



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Clearwater

on 10/24/2012

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	Satisfactory
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	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 Psychosocial 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 3: Shelter Care

3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Limited
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	Satisfactory

Percent of indicators rated Satisfactory: 88.89%
Percent of indicators rated Limited: 11.11%
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%

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.43%
Percent of indicators rated Limited: 3.57%
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

- Keith Carr, Principal Consultant, Forefront Consulting LLC
- Carolyn Kehr, Non-Residential Director, Youth and Family Alternatives, Inc.
- Fern Ellenwood, Assistant Director, Sarasota YMCA



Quality Improvement Review

Family Resources-Clearwater - 10/24/2012

Lead Reviewer: John Robertson

Shelia Woods, DJJ Office of Victim and Prevention Services

Nicole Hartsock, Director, Sarasota YMCA

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 1 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 3 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input type="checkbox"/> Fire Prevention Plan | <input 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 | 8 Health Records |
| <input 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 type="checkbox"/> PAR Reports | 7 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 14 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 10 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 16 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 3 Youth 7 Direct Care Staff 0 Other

Observations During Review

- | | | |
|--|---|---|
| <input type="checkbox"/> Admissions | <input type="checkbox"/> Posting of Abuse Hotline | <input type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage |
| <input type="checkbox"/> Facility and Grounds | <input type="checkbox"/> Recreation | <input type="checkbox"/> Toxic Item Inventory and Storage |
| <input type="checkbox"/> First Aid Kit(s) | <input type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input type="checkbox"/> Medical Clinic | <input type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input type="checkbox"/> Medication Administration | <input 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 operates a broad range of youth and family focused programs that include the Safe Place 2B residential youth shelter, Street Safe Outreach, Safe Place Outreach, Family Connect, Kinship Care and Youth Art Corps. In addition, Family Resources recently opened the recently completed Fountain View apartments. These apartments were funded by the Neighborhood Stabilization Program in partnership with Boley and Catholic Charities. They are for youth aging out of foster care and there are 6 apartments.

The agency employs licensed clinicians in both their residential and non-residential programs. The agency recently partnered with a local pet therapy organization to visit residents in the youth shelter. .

Agency has provided introductory or baseline Trauma Informed Care (TIC) training to all staff members. Further, the agency has recently begun providing a secondary round of TIC boundaries training for all staff members. Further, the agency recently completed agency wide training on medication distribution provided by the Department of Juvenile Justice's office of Health Services.

The Family Resources agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency trainings 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. Staff must all meeting all initial and ongoing training requirements.

The Family Resources agency requires all staff members to abide by its employee handbook. Staff members are required to report all qualifying incidents and situation that involve clients, their families and other staff members. Staff members are required to follow practices taught to them through training and be knowledgeable of all applicable policy and procedures.

The agency also has an established levels supervision that require supervisors to be responsible for overseeing the work performance of staff members that report them. Supervisors review staff member's performance on an annual basis and document deficiencies and exceptions on internal performance and disciplinary issues on a case by case basis.

The agency is nationally accredited through the Council on Accreditation (COA). In addition the agency has an internal system of Continuous Quality Improvement (CQI) that encompasses internal teams that focus on risk management, safety, quality improvement, training and other areas. These area are reviewed by internal teams ranging from monthly, quarterly, and annually based on the discretion of agency leadership.

The agency also conducts outreach services through partnerships with local community stakeholders and various system partners. The agency has on-going initiatives with nearly twenty (20) partners including the local and area municipal police departments, County School System, local faith-based organizations and the Junior Achievement of Northwest Florida.

Standard 1: Management Accountability

Overview

Narrative

Family Resources, Inc. – North youth shelter named Safe Place 2B 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 a sister youth shelters also called Safe Place 2B that are located in St. Petersburg and in Bradenton, Florida. These agencies service youth and families in Pinellas, Manatee and other surrounding counties. The programs share the position of Vice President. 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 departments handle 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 (3) service locations in the areas of operations and programming for both residential and non-residential services. Other uniform protocols for all 3 locations include training and professional development.

The agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency trainings 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

The agency policy meets the major requirements for adherence to the Background Screening of Employees/Volunteers indicator. The reviewer assigned to this indicator assessed a sample of Staff/intern records. The records reviewed indicated that the background screenings were conducted for all department employees/interns with access to youth.

Four (4) employee records were examined. Four (4) of the 4 open files documented timely background screenings prior to each staff member's date of hire. One employee was required to have a five year rescreen completed by the agency's Human Resources Department. Evidence of this employee's five year re-screening was provided by the agency. The documentation found in the file verifies that the employee was re-screened in time to meet the required deadline.

The annual affidavit of Compliance with Good Moral Character Standards was signed and notarized and set to the Department of Juvenile Justice on January 4, 2012 and the Department of Juvenile Justice acknowledged receipt on January 5, 2012, well before the January 31st deadline.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy that addresses the Provision of an Abuse Free Environment. The policy requires youth served by the agency to have unimpeded access to a telephone to self-report abuse at all times. All abuse and reporting numbers must be prominently posted in the facility. A tour of the facility found that the abuse number(s) are posted in conspicuous areas and in all common areas. Survey results indicate that the youth report knowledge of the Abuse Registry telephone numbers.

