in the living areas. The program provides a grievance procedure for the youth to document their concerns and present them to management. The procedure involves the completion of grievance form, the submission of the completed form into a locked box to ensure direct care workers do not have access to completed grievance forms, and a review by the program or residential supervisor within 72 hours. There is an appeal process if the youth is not satisfied with the supervisor's response to the grievance. All grievances and findings shall be maintained in a central file for the period of one year. Procedures are in place for management to address all incidents of abuse, verbal intimidation and excessive use of force and the use of profanity by staff in the presence of children.

The program has a Code of Conduct requiring staff to maintain high standards of personal conduct while an employee of the facility. A review of the Code of Conduct indicated behavioral expectations of staff are clearly outlined and the possible disciplinary consequences of staff violations of the Code are stated. All staff are required to sign an Affidavit of Compliance with the Code of Conduct as evidenced by a review of a random sample of six staff signed affidavits. Observed, the program posts the Florida Abuse Hotline number in the youth lobby of the facility and in the youth living area. Additionally,



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reviewed documentation reflected staff informs and educates youth of the procedures to report abuse during the intake process and this information is provided to the youth in their copy of the Youth Handbook. Seven of seven reviewed staff training records documented staff are trained regarding abuse reporting. Program practice is to document and record all abuse reports on incident forms. A review of incident reports completed in the past six months documented one call to the Florida Abuse Hotline.

The program has process in place for youth to share their concerns with staff. A review of orientation documentation reflected staff informs and educates youth of the process and this information is provided to the youth in their copy of the Youth Handbook. Observed, a locked box in the youth living area readily accessible to youth where youth can submit their grievance/feedback about the program. Program practice then requires the program supervisor to retrieve, review, and address youth grievances. There were three grievances submitted over the past six months. All three reviewed grievance forms related to youth feeling disrespected by staff. Each grievance was addressed in a timely manner with conflict resolution techniques between the youth and the applicable staff member facilitated by the program supervisor.

During this review, administrative staff advised there have been no incidents related to the abuse of youth requiring the attention of management including physical or psychological abuse, or other staff misconduct including threats or intimidation of youth, the use of excessive force, or staff use of profanity in the presence of youth. Congruently, a review of five reports to the Central Communications Center in the past six months indicates no such incidents.

Exceptions

There were no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There are written policies in place which asserts a reporting process for incidents that may pose a risk or liability to the organization or its clients. This process will assist in the identification of problems and document trends and corrective actions taken to minimize future risk. Per policy, management will take immediate action to address founded incidents of abuse and incidents of verbal intimidation, use of profanity, threats and/or the use of excessive force. There is a formal, written risk management system in place for



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identifying and addressing significant change in the number or severity of incidents. This includes but is not limited to: use of force (by staff and shift), youth on youth battery and/or assaults, staff misconduct with youth and allegations against staff. There is also a policy stating the provider complies with the DJJ policy 8000 “Central Communications Center” (CCC) on incident reporting. The CCC will be notified as soon as possible, but no longer than two hours after reportable incident occurs, or within two hours of the program learning of the incident.

All staff who have direct knowledge of an incident that constitutes a risk to the organization and/or clients must complete an Incident Report and must report the incident within one hour of occurrence to the appropriate senior staff member and within two hours to the CCC. Follow-up will be provided to the CCC assigned staff with requested information until they indicate the case is being recommended for closure. The procedure lists numerous types of activities which would require incident reporting.

The program documented five reportable incidents to the Central Communications Center (CCC) during the past six months. Two of the reported incidents related to medication errors, two others related to the need for emergency services to evaluate a youth and one was a youth report of inappropriate physical contact by another youth while in the program. A review of documentation indicates four of the five incidents were reported to the CCC within the required time frame. In all applicable cases, the program completed all tasks and submitted all requested documents as required by the CCC. Three of five of the CCC reportable incidents were detailed in the program logbook on the date/time of the incident. A review of incident reports verified that in four of five CCC reported instances, the program completed an incident report. Each of the completed incident reports was signed by the senior staff.

Exception

There was one reportable incident, during which, a youth ingested marijuana on-site and subsequently required medical evaluation. This incident occurred at approximately 11:00 p.m. however, it was not reported to the CCC until the following morning at 9:24 a.m.

Two of five CCC reportable incidents were not documented in the program logbook.

One of the five CCC reportable incidents was not documented on an incident report form.

1.04 Training Requirements

Satisfactory

Limited

Failed



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Rating Narrative

The agency has a policy in place for Training Requirements last reviewed in July 2016.

Each staff member has an individual training file with an individual training plan. The training plan lists all required trainings and staff are to document the date next to each training as it is completed and then the supervisor will initial next to the training to confirm it has been completed. All supporting documentation is placed in the staff's file once the training has been completed. At the time of the review the training plans were updated to reflect that all new hires received required trainings within the first 120 days of employment. The plans were also updated to add the new trainings—Serving LGBTQ Youth and Cultural Humility.

There were seven staff training files reviewed—three training files for first year training requirements and four training files annual training requirements to be completed after the first year.

The three training files reviewed for first year training requirements documented 97.5, 63, and 75.75 hours of training. The two staff members who had received 97.5 hours and 75.75 hours of training still have approximately two weeks left in their training cycle to receive additional trainings. Both staff still needed to receive CINS/FINS Core training and Signs and Symptoms of Mental Health and Substance Abuse. All other trainings had been completed. The third staff member 63 hours of training with no time left to receive additional trainings to reach the required 80 hours for the first year. This staff was also missing CINS/FINS Core training and Signs and Symptoms of Mental Health and Substance Abuse, but had all other trainings.

There were four staff training files reviewed for annual training requirements following their first year of employment. The shelter is licensed by DCF so staff are required to have 40 hours of training each year. The staff documented 47.25, 5.5, 13.75, and 46 hours for the last full training cycle. The two staff members who documented more than the required 40 hours, documented all required trainings. However, one of those staff members did document a two-month lapse in CPR and first aid certification as the certification expired in July 2016 and the staff was not trained again until September 2016. The two staff members who did not reach their required 40 hours, one staff was missing Suicide Prevention, and although this staff was currently certified in CPR and first aid they did document a two-month lapse as the certification expired in July 2016 and the staff was not trained again until September 2016. The second staff who did not reach their 40 hours had an expired CPR and first aid certification but did have the other required trainings.