Additionally, according to the agency Administrative and Operating Manual, all agency staff members must report cases of suspected abuse, neglect and exploitation. Under this requirement there are seven (7) major procedures.

The agency Human Resources Policy Manual requires that staff members be responsible for reporting any evidence of any improper practice of which they are aware of. Further the agency Behavior Management Strategies policy restricts the use of Corporal Punishment is strictly forbidden under any circumstance. It permits the use of isolation, manual or mechanical restraint or locked seclusion of clients. The only circumstance under which a client may be restrained is to protect another client from an imminent attack. There are also policies related to the prohibition of Weapons and Workplace Violence.

The monitor reviewed a total of ten (10) documented incidents. Of these, eight (8) were internal agency write ups. There were a total of two (2) incidents documented by the DJJ Central Communications Center (CCC) between April 2012 and October 23, 2012. Of the 2 CCC incidents, none were related to behavior that violates the agency Code of Conduct or work performance requirements. The agency provided documented evidence of a total of four (4) Grievances over the last 6 months. None of 4 grievances revealed youth grievances related to staff disrespect, attitude, being put off, being ignored or lack of safety.

The agency provided copies of seven (7) documented internal written reports related to staff member work performance. Of these, two (2) were formal Notices of Disciplinary Action and the remainder were five (5) Memorandums of Understanding (MOU). The Notice of Disciplinary Action (NODA) required the Residential Director. The MOUs indicate that the Residential Director conducted a verbal intervention with a staff member to address their work performance related a specific area. In these 5 cases, each employee had knowledge of a youth missing a medication on a certain day and failed to report it to their supervisor. The NODA describes the Violation, Reason for Action, Description of Performance, State of Consequences and Employee Acknowledgement. The agency management also lists Previous Corrective Action(s) if applicable. Of these Memos, 1 had evidence of a staff person conversing about another staff's in the presence of youth. The second memo indicated that a staff member violated the agency computer policy and resigned as oppose to accepting the agency disciplinary. The agency documented said incidents, all related facts and the prescribed disciplinary measure to address the situation. The current document does not include a specific plan for improvement and or disciplinary measures to be taken if behavior occurs again.

The current policy is dated and is documenting as being last updated in March 2009. However, the agency does conduct a comprehensive review its policies annually and only produces fully updated policies on an as needed basis. At the time of this onsite review, the agency provided evidence of a letter signed policy approval letter that was signed by the agency's Chief Operating Officer for 2012.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The agency has an Incident Reporting Policy that addresses incident reporting requirements. The agency's policy addresses all major requirements of the Florida Network of Youth and Family Services and the DJJ Central Communication Center (DJJ CCC) policies. The current policy was last reviewed and approved by the agency's COO in 2012. The agency's policy program specifies that the agency notifies the Department's Central Communications Center (CCC) within two (2) hours of the incident, or within 2 hours of becoming aware of the incident. The agency procedure requires that once a staff member gains knowledge of an incident, it must be reported to the agency's Residential Supervisor. The Residential Supervisor then determines if the incident is reportable. All incidents contain general content and information regarding the circumstances and events that are acceptable.

The agency incident binder organizes all incidents (internal and DJJ CCC) by month. According to a report provided by the DJJ CCC database a total of 2 official incidents were accepted and documented in the system with in the last six (6) months.

Of these CCC reports, one (1) involved a medication error and another incident involved a youth injury. Both incidents were reported to the DJJ CCC within the 2 hour reporting requirement. The agency provided documentation of all incidents reported to the DJJ CCC and are maintained in a incident binder. The agency incident binder organizes all incidents (internal and DJJ CCC) according to month.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place to ensure new employees receive 80 hours of required training their first year and 40 hours for subsequent years. A total of seven (7) current staff files were reviewed which included full and part time staff. The files included training hour tracking logs and certificates of attendance. The staff play an active role in updating their training hours. In some of the files it was difficult to locate the training information, however the program is updating forms to make it easier to read/maintain. All 7 staff member files reviewed were in compliance with this indicator. Files reviewed indicated that new employees complete an orientation which includes, but not limited to trainings on CINS/FINS Core, Suicide Prevention, and Title IV-E. Files reviewed also indicated that following the first year of employment staff complete fire safety training, suicide prevention, and maintain current CPR/First Aid certification.

The reviewer found that it was difficult to locate evidence of the training materials in some of the staff member files. This was due to some staff training topics/courses being titled differently than other topics/courses.

1.05 Interagency Agreements and Outreach

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in effect that addresses the requirements for this Interagency Agreements and Outreach indicator. This review of the current policy indicates that the Interagency Agreements policies were last reviewed and approved by the agency's COO in 2012. The majority

of the Agreements are considered by the program as active. The Program documents outreach activities and events over the last six (6) months via a calendar and NETMIS that clearly demonstrates the program's efforts to reach its target population. Outreach activities are led by a designated staff person and shared with designated outreach staff, as indicated on the NET MIS report.

The program participates in group presentations, discussions, individual meetings and outreach activities all documented in the NETMIS data base. Review of four (4) out of 4 youth files revealed that the program builds strong collaborations to ensure youth and families receive medical, educational, therapeutic and other support services identified in each individual service plan for each youth.