The agency is currently in the process of getting all staff trained in crisis intervention techniques. The training is approved and used by the Florida Network. The agencies Director of Quality and Integrity is signed up with the Florida Network to receive the training and be a trainer for the rest of the agency. Once she has attended the training and is certified she will begin training all agency staff.



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Exceptions

One staff training file reviewed for first year training requirements only documented 63 hours of training with no time left to receive additional trainings to reach the required 80 hours for the first year. This staff was also missing CINS/FINS Core training and Signs and Symptoms of Mental Health and Substance Abuse.

Two staff training files documented a two-month lapse in CPR and first aid certification as the certification expired in July 2016 and the staff were not trained again until September 2016.

The two staff members did not reach their required 40 hours for annual training requirements. One of those staff was missing Suicide Prevention. The second staff who did not reach their 40 hours had an expired CPR and first aid certification.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy asserting the belief the decisions made by the organization makes in order to maintain and improve the quality of services must be based on input from consumers, staff and the community, as well as, reliable data regarding the services population, the community needs, the provision of services, and the effectiveness of the services. The provider has put into place a variety of processes that work together to provide and analyze pertinent information regarding program performance and quality of services. This information analyzed and put into report form and then conveyed to the program staff, the management staff, and the Board of Directors for discussion and decision-making.

The program gathers and reports the following information to generate a monthly report of relevant program data including incidents, accidents and grievances. The CEO reviews the report, as well as, the NETMIS data reports. On a quarterly basis, the Chief Operating Officer compiles a report of incidents, accidents and grievances. Case record peer reviews are also conducted quarterly using a standard form and data that is compiled and summarized in a report. These reports, along with NETMIS data reports, funder and licensing reports and reports from Human Resources are all reviewed by the program directors and Supervisors Team at their bi-monthly meeting. An Annual Report is developed for each program aggregating specific data to highlight specific activities, trends, successes and recommendations, achievement of goals, consumer satisfaction data and client outcomes. This report is ultimately published on the agency's intranet



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(the FamilyNet) for staff and consumers to review, and highlights are also discussed during the quarterly agency-wide meetings.

The program provided a sample of aggregate data, summarized in detailed graphs for review. Also reviewed was a copy of the last quarterly report and the last annual report. The program also provided evidence of an internal Quality Improvement Compliance Review with a detailed report documenting deficiencies and areas in need of improvement. A review of this compliance report substantiated the program staff are working to identify program weaknesses and areas of improvement and then developing strategies to enhance performance in these areas. For example, with report findings documenting an issue in maintaining Cardiopulmonary Resuscitation/First Aid certifications for staff, more frequent and accessible trainings were provided. A review of documentation provided by the program verifies the consistent collection and analysis of various data to identify program patterns and trends, program strengths and weaknesses and to enhance decision making to maintain and improve the quality of services provided by the program. There is an agency-wide workbook where information is stored and communicated. Reviewed documentation indicates reports are completed monthly regarding a variety of data including, but not limited to the daily census, admissions, length of stay, the provision of family counseling services, program incidents, accidents and grievances, as well as, youth and family satisfaction survey results.

Monthly review of NetMIS data reports is also completed by the program director. Quarterly analysis reports are completed regarding case file reviews, logbooks, and other documents as part of the program's comprehensive performance and quality improvement plan. Each quarterly report focuses on identifying where improvement is needed to enhance the provision of services. A review of a CINS annual data analysis report indicated the collection of statistics on almost every aspect of program operations. Additionally, the report documented trends and action items addressed for clarification of issues and goal setting for positive change.

The provider agency has a system in place to communicate with all staff regarding program operations and performance. There are postings of reports and information on the agency intranet. Monthly telephone conferences for administrators and supervisors also serve as a forum for information exchange. Focused e-mails are also sent on occasions to communicate information obtained through data analysis. A review of staff meeting minutes indicates the administrative staff seeks to inform all staff regarding data analysis results regarding program strengths and weaknesses, as well as, trends in program performance.



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Exceptions

There were no exceptions observed in a review of this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy requiring all agency vehicles used to transport youth are inspected at least annually by a certified mechanic to minimize risk of mechanical problems. Additionally, policy states the following safety equipment be in each vehicle during a transport: anchored seat belts, a fire extinguisher, a first aid kit, a seat belt cutter and a window punch.

The program's transportation policy, focuses on youth and staff safety, both in the actual transport of the youth and in the avoidance of situations where the staff or the youth could be in danger of allegations of inappropriate conduct. Integral to the policy is the approval of specific staff drivers who have been screened to ensure they have a valid Florida Driver' Operators License. These staff are then covered by the agency's automobile insurance company. The program policy also acknowledges it is best practice to have a third party (approved volunteer, intern, agency staff or another youth), present in the vehicle when transporting a client. However, the policy also allows for situations when a third party is unavailable. The program maintains a Vehicle Mileage log to document the date, time and the destination of the trip, the occupants of the vehicle, the starting/ending mileage and the anticipated time of arrival/actual time of arrival.

Staff are responsible for reporting any signs of vehicle maintenance issues, communicating the concern to the program supervisor and taking the vehicle for regular safety inspections. All required safety equipment will be available prior to each transport. A single youth can be transported without a third party if the youth is screened taking into account, the youth's previous evaluations, history, personality, recent behavior and length of stay all of which may indicate whether inappropriate behavior may occur. The driver is also screened regarding his/her work performance and history and length of employment. The residential supervisor will communicate with staff via log book entry or the white board, which youth are appropriate for single transport. Another optional safeguard in place for a staff when transporting a youth without a third party is the audio witness accessed when a driver calls the program and maintains an open line on the telephone while making the transport. This safeguard is required if a single youth has to be transported prior to the residential supervisor being on site to determine if the



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youth is appropriate for single transport. A vehicle log book is maintained in a binder which is kept in the vehicle and reviewed by the residential supervisor once monthly.

The program utilizes a six-passenger van to transport youth. Compliant with an internal policy regarding agency vehicles, the van is inspected annually and contains emergency and anchored seat belts to equipment to enhance safety. A review of the vehicle logbook contained a receipt for a vehicle inspection in September 2016. The program maintains a list of authorized staff drivers. The current list has twenty staff members listed. Each of these drivers were screened at admission to have a valid driver's operator's license. Additionally, the human resource department conducts annual checks to ensure each authorized driver's license is valid. Each authorized driver has received training regarding the transportation policies and procedures.

A review of the vehicle logbook indicates each trip the van makes is logged with the following information: date, time of departure, time of arrival, driver's initials, youth initials, destination/purpose of travel, mileage, number of occupants, and supervisory approval.

The program policy stipulates having a third party presence in a vehicle is best practice when transporting a single youth, and lists these parties as an approved volunteer, intern, agency staff or another youth. It also provides, however, for instances when a third party is not able to be present during a single youth transport. This policy includes a review by program management staff, the youth's history, evaluation data, and recent behavior to determine if such a transport is acceptable. A review of the facility logbook indicates the program supervisor reviews youth information and determines if the youth is appropriate for single staff transport. He then documents his findings in the program logbook to ensure staff are able to differentiate which youth can be transported at a 1:1 ratio. There is documentation in the logbook indicating the supervisor has consented to single youth transports and he is aware the transports are taking place.

Exceptions

There were no exceptions observed in a review of this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative



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The provider has a policy stating staff are sent to participate in local DJJ Board and Council meetings to ensure CIN/FINS services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services. The assigned staff person (Chief Operating Officer, Program Director, or Residential Supervisor) attends local and circuit level meetings convened by DJJ to advocate for the effective use of CINS/FINS services and to update agency leadership on meeting activities. Policy further states the provider maintains written agreements with community partners that include services provided and comprehensive referral process.

The agency provides support and accommodation for staff who are participating in assigned meetings and staff attending the various DJJ/Community meetings will obtain copies of the minutes to the meetings and provide the minutes to agency leadership. Staff attending the meetings will also provide verification of attendance at DJJ Board and Council meetings.

A review of a binder focused on program outreach documented the Chief Operating Officer's attendance to several DJJ Circuit meetings. Reviewed minutes of these quarterly meetings and observed the Chief Operating officer provided a presentation during one of the most recent meetings. Also in this binder was a lengthy list of various meetings attended by the Chief Operating Officer or the Program Director to interface with various community agencies who might have services to offer the youth in the program. Another binder contained a listing of several community partnerships established by the program to help better serve the youth. Some of these partnerships were with local counseling centers, others were forged to ensure the provision of health and/or mental health services for youth in the community.

Exceptions

There were no exceptions observed in a review of this indicator.

Standard 2: Intervention and Case Management

Overview

Family Resources, Inc.'s SafePlace 2B South Campus in St. Petersburg is contracted through Florida Network to provide CINS/FINS non-residential and residential counseling services for youth and their families in Pinellas County and neighboring counties. The program provides an intake and screening process twenty-four hours a



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day, seven days a week. The program consists of trained staff that are available to discuss the needs of the family and the youth.

Residential services within the program include individual, family and group counseling services. Case managing services and substance abuse prevention education are also offered in the program. Referral and after care services begin when the youth is admitted into the program for services. Aftercare services consist of referring the youth and family to community resources, on-going counseling services and additional educational assistance. The Youth Development Specialists (YDS) are responsible for completing all admission paperwork, orientation of the youth to shelter, and supervision of youth while in shelter. The residential component consists of one full time Master's level counselor and one full time Bachelor's level case manager.

Non-residential services within the program include individual and family counseling. Non-residential services counselors provide case management services for truant and ungovernable youth while also linking youth and families to community services. The non-residential component also encompasses the Case Staffing Committee. This is a statutorily mandated committee that develops a service treatment plan for truant youth, ungovernable youth and runaway youth when all other interventions have been exhausted or upon the request of the parent/guardian. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court as needed. The non-residential component consists of one full time Master's level therapist, two contract specialists, one full time Bachelors level case manager and one student intern to elevate the workload of the counselors encompassing completing intakes, sessions, etc.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place (Family Resource: 2.01) for Screening and Intake.

The policy is implemented by the following listed procedures: At first contact with the youth a screening of eligibility will be conducted to determine if the Residential or Non-Residential facets of the program will be deemed appropriate for the youth. The youth must meet several points of criteria including but not limited to: must be between the ages of 10-17, may not be currently adjudicated delinquent, may not be a danger to self or others, mental health issues must be under control and the youth is not in need of any immediate medical care. The screening will also be utilized to serve as an overview of the presenting problems and any other pertinent history which will help



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determine the best course of action for the youth. If the youth is not deemed eligible for services through Family Resources three community referrals will be issued to the family for follow-up.

There were five non-residential files that were reviewed; two closed and three opened. Of the five files all five of the eligibility screenings were completed within the seven days of the referral. The five files were also reviewed for Consent for Treatment, Youths Rights and Youths Responsibilities within the intake process.

There were five residential files that were reviewed; two closed and three opened. All five files had completed the eligibility screenings within the seven days of the referral and all five contained the Consent for Treatment, Youths Rights and Youth's Responsibilities form. Residential youth and their parent/guardian are provided with a Youth Handbook which details the expectations of program services and behavior within the shelter.

Exceptions

There were no exceptions noted to this indicator.

2.02 Needs Assessments

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place (Family Resources: 2.02) for Needs Assessment.

The policy is implemented by the following procedures: The assessment must be completed within 72 hours of admission in residential and non-residential should be completed within two or three face to face contacts with youth. Within either component of the program if a suicide assessment is necessary this must be conducted immediately following the intake form and reviewed and signed by clinical supervisor or written by licensed clinical staff.

There were five non-residential files reviewed; two closed and three opened. Of the five two did not have a completed suicide assessment after there were indicators on the CINS intake form of risk factors and one of the files did not have a supervisor's required signature on the needs assessment. All needs assessments were completed by Bachelor's or Master's level staff.