1.06 Disaster Planning

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on Disaster Planning that meets the major requirements for this indicator. The agency has a written individualized disaster preparedness plan in the company operational procedures. The plan outlines in detail emergency evacuation protocol, procedures to follow in severe weather and conditions under which evacuations would occur. Program files document training provided to all staff regarding the disaster preparedness procedures training. Evidence of this information was found in detail in four (4) out of 4 staff files reviewed. The disaster plan details the responsibility of staff members, including a volunteer employee list with current phone numbers and evacuation procedures. Records indicate annual staff training for emergency preparedness with signed attendance sheets in the training manual. Review of the weekly Safety Physical checklist found evidence of three (3) fire drills documented each month and the staff emergency drills every 3 months.

The program has secure transportation (eight (8) passenger van) to transport residents and staff members in case of an emergency. This vehicle is part of a weekly maintenance check. The agency disaster plan identifies and lists designated evacuation facilities. There is a process in place to contact the Florida Network of Youth and Family Services if the decision is made to close the facility in case of emergency evacuation. This process is outlined in detail in the agency disaster plan. Each youth is given a client orientation handbook during the initial orientation that outlines the emergency evacuation procedure. The reviewer assigned to this indicator requested access to the agency's emergency supplies that are to be used during an emergency situation. Staff could not produce the emergency supply room key on demand. However, once the key was located an inspection of the supply room revealed that it was stocked with the necessary emergency equipment and supplies.

1.07 Analyzing and Reporting Information

Satisfactory Limited Failed

Rating Narrative

The agency does not currently have a policy on analyzing and reporting information. However, the agency does have an agency-wide approach and multiple processes that involve reviewing specific agency services, incidents, client satisfaction, NetMIS data reports as well as Risk Management issues. The agency has a specific Risk Management policy that focuses on reporting incidents that pose a risk or liability to clients or the organization. Staff members are required to complete incident reports on risk management issues. The agency has three (3) internal teams that work on addressing work performance issues.

The agency has a Safety Team that includes Residential Supervisors and other agency staff members representing several program areas. This team meets monthly to review new data, risk issues and trends. All residential sites are inspected for safety concerns twice a year and the administration office on an annual basis.

The agency has a Risk Management Team. The Risk Management Team includes all agency Directors and Residential Supervisors. This team reviews incidents and other risks related topics. Meeting minutes were provided to the reviewer of this indicator. The July 2012 report cites medication, workers compensation, de-escalation training issues. A review of incidents, types of incidents to detect major trends and risks were addressed by the team. These reports are generated quarterly for the Risk Management Team and produced on an annual basis for the Family Resources agency Board.

The agency has a Quality Improvement Council (QIC) that is comprised of Senior Leadership, Directors and Supervisors. The QIC focuses on trends and issues identified during the peer review process. The agency also reviews recent reports/CAP issued, measurable objectives specific to each contract. One example of this was the agency efforts to address the low 180-Day review data results.

The agency is a member of several organizations. The agency is a member of the National Runaway Network, Homeless leadership-PG, JJAC advisory board, Family Law Advisory Group-SW and the FL Coalition Against Sexual Violence Board. Further the agency is a member of the Council On Accreditation (COA). The COA was recently onsite in September 2012 and completed their recertification review. Following this review the agency has submitted an request to COA for recertification purposes.

The agency references several resources to assist them with assessing areas of performance and risks that include Florida Network of Youth and Family Services (FNYFS) compliance monitoring reports, NetMIS data extracts, incident, accidents and medication errors reports. The aforementioned information is provided on a monthly and quarterly basis. The agency also tracks training topics and hours completed by staff

members on a quarterly basis.

The agency presents relative examples to demonstrate how internal oversight measures lead to actual examples of them implementing an intervention to address a problem. The example demonstrated the internal process that the agency utilized to identify and address medication errors. In this case, the agency identified medication errors and requested training assistance from a Licensed Nurse with the DJJ Office of Health Services to deliver onsite training to their staff members.

Activities of the QI Team are dated from August 2011. The agency did not make reference to the percentage or its effort to reduce certain risks related to addressing a certain outcome. For example, the agency could develop a plan to address the problem and set a target goal to address the identified problem. At the time of this onsite review, the internal oversight process used by the agency demonstrates general awareness of issues. The agency should consider focusing on increasing its efforts to document the various intervention and strategies it uses to address a problem in more detail and track progress overtime to test whether the intervention was effective.

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. Family Resources Non-residential program has one Program Director, Carol Albrecht, LMHC who also provides direction to other family help programs. There is one Non-residential counselor, Susan Harrison, Counselor 3 who has a MA, and is a Registered Mental Health Counselor Intern. Safe Place 2B Residential Shelter has a Residential Supervisor, Nicole MacKnew who is a LCSW. Centralized Intake Services are evidenced throughout all five (5) charts reviewed. The charts include 2 Non-residential charts, 3 Residential charts with 1 being a Staff Secure youth. 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 language used is appropriate for many levels of education parents might possess. The Non-residential program also provides each family with the FLN "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 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 are gathered 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 resolve issues faced by the youth and their family.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

A total of five (5) client charts were reviewed with four (4) open and one (1) closed Staff Secure chart. Family Resources has a policy that coordinates CINS/FINS Objectives for Services to FLN Indicator 2.01. The procedures follow the Indicator and are clearly written to be understood by staff with different levels of education. All 5 charts reviewed had admission dates visible. Family Resources staff complete Screenings at time of phone call for services; therefore, there are no written referrals. Available service options are presented to each family through the Florida Network "A Guide to CINS/FINS Services for Parents" in Non-residential. "Strong Families Are the Cornerstone of Our Community" provide services rendered by Family Resources Safe Place 2 Be Residential Program.