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There were five residential files reviewed; two closed and three opened. Of the five, all files completed the needs assessment in the required time frame of 72 hours. The shelter supervisor signed the assessments within a timely manner. None of the youth were identified as a suicide risk through the CINS risk factor form or the needs assessment.

Exception

Two non-residential files reviewed did not have a completed suicide assessment after there were indicators on the CINS intake form of risk factors and one of the files did not have a supervisor's required signature on the needs assessment.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place (Family Resources: 2.03) for the Case/Service Plan.

The policy is implemented by the following procedures: The case/service plan is to be developed within seven working days of the completion of the needs assessment with the youth and the family. The plan is developed based on the information that is ascertained from the screening, the intake, and the assessment. It is ideal for the youth and the family to be involved in the development of the plan. Each Plan will include but not be limited to: specific needs identified, realistic time frames for completion of the goals, actual goal completion dates, stated responsibility of the youth and family members to complete the goals, specific service and treatment to be provided to individual youth. Required signatures of all parties and the date the plan was initiated.

Within seven days of a youth entering the residential program the service plan will be completed with the youth along with the parent/guardian by telephone or during session. If the youth or family member is unwilling to sign the case/service plan the information will be documented in the plan and the progress notes. The counselor will then be responsible for reviewing and implementing the plan with the youth and to make continuous contact with the parent/guardian.

There were five non-residential files reviewed: two closed and three opened. Of the five, one was missing signatures from the parent and the youth, one was not developed as the youth did not return after the initial session, and three did not have completion dates as the charts were still active.



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There were five residential files reviewed: two closed and three opened. Of the five, one closed was missing an actual completion date. The remaining did not have the completion date as the charts are still active.

Exception

One non-residential file was missing signatures from the parent and the youth.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place (Family Resource: 2.04) for Case Management and Service Delivery.

The policy is implemented by the following procedures: A counselor/case manager is assigned to each youth who enters the residential program or the non-residential program. Said counselor/case manager will follow the youth' case to ensure the delivery of services through direct supervision and sessions. This includes but is not limited to; the counselor establishing the needs of the youth and completing referrals to community agencies, coordinating the service plan implementation, monitoring the youth and the family's progress in services, providing overall support for the family, possible referral to the case staffing committee as needed to address increasing issues with youth, accompanying the youth and parent/guardian to court hearings and applicable appointments, and case termination with follow-up.

There were five non-residential files reviewed: two closed and three opened. Of the five, one did not have case management and service delivery as the youth did not return after the initial visit. All youth were monitored appropriately and counselors provided efficient support and care to the youth and family. All sessions were documented appropriately.

There were five residential files reviewed: two closed and three opened. Of the five, all were provided with sufficient case management and service delivery according to the needs of the youth. All youth were monitored appropriately and counselors provided efficient support and care to the youth and family. All sessions were documented appropriately.

Exceptions



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There were no exceptions noted to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place (Family Resources: 2.05) for Counseling Services.

The policy is implemented by the following procedures: All information contained in the case file on the youth and the family in care conform to all laws regarding confidentiality. All case files are to reflect the coordination between the presenting problems of the youth and family, the needs assessment, the case/service plan that is formulated, the case service plan reviews (if applicable), counseling and case management notes, and follow up with youth and family. Chronological notes are also kept on the youth's progress throughout the program participation.

Residential counseling is responsible for engaging the family in a variety of services. Counselors are to make at least two attempts for family counseling. All youth are offered the opportunity for counseling sessions along with family sessions. The primary goal of the residential counselor is to develop family reunification and explore options with the approval of the youth and family for appropriate placement (if deemed necessary) outside of the immediate home environment to ensure a safe place for the youth.

Non-residential counseling includes but are not limited to crisis intervention, assessment and screening of the youth as well as individual, family, and group counseling. The non-residential program also accepts referrals from school guidance counselors, school resource officers, local law enforcement agencies, DJJ as well as any concerned adult in the youth life. Referrals are also taken from the youth themselves. This program must have an annual average of twelve sessions per family.

Family involvement is crucial to the youth and the reunification of the family. Family counseling is offered to bring the youth and the family together in order to resolve the issues that separated the family initially. Once the youth and the family are reunified additional counseling will be recommended. The counselor will then assist the family in the referral process to community agencies.

There were five non-residential files reviewed: two closed and three opened. Of the five files, two did not have continuing counseling services as one did not return after the initial visit and the other declined services after the second session. All other files



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indicated that counseling services were continuously provided to the youth and the family based on the findings of the initial screening and needs assessment. All files were reviewed and signed.

There were five residential files reviewed: two closed and three opened. All five files had continuing counseling services in place for the youth and the family. The youth's presenting needs were identified and addressed in the counseling sessions with the youth and the family as outlined in the case plan and progress notes of each youth. All files were reviewed and signed.

It should be noted that posted schedules of group counseling sessions were in the living room area of the shelter visible for all youth to view.

Exceptions

There were no exceptions noted to this indicator.

2.06 Adjudication / Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place (Family Resources 2.06) Adjudication/ Petition Process.

The policy is implemented by the following procedures: In the event that the assigned counselor of the youth is unable to resolve the issues presented of the youth and the family or the youth has not made substantial progress in improving on the said issues the youth can be referred to a Case Staffing Committee. The counselor will provide the committee with the progress and barriers that have prevented the youth from achieving the goals of the Case Service Plan.

This committee is comprised of representatives from local community agencies: representative of DJJ, youth's school, the State Attorney's Office, local law enforcement along with various areas of mental health, educational and social services and any other individual recommended by youth or the family. This committee will recommend services and treatment to the case manager/counselor to implement with the family. The committee will also have the final decision on filing a CINS/FINS Petition in Court when the case manager/counselor brings the recommendation before the committee. The case manager/counselor will provide the youth and the family a written report



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outlining the recommendations of the Case Staffing Committee and if a petition will be filed in Court (as applicable).