Supervision of case reviews is indicated by supervisor's signatures with dates. All three (3) Residential charts had signatures and dates of supervisor on weekly Case Review forms. The 3 Residential charts had group forms indicating the group topic, the instructions for the activity, the youth's response to the activity and were all signed and dated by staff. One chart had 3 groups in a 4 day period and 5 groups in two 7 day periods = 6.5 groups per week. One sample chart documented 4 groups in 7 days, 5 groups in 7 days, 3 groups in 7 days, 4 groups in 7 days and 6 groups in 7 days = 4/7 groups per week. One closed staff secure chart had 5 groups for three 7 day periods = 5 groups per week.

There were not 5 groups in every 7 day period, but there were an average of 6.5 groups one week; 4 out of 7 days; and 5 out of 7. The youth are receiving groups consistently throughout the week.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

Family Resources provides Policy and Procedures for staff members to follow and complete the Psychosocial Assessment process. The two (2) files from Non-residential had both psychosocial assessments completed at face-to-face meetings with the youth and parent present. One assessment was completed in one setting and one was completed in two (2) consecutive meetings. Two of the three (3) Residential assessments were initiated and completed within the 72 hour window of admittance. The same 2 files were reopened cases and had been closed within the last six (6) months. Both addendums were completed within 24 hours of admission into the program. The third residential chart assessment was completed in two (2) consecutive sessions with the first being within 48 hours of admission. All 5 psychosocial assessments were completed by Bachelor and/or Master level staff. All assessments were reviewed and signed by a supervisor as evidenced by signatures at the end of the assessments. None of the 5 assessments indicated any suicide risk; therefore, there was no need for a Suicide Risk Screening. While these charts reviewed did not have the need for a Suicide Risk Screening, there is an agency policy with procedures and information including training, information concerning Environmental Safety at the shelter and a written plan that details the suicide prevention and response procedures used.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Both Family Resources Non-residential and Residential programs follow, as designated through chart review, the agency Policy and Procedures for Case/Service Plans. The said policy and procedure follows the CINS/FINS Quality Improvement Standards. All five (5) charts had completed and individualized Case/Service Plans. The two (2) Non-residential Case Plans were completed on the same date as the assessments were completed. One Residential chart was completed within 24 hours of the Assessment; one Plan was completed at the time of the Assessment; and one Plan was completed with 48 hours of the Assessment completion. While there is a system in place and "triggers" for the information to be obtained on the Case Plans, only 1 Case Plan had documented service type, frequency and location. Frequency of services was not documented on four (4) of the 5 Plans. There was no location of where services would be provided on one Non-Residential Plan. All 5 Case Plans documented clearly what persons would be responsible, the target dates for each goal, signatures of the youth, parent/guardian, with one parent not physically present but on the phone for the development of the Plan. All signatures of the counselors and supervisors were in the documentation. In this Indicator, there were missing review dates: 1 Non-residential file was missing the 30 and 60 review signatures; 1 Non-residential file was missing the 60 and 90 day review signatures; 2 Residential files had 30/60/90 day review signatures with having 30/60 as youth was discharged before the 90 day period.

The actual frequency of services was not documented on 4 of the 5 Plans. There was no location of where services would be provided on one Non-Residential Plan.

In this Indicator, there were missing review dates: 1 Non-residential file was missing the 30 and 60 review signatures; 1 Non-residential file was missing the 60 and 90 day review signatures; 2 Residential files had 30/60/90 day review signatures with having 30/60 as youth was discharged before the 90 day period.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

As evidenced by documentation found in the files, Family Resources Non-residential and Residential programs have a consistent and regularly used method of establishing referral needs and providing referral information to family at the time of admission and time of discharge. The referral form includes the service recommended, the resources available for that recommendation and the agency names and phone numbers. The Residential program also provides the family with the brochure "Strong Families Are the Cornerstone of Our Community" with services offered, description of services, phone numbers and website information for internal Family Resources opportunities. All five (5) charts provided documentation of the client/family's progress, interventions in cases of lack of progress toward goals, and support provided by staff to clients and/or families. There were referrals to the case staffing committee for two (2) youth. A designated staff accompanies the client/family at court, monitors the case and court documents and provides follow up on discharge.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Both the Non-residential and the Residential programs at Family Resources coordinate counseling with the Case Plan development per the agency Policy and Procedures. This was evidenced in the Case Notes from Youth Care Workers, Bachelor's level and Master's level staff. Throughout all five (5) client files reviewed, the issues identified at the Screening level were addressed in the Psychosocial and had goals set to remediate issues in the Case Plan. Non-residential and Residential case notes in all 5 charts indicated that the aforementioned issues were

addressed at the client level with parents invited to participate. The two (2) Non-residential charts have a quarterly internal process for Supervisory Review documented by supervisor's signature and dates. Case notes written by Bachelor level and Master level staff members are in all 5 charts. These notes show close attention is provided to the issues of the youth, needs of the youth, and a pursuit of support, remediation of problems, steps toward improvement, paths to help child upon discharge from both Non-residential and Residential programs, and referrals for after services. The Counseling Notes and Group Notes could be used by any new staff to follow through and maintain the continuum of services for that child. The notes are clear, concise and focused in all 5 client files.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The Family Resources policy and procedures provides a clear guideline for the Adjudication/Petition Process in line with the Florida Network of Youth and Family Services policy and procedure manual for CINS/FINS. There is one person designated for this process. The staff member assigned is Sajka Korajkic, BS, Families In Need of Services Case Manager. All court documents are written, filed and presented to the DJJ Assistant General Counsel, Dan Kirkwood. These documents are also signed by Stacey Welton, MS, Vice President of Families Resources / Family In Need of Services Supervisor. The samples of adjudicated cases were two (2) open charts were reviewed onsite. There is a CINS Case Management / Case Staffing binder for each fiscal year, July 1 – June 30. Neither parent requested a staffing to be held. The Families In Need of Services Case Manager sends notification to the family within 12 to 14 days for both families, as well as a random review of other cases in the Case Staffing binder. Copies of letters are in binder to document notification. There is a pre set Case Staffing Committee that is notified within 14 days of the case staffing per e-mail documentation in the Binder. Participants are sent the agenda at this time. A written summary is presented to all persons present at the Case Staffing. The Committee makes recommendations for the youth, and a letter is sent to the family with the results within 7 days. One chart indicated those present on the Committee were: 3 local school representatives, a CINS/FINS provider, a State Attorney's Office representative, and 1 Law Enforcement representative. The second open sample had signatures of Committee members present as: 3 local school district representatives, a CINS/FINS provider, a State Attorney's Office representative, and a Law Enforcement representative. There was no evidence of others attending the Case Staffing or that anyone had been invited by the parents. Both charts had new a plan for services. Both charts had Case Staffing Recommendation forms showing the new plan for services signed by all present. The Case Management Binder had a copy of the letter sent for both cases to the parents within 7 days of the Case Staffing explaining the recommendations made by the Committee. Sajka Korajkic, Families in Need of Services Case Manager, attends court with those adjudication CINS/FINS, follows up with families to make sure there is compliance with the Court Order, maintains a file for each youth and the CCS binder. There is a clear and concise plan for the Case Staffing process and follow through with the youth and family. All indicators were documented and easily accessible.

2.07 Youth Records

Satisfactory Limited Failed

Rating Narrative

A sample of five (5) client files were used to assess this indicator. All 5 samples reviewed were clearly marked "CONFIDENTIAL". Protocol forms were on the right side of each chart reviewed indicating where specific paperwork could be found. This made finding documentation that is available and/or missing easy to be completed. The two (2) Non-residential files are kept in a locked filing cabinet in a locked room on the Family Counseling side of the facility as shown to peer reviewer by CINS/FINS Non-residential program supervisor, Carol. The three (3) residential charts were kept in a locked filing cabinet in a locked room outside the youth areas on the residential side of the facility. The 2 open Residential files were in 3 ring binders filed alphabetically in one locked file cabinet, along with all other currently open charts. The closed Staff Secure chart was filed in a paper file folder alphabetically and by the month of the discharge in a locked file cabinet marked Closed. Verbal policy of chart retention was provided by Residential Supervisor, Nicole MackKnew. The charts closed for a year or more are taken to the main agency office and stored in locked room.

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 Safe Place 2B shelter is located in Clearwater, Florida. At the time of this Quality Improvement review, the program is staffed with a Residential Supervisor, a Counselor III, Shelter Counselor, eight (8) Youth Care Workers, an Intern Counselor, a Secretary and a Cook. The Residential Supervisor who is a Licensed Clinical Social Worker (LCSW) oversees the day-to-day operations of the youth shelter. In addition the residential program's Counselor III is a Licensed Mental Health Counselor (LMHC).

The Residential provides a "Client Handbook" to each child upon admittance. Beyond that, each parent sits with the child while staff goes through the handbook so both client and parent will know what the expectations are while the child 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 client showing an understanding of these This identifies and explains the many family services offered by Family Resources.

3.01 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The program has a policy and was reviewed and approved by the agency's COO in 2012. The policy outlines determining factors for appropriate room and bed assignments based on safety and security for each new intake. There were four (4) opened files reviewed, all files included documentation which included, but were not limited to, the client's age, sex, physical size and strength, their level of aggression, both physically and/or sexually, as well as the client's current emotional state. The documentation was clear and concise. There was evidence that the program entered the appropriate medical and mental health alerts in the designated locations (communication board and client's files), which made staff aware of the client's alerts. One (1) of the four (4) files reviewed did not include the room or bed assignment on the intake form. The current program policy has not been updated since March 2009.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has a policy that contains the major components to address the requirements of the Program Orientation indicator. Four (4) out of the 4 records reviewed were in compliance with the Standard. The program has in place a one-on-one orientation process that is completed within a 24 hour time frame. The case files examined by the reviewer indicate that orientation is completed immediately after the youth intake process is completed. Orientation documents have evidence that documents are signed and dated by both the youth and the staff and are maintained in the individual youth file.