Four Case Staffing files were reviewed. All four were truancy oriented. All steps in the process were completed within the time constraints including the initial CCS letter to the family. This was documented by a letter in the file. Notification to the CCS committee members were documented through emails. There was a revised plan for services for each youth within the file and signatures were present on all forms. If the parent/guardian was present a copy of the report was provided to them at time of hearing. If the parent/guardian and youth did not attend a copy of the report was mailed within the allotted seven days. Of the four files two were court involved. Each file contained appropriate paperwork including the court review and documentation that counselor attended the court hearing with youth and family and offered additional support.

A schedule of the CCS meetings for the year was provided for review. The list of committee members is listed on the case staffing review form. An agenda for the CCS was provided in the Case Staffing binder.

Exception

There were no exceptions noted to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place (Family Resources 2.06) for securing youth records:

The policy is implemented by the following procedures: All client records are placed in a physically secure area or contained within locking cabinets under the control of the supervisor. Files can be removed for staff access but are to be returned to the secure location by the end of the day. The youth's file should be available at all times to utilize within the facility or direct care of youth. While the records are utilized they are to be kept in a secure area at all times and not left unattended at any time. Recording information in the youth's file should be completed in a private location. Original records should not be removed from the property for the exception of transporting to court or another program site. All records should be retained according to legal, accrediting or regulatory requirements, then destroyed according to approved agency retention



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protocol. The protocol of destruction of the youth's file shall be witnessed and attested to in writing.

There were five non-residential files reviewed: two closed and three opened. All five were organized according to chart protocol and easy to follow. Each file was marked in red "confidential" and in good shape. Files are kept in a locked filing cabinet behind a locked door. Files, if necessary, were transported in a locked confidential container.

There were five residential files reviewed: two closed and three opened. All five were organized according to chart protocol and easy to follow. Each file was marked in red "confidential" and in good shape. Files were kept in a secure filing cabinet. Files, if necessary, were transported in a locked confidential container.

Exceptions

There were no exceptions noted to this indicator.



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Standard 3: Shelter Care

Overview

The SafePlace2B St. Petersburg youth shelter is located in a modern structure that is licensed by the Department of Children and Families (DCF) for twelve beds. The shelter also admits youth from the Department of Children and Families (DCF) and as part of the Basic Center and Street Outreach Programs. At the time of the Quality Improvement review, the shelter was providing services to five CINS/FINS youth.

During the tour of the facility, the review team toured all major areas include sleeping rooms, kitchen, bathrooms, dining area, medication storage area, recreation area, wash room, as well as other areas. The structure was found to be clean and in good working order and all major furnishings were in good repair. Major areas such as the bathrooms, the common area and dining room were clean. The Youth Development Specialists are primarily responsible for hygiene and cleaning of the shelter. The bedrooms were found to be clean. Each sleeping room is categorized by a right, middle and left sequence. Four of the bedrooms house three beds each with an individual bed, bed coverings and pillows. The outside grounds are surrounded with a privacy fence and residents have access to green space, a gazebo and an open basketball court.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The Family Resources Shelter Environment Policy is up-to-date, meets standards and was last reviewed July 2016.

It is also the policy of the Family Resource Center to conduct weekly inspections of the facility and grounds which is facilitated by both the Residential Supervisor and Facilities Coordinator. The weekly inspections cover the external grounds, fire sprinkler/safety, cafeteria, bedrooms, bathrooms, laundry, living room, and staff office/restroom.

Health and Fire Inspections are current. Health Inspection completed 11/9/15; Fire Inspection completed 8/8/16; Fire Sprinkler 6/6/16; Fire Extinguishers 7/21/16. DCF License 12/15/15; COA accredited 11/6/15. There is also a Pest Control Company that visits the facility once a month to ensure the program is free of insect infestation. The facility is organized and clean, furnishings are in good repair, bathroom/shower areas are clean and functional, bedrooms were clean and tidy, there is no graffiti on walls, doors or



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windows; and lighting is adequate. There is a lockable drawer to keep youth personal belongings. Youth are engaged in meaningful structured activities to include allotted time for homework, Life and Social Skill training, at least one hour of physical activity, and one hour of free time. The grounds are well groomed. The programming schedule is publically posted and accessible to both staff and youth. Off-site religious services can be attended by any youth in the program.

There are currently seven youth in the program. Upon review of each individual youth's bed, three beds had flat sheets only, four beds had no sheets, and two did not have fitted sheets. All beds had comforters and pillow cases. It was noted that all youth received all necessary sheets immediately once brought to the attention of staff.

Exceptions

There were no exceptions noted to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The Family Resources Shelter Policy is up-to-date, meets standards, and was last reviewed July 2016.

All new clients are oriented into the program within 24 hours of admission to the program. This orientation serves to introduce clients to the program's philosophy, goals, services and expectations. The youth orientation checklist is signed by the client and staff and placed in the client's file. The client is also provided with a copy of the SafePlace2B handbook which details the program, explains disciplinary process, grievance procedure, emergency/disaster procedure, contraband rules, provides a physical/facility layout map, and explains room assignments. The daily activity schedule is also reviewed and abuse hotline number provided. Staff will designate a resident (when available) to provide the client a tour of the shelter and introduce to available staff person and during introductions provide a description of the staff function. All program postings are pointed out and explained. In the event a client is admitted during late hours, orientation items are noted with an asterisk on the Youth Orientation checklist that is completed prior to the client retiring to bed. Of these items, an initial by the staff and client will suffice until remainder of the times are completed the next day. Staff inform clients of the need to alert staff of suicidal feelings or awareness of others having suicidal thoughts.



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There were three youth files reviewed that reflected all procedures were followed and that youth reviewed and received the SafePlace2B Youth Handbook and were oriented into the program within 24 hours. Signatures for youth and parent/guardian were obtained for all files.

Exceptions

There were no exceptions noted to this indicator.

3.03 Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The Family Resources Policy is up-to-date, meets standards, and was last reviewed July 2016.