New staff orientation includes training on Safe Place which is part of the program's outreach strategy. Staff are trained how to orient youth to the Program in order to make them feel welcome. This is done in addition to the initial orientation. The staff training occurs as on-the-job training with the Program Director and Counselors. Mandatory trauma informed care training is also documented in the training manuals for each staff (three files reviewed).

A "Welcome to Family Resources Client Orientation Handbook" is a thorough informational pamphlet that is provided to each youth at the one-on-one orientation meeting. The handbook serves as a hands-on reference guide and reminder of the program rules, staff, agency contacts, daily schedules, grievance process, shelter guidelines, phones, consequences and rewards, school, dress code, house meeting, behavior enhancement, emergency evacuation, personal belongings, visitation schedule, etc.

3.03 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The program has general protocols for maintaining a clean and sanitary residential youth care. The Shelter's overall appearance presents as being maintained. General areas are clean and the environment is safe environment. All health and fire safety inspections are current, as well as the program's disaster plan, and Child Care License. The program has adequate lighting and security measures are in place. The staff seems knowledgeable of their jobs, and their rapport with others was professional. The client's bedrooms were adequately equipped with

furnishings for proper sleeping and storage areas for personal belongings. Bathrooms and shower areas were functional, and provided both hot and cold water for use. Menus were reviewed, meals are approved by a licensed dietician and the menus were posted for easy view. There was documentation to support that fire drills, as well as, mock emergency drills are completed. All currently used chemicals are listed on an inventory sheet, and they are secured in a locked closet.

At the time of this review, tiny ants are visible in the kitchen on the countertop ledge. The hand washing sink was not clean. There was a noticeable amount of dust in the kitchen area. The shelves and floors in the dry food storage area were unclean. There was some graffiti found on some of the bedroom furniture. One pillow was soiled as well as a pillowcase that was being used by a client. The shower curtains in the girl's bathrooms were soiled and mold was present which could present a health issue. There is an exposed rusted area on the metal soap dispenser which is a potential hazard. The boys' dorm on the furthest west side of the building had debris underneath two (2) of the beds. Several vents throughout the dorms are full of dust. Lint, rags and socks were found behind the washer and dryers. Many of the MSDS forms are outdated. The communication tool used (log books) had several inconsistencies with the documentation.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The program's log books were reviewed over a six (6) month time period. Three (3) log books were reviewed and all were written legibly in ink. The entries that were documented highlighted the program's daily activities. Staff's arrival upon shift was logged and included documentation of reading the previous (2) two shift's activities. Review of the log books by supervision was documented as well.

The programs current policy and procedure manual did not contain a policy for indicator 3.04. The logs were not user friendly and lacked the ease of accessibility to obtain pertinent information. The programs format for entries made in the log was not consistent. There were several inconsistencies identified in all three (3) logs that were reviewed. There was no Header on several of the log pages; therefore, the dates of the entries were not readily known. Several demographics of the client's were omitted at varying times. Inconsistencies occurred when some staff included the client's SS# and others did not, also the clients race wasn't always included. Oftentimes entries were made, but did not include the signature of the writer. The correction of errors did not follow the policies guidelines; errors were at times x'd out, crossed out or sometimes had the word error written next to it. There were only a few that had the required single line strike-through, and the staff's initials and date were omitted as well. There was a color-coded reference sheet on the front of each log used to identify the specific color for specific entries, colors not listed on the sheet were used throughout each log.

Rating Narrative

The program has a daily schedule which is included in the handbook and posted in the living room. There are two (2) different schedules. One reflects a schedule for the school year and the other a schedule for the summer. Youth are engaged in activities such as school, counseling services, and recreational activities seven days a week. . The program does a very nice job completing Life Skills groups with the youth. Activities that are meaningful and structured such as trips to the theater, local parks, and bowling are offered. The youth are given numerous opportunities throughout the day to have time for physical activity, such as utilizing the programs outside area where they can play basketball and other games. They also take walks with staff if the youth is on an appropriate level. Youth have the opportunity to participate in faith-based activities through transportation by their guardian. The program schedule allows the youth the opportunity to complete homework. Quiet time takes place with youth when they either complete homework or read age appropriate books.

3.06 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program has a current policy in place that describes their behavior management strategy. There is a detailed handbook which explains the model used. The program utilizes a level system which begins upon entry to the program. Orientation is the beginning level followed by Bronze, Silver, and Gold. The youth have the opportunity to complete their level paperwork and submit to staff on a daily basis. Every evening the staff review and discuss whether the youth will be advanced a level, stay the same, or be demoted dependent on youths behavior. Rewards are increased as youth progress through the levels. These rewards include, but are not limited to outings to the theater, bowling, parks, co-lead groups, mentor new residents, and enjoy the gold room. The gold room is being updated to include new television and appropriate video games for the youth on gold level to enjoy. Consequences used in the program for violation of program rules are applied when appropriate, such as loss of level when suspended from school or not advancing a level for not following rules. Staff are trained during new employee orientation and yearly on the behavior management system. The Program Director monitors staff execution of the BMS and reviews her findings with them at their three (3) month orientation, yearly evaluation, and at staff meetings.