During the intake process, staff will observe clients and interview them to make the most appropriate room assignment. Clients who are determined to need special accommodations for their own protection or for the protection of the other youth will be assigned appropriately. The reason for the special accommodations should be documented in the client file or milieu and approved by the Residential Supervisor or Program Director within 24 hour of admission. This also applies to medical or mental health conditions. Any youth admitted with a medical or mental health condition, staff are to document in the milieu log, condition/action taken will be recorded in the form of a progress note highlighted in yellow. The condition and action to be taken will be recorded in the shift exchange log and carried forth from one shift to another until the youth is discharged. Client files are coded with a system alert sticker on the outside indicating any serious conditions. Staff review files and the milieu log at the beginning of each shift. Staff are to follow policy and procedure for medical emergency care. Information regarding HIV/AIDS will only be disclosed on an as-needed basis.

There were three youth files reviewed for Room Assignment. All files indicated room assignments. The files included a review of youth's history, status and exposure to trauma, risk factors, gender identification, alerts, collateral contacts, and initial interactions and observations. Alerts were noted in the log book. None of the files noted a medical condition that may result in the need for emergency care. There is a shift exchange log that is carried forth from one shift to another with medical/mental alerts that is reviewed daily. Alerts were indicated on the outside of all files and on the white board located in the day room.



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Exceptions

There were no exceptions noted to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program will maintain bound log books with sequential pages to document daily activities in the program to include admissions, discharges, youth alerts, each time a youth enters or leaves the facility, transports, any significant incidents or events which could impact the safety and security of the youth, as well as, staff/supervisory reviews of log book information.

The staff shall review the log books upon entry to the facility to review updated information on youth who were in the program the last time the staff worked, new youth who were admitted to the program and information regarding youth who have left. They will document their review of the log book each time a review occurs. Staff will highlight key entries with the established color coded system including orange for any entry relating to the safety and security of the youth and yellow for admission/orientation information. Staff shall document an error by striking through the error and then initially the strike-through.

The program maintains one active logbook, which documents routine daily activities and events and incidents in the program. A review of three logbooks found them to be bound, with numbered pages. Though two of the three reviewed log books were observed to be worn and ragged, there were no missing pages. All entries were documented in ink and many were highlighted in various colors. The logbooks were dated once for each day and all entries subsequent to the date (highlighted in pink) were understood to have taken place on that date. The logbook contained entries documenting safety and security issues including youth searches, youth leaving the facility without permission, and fire drills. Other entries included youth admission and releases, youth leaving and returning to the facility, youth medical issues, behavioral issues and other significant incidents. Resident counts and room assignments were also consistently documented. There is documentation staff review the logbook at the beginning of the shift. There is a supervisory review of the logbooks at least once weekly, but typically more often.

Exceptions



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Not all entries were legible.

Errors were often corrected with either scribble or a write-over. The write-overs were often numbers reflecting counts.

Two CCC reported incidents were not documented in the log. Two of the three CCC reported incidents that were documented, did not document the call to the CCC.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The policy is up-to-date, meets standards, and was last reviewed July 2016. It is the policy to incorporate a behavior management system designed to foster accountability and compliance with the program's rules and expectations. The behavior management system is designed to promote a positive peer based feedback process aimed at personal growth and fostering a model for effective community living. The behavior management system is described in the client handbook given to each client upon intake.

When a youth is admitted and on orientation, they must wait 24 hours before the youth can request to complete a "scavenger hunt test" to move up to the Citizenship level. The test involves the youth going back to the client handbook to review the rules and expectations of the program. If they pass, they move up to Citizenship Level. Value points are earned to purchase from the canteen. Within 48 hours, a youth can request to be on leadership level where they are then required to complete one activity which may involve writing an essay, leading a discussion with peers, lead a fitness group, or write and perform a skit. Leadership levels earn more value points to purchase from the canteen. A Behavior Grading Sheet is completed each day by staff. If a youth violates any of the following: school attendance, respect towards others, or safety, that youth will revert to an 'Ownership Level' where they will need to complete a form that promotes accountability for the youth's behaviors by asking the youth how they can learn and make better choices in the future and develop a positive replacement behavior, such as anger management techniques, communication skills, etc. and agree on appropriate consequences.

Staff verbally recognize residential clients on an ongoing basis for tasks successfully accomplished, areas of improvement, and for strengths that a client may possess. Praise, encouragement, and support are practiced daily to promote and foster growth and provide an emotionally safe environment to facilitate learning and adolescent development. At no



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time, is a staff permitted to restrain or restrict a youth's movement unless it is imminent that there will be physical violence. Once the imminent danger has passed, a staff cannot continue to restrain a client.

The program has a detailed written description of the behavioral management system utilized to include incentives for positive behaviors, interventions used to teach youth new behaviors and help youth understand the consequences for their actions. BMS provides for positive reinforcement & recognition; constructive dialogue & peaceful resolution; and minimizes separation of youth from the general population. The Residential Supervisor must give prior approval for the use of room restriction. Staff and youth must then have a discussion every ten minutes to determine the need for continued restriction. Room restriction must not exceed one hour and is documented in the daily log and in the youth's case file. There were no documented incidents of any youth placed on room restriction in the log book.

The Client handbook was reviewed that details the BMS. Weekly Point sheets and supplemental handouts were also reviewed that support the promotion of levels or reverting back to ownership level. Training records reviewed for two staff presently working on the floor reflects both staff trained in BMS. The Residential Supervisor reviews the grading sheets weekly, signs off that they are being done correctly and provides feedback when needed. The Residential Supervisor's training record also reflects his current training in BMS.

Exceptions

There were no exceptions noted to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The policy is up-to-date, meets standards, and was last reviewed July 2016.

The program has a policy in place that meets general staffing ratio requirements by Florida Administrative Code and contract. There are two staff members on duty in each residential program at all hours of the day, one male and one female. The shifts overlap throughout the day which provides a great opportunity for staff to debrief for the oncoming shift. The program staff schedule is provided and visible to staff. A contract labor roster is maintained containing home and work telephone numbers of staff who may be called



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to provide coverage when needed. The Program maintains 1 staff to 6 youth during awake hours and community events and 1 staff to 12 youth during sleeping hours.