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

The program has a Behavioral Intervention policy which was last reviewed and approved by the agency COO in 2012. The program staff are not trained to use any physical interventions, which is in accordance with their "hands off" policy. The staff are trained in crisis intervention and de-escalation techniques during new employee orientatin. If a youth's behavior becomes beyond the staffs control no physical intervention takes place, instead law enforcement is called. The program does not use group punishment, room restriction, or deny any youth their basic needs such as but not limited to meals, clothes, sleep, or contact with guardians.

3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency policy meets the major provision required to address the Staffing and Youth Supervision indicator. The agency provides the staff schedule for the last six (6) months. The agency maintains a 1:6 ratio with two (2) direct staff members on duty during sleeping hours and maintains the same ratio with 2 staff members on duty during sleeping hours. Both a male and female staff members are scheduled to be on duty on each work shift.

The agency utilized a scanning gun that captures the exact time a youth count is conducted by scanning a bar code assigned to each youth resident's bed room. Some scanned recordings are capturing some rooms and appear to not be reflecting counts accurately. The scanning gun or the bar codes should be checked to ensure that they are working properly and capturing youth counts as designed. In the event that the automated scanning system does not work, it is recommended that staff members document all youth counts in the agency's program logbook to ensure that these counts are being documented as required.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on the process of providing Staff Secure Shelter services at this Family Resources location. One (1) example was reviewed for Staff Secure services provided in the last six (6) months. The Staff Secure additions to shelter service were sent by e-mail from the Residential Supervisor to staff. The e-mail provided the information that one specific staff member is to be assigned each shift. This procedure was documented in the youth's file with a specific form for the specified staff member to be indicated. The file also had documentation in a Case Note that the designated staff member for one of the first shifts introduced himself to the youth and said he was available if the youth needed anything. Assigned staff was documented each shift on the continuously running forms. The instructions from the Residential Supervisor also provided direction that a door alarm was to be attached to the youth's room each night. Instructions included that the alarm must be removed and reset each time bed check was done. Recommendations were also provided to staff on how to appropriately answer question from other children as to why youth had an alarm on door. The chart had documentation that this alarm was used regularly. The sample had a resource referral form for the youth and family. The file reviewed had documentation of weekly Case Review meetings with counselor, youth care worker, and Residential Supervisor. This form was complete with any changes or recommendations for the child and signed and dated by all.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Family Resources agency provides screening, counseling and mental health assessment services. The agency has a Vice President of Residential Services, Residential Supervisor, eight (8) Direct Care Staff, two (2) Counselors, a Cook, a Intern and an Administrative Assistant. The Residential Supervisor is a Licensed Clinical Social Worker and one Safe Place 2B Counselor III is a Licensed Mental Health Counselor (LMHC). The Family Resources agency has staff members are 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. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. 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 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. 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. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury.

The agency has a full complement of staff of both male and female staff members across all three (3) work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The shelter has written policy to address the Health and Mental Health Services during the admission screening process. The agency's measures to address these include an in-depth health screening that is a part of the CINS Intake form and completed during the Intake process. The health screening form addresses all elements of the indicator including current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc.

Agency protocol requires that youth have unimpeded access to emergency medical care at all times. The procedures indicate that if a major medical condition exists the youth will be immediately referred to their physician, emergency room or a public health care department. The policy lists examples of major medical conditions to include diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia; head injuries which occurred during the previous two weeks, acute allergies, chronic bronchitis or other chronic disorders. The procedures indicated staff would contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medications and general precautions in the case of an emergency. All medical referrals were documented on a daily log. All five (5) files (4 open and 1 closed) reviewed contained documentation of the CINS/FINS Intake form that was completed the day of the youth's admission. The form addressed all elements of the indicator with the exception to observation of scars, marks or tattoos. The current form does not have a subject reference section that observes for the presence of scars, tattoos, or other skin markings. The program does attempt to identify this section by reviewing a list of identifying marks in the "Other Observations" section on page 1 of the CINS Intake form. All five (5) files reviewed contained the required forms. The written procedures addressed the referral process and follow-up medical care.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The program has a plan in place which details the programs suicide prevention and response procedures. This plan complies with the procedures required by the Florida Network Policy and Procedure. A total of three (3) closed youth files were reviewed and they were all in compliance with the standard. Youth suicide risk screenings were completed at intake and when a youth answered "yes" to any of the 6 questions they were placed on sight and sound supervision. The 3 youth remained on sight and sound until they were assessed by a licensed professional or non licensed professional under the supervision of licensed professional.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

The agency has a dedicated policy on Medications. The agency's current policy is labeled Medications and was last approved by the Agency Chief of Operations in October 2012. The agency's written policy contains specific procedures that address Storage, Access, Inventory, Verification and Disposal. The agency provides training to staff on Medication. A review of staff training files revealed as many as four (4) different Medication related training that included: Medication Management (2 hours), Medication Administration (1 hour), Assisting in the Delivery of Medication (1 hour), Distribution of Medication (1 hour).

In general these medications cover the majority of the requirements for medication distribution in accordance with the DJJ Health Services Manual.

The agency received training from Christine Gurk, Nurse Consultant with the DJJ Office of Health Services in August of 2012. Following this training the agency updated its Medication policy to include Medication Verification. The agency provided a list of staff members that reviewed, acknowledged and signed their understanding of the policy.