Bed checks are to be conducted every fifteen minutes; however, bed checks reviewed back to April 2016 reflect some inconsistencies in meeting the fifteen-minute rule of checking on youth. In the last two months, bed checks outside of the fifteen-minute requirement were noted on 8/23, 8/25, 9/2, and 9/15. Some bed checks on these days ranged over twenty minutes. A random review of three different dates of overnight shifts in September was conducted, via the programs video surveillance system, which reflected that fifteen-minute bed checks were being conducted appropriately during those time frames.

Exception

There were four days reviewed in which some bed checks ranged over twenty minutes.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The policy is up-to-date, meets standards, and was last reviewed July 2016.

It is the policy of Family Resources to provide a higher level of security for Staff Secure Shelter Youth and to implement strategies that work to reduce runaway incidents. There have been no Staff Secure or Domestic Minor Sex Trafficking youth since the last Quality Improvement Review.

There were four Domestic Violence (DV) files reviewed. All four files contained the necessary documentation to verify the youth was eligible for DV respite services which included: referrals from PJAC, signatures on all documents, and completed Needs Assessments. All files contained case plans that reflected goals focusing on aggression management. Only one youth was in the shelter more than twenty-one days and there was an Intake/Discharge Summary that reflected the youth's discharge and transition into CINS.

There were four Probation Respite (PR) files reviewed. Three of the four files reflected that they came from DJJ Probation and Adjudication was withheld. One file reflected that a youth initially came in as CINS and then was later approved for PR placement. It could not yet be verified that FNYFS was contacted for approval prior to admission for PR placement of all four of the files due to the FNYFS system being down. Length of stay for



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a PR youth is not always definitive or pre-determined at admission; although PR youth are to stay no more than fourteen to thirty days. There were no files that reflected a PR youth staying beyond 30 days. Case Management, Counseling, and all other services provided were consistent with all CINS/FINS program requirements.

Exceptions

There were no exceptions noted to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The policy is up-to-date, meets standards, and was last reviewed July 2016.

It is the policy of Family Resources to have a video surveillance system that operates 24 hours a day, 7 days a week to monitor and capture a recording of agency happenings to assure the safety of all youth, staff, and visitors to residential shelters.

Due to a reported hard crash drive in July 2016, the current video surveillance system can only retain two weeks' worth of surveillance; although the analog system of the outside exterior of the facility can go back thirty days. IT continues to work on repairs to the system and it was noted during the on-site review that IT had fixed the issue and reported the system should now be recording thirty days of footage. A full thirty days must pass to ensure the system is recording properly. This was unable to be determined while on-site. There is a total of thirteen cameras located in the interior and exterior locations of the shelter where youth and staff congregate and where visitors enter and exit. A written notice has been ordered which will be posted on the premises for the purpose of security. All cameras are visible and can capture and retain video photographic images including facial recognition and records date, time, and location. There is a backup system in place for power outages. There are only three individuals that can access the video surveillance system; Residential Manager, Program Director, and Chief of Operations Officer (COO). A supervisory review of video footage is conducted frequently and within a two-week time frame and goes back to July 2016. There are consistent reviews by the Residential Manager of overnight shifts. In addition, three random dates were reviewed of overnight shifts in September during this review which reflected that fifteen-minute bed checks were being conducted. In addition, per the Florida Network of Youth and Family Services Policy, review of all surveillance should be documented in the logbook. There is a process



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in place for third party review of video recordings after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.

Exceptions

There were no exceptions noted to this indicator.



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Standard 4: Mental Health/Health Services

Overview

The SafePlace2B St. Petersburg youth shelter provides screening, counseling, and mental health assessment services. The Program Director is Licensed Clinical Social Worker (LCSW). The shelter has staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both the residential and non-residential CINS/FINS programs. The shelter provides risk screening and identification methods to detect youth referred to their program with mental health and health related risks. Specifically, the shelter utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth's past mental health status, as well as, their current status. The shelter also screens for the presence for acute health issues and the shelter's ability to address these existing health issues. The shelter 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. Trained shelter staff assist in the delivery of medication to all youth admitted to the residential youth shelter. The shelter operates a detailed medication distribution system and utilizes the Pyxis Med-Station 4000 Medication Cabinet. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. Shelter 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 Healthcare Admission Screening policy in place that was last reviewed in July 2016.

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 public health department. In the event that a health condition exist, staff will contact the parent/legal guardian to obtain information about pending appointments with medical professionals,



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current medication, general precautions, and how to proceed in the case of an emergency. Any medical referrals will be documented on a daily log.

There were six open residential youth files reviewed for Healthcare Admission Screening. All six files documented the CINS Intake Assessment Form was completed on the day of admission. Three of the files documented the youth were taking medication. The name of the medication, as well as, the reasons for the medication were listed. None of the youth required any type of follow-up medical care. Five of the six youth also documented some type of seasonal or food allergy. Five of the six youth documented some type of mental health or substance abuse concern.

Exceptions

There were no exceptions noted to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Comprehensive Master Plan for Suicide Prevention and Response. The policy was last reviewed in July 2016. The policy 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 2 and 3, the youth is considered to be at high risk of suicide and must be placed on one-to-one supervision. Staff will refer the youth for a Baker Act. If the youth answers "yes" to questions 1, 4, 5, or 6 on the CINS/FINS 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.

There are four different levels of supervision used in the shelter. One-to-One Supervision, this 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, this 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, this 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 who's 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. All four youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. All four youth were immediately placed on sight and sound supervision until an



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Assessment of Suicide Risk could be completed. All four files documented the youth were seen and assessed by the Licensed Clinical Social Worker (LCSW) within twenty-four hours. Thirty minute observations were maintained the entire time the youth were on suicide precautions. All youth were placed on standard supervision after being assessed.

If the youth were on sight and sound supervision during the overnight hours there was documentation the youth slept on the couch in the dayroom. All supervision levels and changes were documented in the shelter logbook.

Exceptions

There were no exceptions noted to this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medications that was last reviewed in July 2016.

All medications in the shelter are stored in the Pyxis Med-Station 4000 Medication Cabinet. Controlled medications are stored in a locked box located in drawer five of the Med-Station. This limits staff access to controlled medications as a staff member must have the key to get into the locked box once inside the Med-Station. All other medications are stored in individual bins, one medication per bin to ensure topicals are separate from orals, in the second drawer of the Med-Station.

The agency has five super-users located at their St. Pete shelter. At the time of the review all staff employed at the shelter have been trained and have access to use the Med-Station.

The shelter does have a Registered Nurse (RN) who is at the shelter Monday thru Friday from approximately 5:30am until 8:00am. The RN dispenses morning medications during the week and direct care staff are responsible for dispensing medications in the evenings and weekends.

The shelter has a refrigerator located in the laundry room that is used strictly for medications requiring refrigeration. This refrigerator is locked and does have a thermometer located inside it to ensure it is kept at the proper temperature.

Inventories of controlled medications are conducted each shift by two staff members. The RN completes a weekly inventory of all other medication. All medications are also inventoried by a perpetual inventory with running balances. Sharps are also inventoried weekly and as used.



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The shelter does not dispense over-the-counter medications. The youth must have a prescription for the medication or the parent must bring the medication in and fill out the appropriate paperwork for the youth to receive the medication.

The RN employed at the shelter does not currently have access to the Knowledge Portal. The RN reported there has been a problem getting a password to gain access. Therefore, monthly reviews of medication management practice via the Knowledge Portal are not being completed.

The RN is clearing out discrepancies as quickly as possible; however, they are not being cleared out at the end of each shift. They are usually cleared out within twenty-four hours. At the time of the review there were no discrepancies in the Med-Station.

There were three youth currently in the shelter on medication. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Med-Station. The youths' Medication Distribution Logs (MDL) reviewed documented the youth's name, date of birth, any allergies, side effects of the medication, dosage, reason, method of administration, prescribing physician, and full signatures of youth and all staff. Each MDL documented when a medication was given, staff and youth initials, and perpetual inventory with running balance. There was a picture of the youth located in front of each MDL. All MDL's reviewed for the youth documented that all medication was given at prescribed times. If the youth refused a medication the date with the reason why was documented on the back of the MDL. All inventories were also documented on the MDL. There were no controlled medications at site at the time of the review. All other medications documented an inventory at least once each day on the MDL. All inventories were generally conducted by the nurse with the exceptions of the weekends.

The shelter has had two incident reports within the last six months relating to medication errors. The first report documented a staff noticed a youth missed a dose of medication while doing an inventory of the medication. The staff involved in this incident did receive training. The pharmacy was also contacted and reported there would be no adverse side effects due this missing this medication and staff should continue with the next scheduled dose. The second report documented a missed dose of medication due to staff on duty not having access to the Med-Station. Documentation was provided to show the staff involved in this error was re-trained on the medication policy and also received a written coaching note. In addition, now all staff members employed at the shelter are trained to use the Med-Station and have access. The pharmacy was also contacted and reported there would be no adverse side effects due this missing this medication and staff should continue with the next scheduled dose. There have been no further medication errors since this one occurred in August 2016.

Exceptions

The RN employed at the shelter does not currently have access to the Knowledge Portal.



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The shelter has had two incidents in the last six months relating to medication errors.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on the Medical and Mental Health Alert Process that was last reviewed in July 2016.

If a youth is admitted to the shelter with a medical or mental health or if a condition is revealed during the intake or screening process, an alert will be generated. 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 is constant sight and sound, yellow is elevated support, green indicates a mental health issue, blue indicates a substance abuse issue, purple is sharps restriction, black is medical issues, orange indicates the youth is on medication, and pink indicates allergies or special diet. The applicable color-coded dot is placed on the spine of the 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. The alert will be documented in the logbook, highlighted in yellow, and also recorded in a progress note in the youth's file.

There were six youth currently in the shelter applicable for alerts. All six files were reviewed and revealed alerts identified during the screening and assessment process were appropriately entered into the shelter's alert system. All four files had all the applicable color-coded stickers on the spine of the file. The shelter has one alert board located in the dayroom for staff to review. At the time of the review all alerts documented on the alert board coincided with the alerts documented on the youth's file. A progress note was also found in each file documenting each alert and the reasoning for the alert. A detailed intake note was also documented in the logbook for each youth admitted to the shelter. This note included all alerts for three of the six applicable youth. The entries for two of the remaining three youth did not document any alerts. The entry for the last youth documented three of the five alerts the youth was on.

Exceptions

There were no exceptions noted to this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed



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Rating Narrative

The agency has a policy in place for Episodic/Emergency Care that was last reviewed in July 2016.

The policy states all staff are to be trained in CPR and first aid within three months of hire. Staff will also be trained on the location and use of the knife for life. First aid kits will be located in designated areas, replenished after each use, and inventoried at least once a week. Emergency first aid drills are to be performed at least once per quarter. Any emergency medical care administered to the youth should be documented in the youth file, shift change log, and incident form if required. The youth parent or guardian should be contacted and notified of the incident.

The shelter has one first aid kit located in a locked closet in the living area, behind the staff work station. There was documentation reviewed for the last six months that the first aid kits were inventoried monthly. The agencies policy requires the kits to be inventoried weekly. The kits were restocked when needed and documented on the inventory sheet. The knife for life is also located in this same closet.

Emergency medical drills have been performed at least once per quarter, with seven documented since February 2016. The drills were documented across different shifts and documented: Nature of Emergency, Staff/Clients involved, Procedure Followed, Notifications needed, Outcome, and Areas for Improvement. The drills consisted of a stomped toe, knee injury, hurt foot, slip and fall, and a burn.

The shelter has had one incident in the last six months of a youth being transported off-site for emergency medical care. The youth was involved in a fight and was injured. The youth's parent was notified and met the youth at the hospital. The youth was released and came back to the shelter with discharge instructions.

A review of seven individual training files revealed all staff had received training on emergency medical procedures. In addition, staff also receive on-the-job training on emergency procedures during the mock emergency medical drills that are completed.

Exceptions

There were no exceptions noted to this indicator.