Onsite observations found that all medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. All medication was stored in a double locked cabinet. The agency utilizes medication storage rack with a oral and topical tray designated for each bed. There are a total of twelve oral and twelve topical medications. Oral medications are generally stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the onsite review. The shelter has a system in place for refrigeration of medication if needed. At the time of this onsite review, there was no medication that required refrigeration during the time of review.

Controlled medications are locked in a cabinet behind two (2) locks. At the time of this review, there were no CINS/FINS youth that were on Controlled medication. The agency maintains a legal-sized Medication Distribution Binder. The agency does not distribute over-the-counter medication unless they are permitted by the parent/guardian. In addition, no youth on prescribed medications are permitted to take OTCs unless verified and approved to be taken with these medications by a pharmacist.

The sharps maintained at the shelter consisted of scissors and razors. The agency maintains a pill cutter. It is recommended that the agency require parents and guardians to have pills cut by the originating pharmacy. Non-licensed staff do not have the authority to split pills, due to it being seen as administering medications and no longer as assisting in the delivery.

Inventories on sharps are conducted on each shift 3 times per day. Documented sharp counts indicated some inconsistencies of actual dates of when counts are conducted. Some staff are documenting the time, but not the date. Other staff are documenting the date in the Time Out or Time In column. It is recommended that the agency adjust to current form to prompt staff to document the date and times in the correct columns.

The agency provided the previous 6 month inventories dating back to March 2012 to April 2012. The program utilizes Medication Distribution Log (MDL) that is specific to their agency that was updated and implemented on October 12, 2012. The MDL is legal-sized and contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff and youth initials on MDL when medication is distributed and received. The form is very functional, legible and reviewed by the Residential Director 1 time per week.

A review of open client medication records was conducted. At the time of this onsite review, only two (2) open CINS/FINS client were on medication. A review of two (2) additional closed files with clients that were on prescribed medications during their residential stay was conducted.

The agency has a comprehensive policy on Medications. The agency's current policy is labeled Medications and was approved by the Agency Director on July 31, 2012. The agency's policy contains written policy content that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. Onsite observations found that all medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. All medication was stored in a double locked cabinet. Oral medications are stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the onsite review. 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. Controlled medications are locked in a cabinet behind two locks. At the time of this review, there were no CINS/FINS youth that were on Controlled medication. The agency maintains a Medication Distribution Binder. The CINS/FINS The agency does not provide over-the-counter medication and did not have any stock over-the-counter medications.

Due to recent concerns regarding risks related to the distribution of medications, the FNYFS has deemed it necessary for all local CINS/FINS service providers to implement Medication verification procedures. The agency revised its current medication policy to include procedures for verification. Staff began new verification procedures on October 18, 2012. This new document requires staff member distributing medications to complete a verification form.

Oral medications are generally stored separately from topical medications. However, the monitor detected two (2) oral medications stored in trays labeled as topical room 1.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a documented policy to address Medical and Mental Health Alert Process. The current policy includes procedures that address the major requirements of this standard. The SP2B Clearwater residential program maintains a large dry erase board located next to the direct care work station. The alert board includes a colored coded dot identification system that identifies various medical/mental health conditions.

The agency utilizes a legend that defines the various conditions relative to the youth current mental health and or medical status. This system helps to maintain the youth's privacy and confidentiality. The Green dot indicates youth with Mental Health and Substance Abuse; Blue dot indicates youth assigned to one-to-one Supervision; Red indicates a youth that is on constant sight and sound; Purple dot indicates a youth cannot have access to sharps; Black indicates a youth with an acute medical condition/issues and allergies; and Orange indicates a youth with a medical or mental health condition that requires medication. Since the last onsite QI program review, the agency has successfully updated its alert system to include 1:1 supervision and sharps restrictions.

A review of five (5) files (4 open and 1 recent discharge) was conducted to assess the agency's adherence to the requirements of this indicator. All open files contained the appropriate color coded dots which were documented on the dry erase board and the individual files. Shift Exchange Information entries and log book entries were reviewed to indicate staff members were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment.

The current form does not include a subject description section that identifies presence of scars, tatoos, or skin markings.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a written procedure to address Episodic/Emergency care. There were a total of four (4) episodic events documented in the last six (6) months. These cases included, two (2) Baker Acts (September 2012 and July 2012 parent notification) and 2 injuries (May 2012 - Yes parent notification (staff accompanied) and April 2012 - yes parent notification no staff accompaniment to hospital). There was documentation of the parent and or guardian being notified in each case. In one (1) case the EMS transported the youth to the hospital and staff accompanied the youth; 1 case involved the paramedics transporting youth to the hospital; and the remaining 2 cases are Baker Acted and were both transported by local law enforcement officers. No cases involve onsite first aid provided by agency staff members. Of the 4 Episodic/Emergency care incidents, all episodic events were documented on the agency's internal incidents log and in the program log book. All cases that required off-site emergency services are documented in the log book and in the Episodic log. One Baker Act is clearly documented and the other is not and is only generally noted the log book. This Baker Act incident, just states that law enforcement is transporting the client to a local receiving facility. The logbook entry fails to clearly state the reason why the client is being removed from the facility due to being Baker Acted.

A review of seven (7) direct care staff members indicates that all 7 staff training files indicated that there was evidence of CPR and First Aid certification. The shelter has two (2) first aid kits, wire cutters and a knife for life. There are also first aid kits both transportation vehicles.