Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Manatee

on 02/11/2015

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 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 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion 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 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
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 and Consultant, Forefront LLC

Al McCray, Shelter Director, Boys Town of Central Florida

Paul Sheffer, Regional Monitor, DJJ

Carolyn Kher, Program Director, YFA - New Beginnings

Karen Mersinger, Quality Improvement Specialist, Sarasota YMCA

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

3 Case Managers
2 Clinical Staff
1 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
1 Program Supervisors
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [x] Exposure Control Plan
- [x] Fire Drill Log
- [x] Fire Inspection Report
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Sick Call Logs
- [ ] Supplemental Contracts
- [x] Table of Organization
- [ ] Telephone Logs
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

7 Health Records
3 MH/SA Records
14 Personnel Records
6 Training Records/CORE
3 Youth Records (Closed)
3 Youth Records (Open)
0 Other

Surveys

2 Youth | 0 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

On October 22, 2014 a report was made to the CCC that a set of facility keys was missing. The entire shelter was searched thoroughly and the keys were never found. It is still unknown if the keys were lost inside the shelter or while the staff was away from the shelter on a transport. The CCC report states the keys that were lost went to youth's room doors, kitchen doors, the key lock box, and closet doors. There were no keys, on the set lost, that went to exterior entrances to the facility. However, there was a key on key ring that went to the key lockbox where restricted keys to the facility are kept, such as keys to the medical cabinet, sharps in the kitchen, etc. It was stated in the CCC report that the agency is going to look into re-keying the facility. At the time of the Quality Improvement review the agency had decided not to re-key any of the doors in the facility. It was strongly recommended to the agency that all doors that were affected by the lost keys be re-keyed, but if that was not possible, at a very minimum the key box that holds the restricted keys be re-keyed. This was of high concern due to the types of keys held in the restricted key box and not knowing exactly what happened to the lost set of keys. They agency reported, during the review, that they would look into at least re-keying the restricted key box.

Strengths and Innovative Approaches

Rating Narrative

The agency received a $100,000 grant from JWB in Pinellas County to receive new computers. The shelter in Manatee County will be receiving the "newer" of the older computers from sister shelters. The other shelter operated by the agency will be receiving the new computers.

The Residential Supervisor received her licensure for a mental health counselor since the last review; however, the week of the current Quality Improvement review was also the Residential Supervisor's last week with the agency.

The non-residential program has started a new truancy program and have become a truancy drop-in center for the whole county. Law Enforcement radios in to a Board of Education staff member located at the non-residential office when a youth is found on the streets during school hours. That person then checks school enrollment, program enrollment, and other pertinent information concerning the youth's school attendance requirements. If there is no legitimate reason for the youth to be out on the streets during school hours, Law Enforcement drops the youth off at the CERTAIN office. CERTAIN stands for Community Effort To Reduce Truancy by Addressing Individualized Needs. At that time the BOE staff talks to the youth to discern what was going on, what kept him from attending school, and determining youth's risks/needs. At that time the staff member calls the parent explaining the situation and lets them know where they can pick the youth up. If the child is in crisis, the youth can talk to one of two counselors with offices in the CERTAIN area. When the parents arrive, services are explained and an Intake is either set, completed, or declined by the parents. If the case is opened, the youth/family receives services for 60 days. At the end of that time, the counselor and family determine if they would like to continue with a case manager/counselor in the CINS/FINS program or to help with linking to other community services. This program is innovative and provides immediate services for intervention of immediate risks in which the youth is currently involved by being on the streets during school hours, as well as, providing immediate access to prevention services.

Standard 1: Management Accountability

Overview

Narrative

Family Resources, Inc. – Manatee youth shelter called SafePlace2B and non-residential programs are located in Bradenton, Florida. Family Resources, Inc. provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The Family Resources agency primarily provides CINS/FINS services in Manatee County and nearby surrounding counties. Family Resources also operates sister North and South youth shelters also called SafePlace2B that are located in Clearwater and St. Petersburg, Florida respectively. These agencies service youth and families in Pinellas and other surrounding counties. Each location has assigned or has access to a licensed clinician. All locations have a Shelter Director, Residential and Non-Residential counselors, Residential staff members and Outreach staff. A centralized Human Resources and fiscal department 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 service locations in the areas of operations and programming for both residential and non-residential services. Other uniform protocols for all three locations include training and professional development. The Family Resources Manatee program 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.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and prodecure in place to address background screening requirements, which was reviewed in October of 2014. The Program hired eleven new staff during the last year. They also had two interns begin working with the program during this same period. Each new employee and intern was screened prior to beginning work with a rating of eligible or eligible with charges. Two staff required the completion of five year background rescreening. This was completed for each of the two staff prior to the anniversary date of their employment. The program submitted their Annual Affidavit of Good Moral Character to the Department's Background Screening Unit on January 5, 2015, meeting the annual requirement.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a policy in place which indicates they will have an environment in which youth, staff, and others feel safe and not threatened by any form of abuse or harassment. During the admission process the shelter explains the client rights to each youth. They are also provided information regarding the Florida Abuse Hotline and reporting procedures. This information was found posted for youth and staff in the common areas. Youth are also advised of the shelter's grievance procedure during their orientation. These forms are easily accessible to youth for them to address any problems they may encounter. A review of the incident reports for the past six months found there were none related to youth being abused or intimidated in any way.

Upon hire, each staff signs a code of conduct that prohibits physical abuse, profanity, threats, or intimidation. They also provide training for child abuse reporting as part of their first year staff training. A review of two staff training records for first year training validated this practice.

There were two youth available to take a survey. Both youth reported they are able to call the abuse hotline if needed. Both youth reported staff are respectful when speaking to youth and they have never heard staff use profanity or threaten another youth. Both youth also reported they feel safe in the shelter.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a policy in place which addresses internal incident reporting and Central Communications Center (CCC) reporting requirements. The shelter had seven incidents during the previous six months which were required to be reported to the CCC. Each was found to be report to the CCC within two hours of them having knowledge of the incident, which meets the CCC reporting requirement. Six of the CCC reports were related to medication errors, and the other CCC report was related to a set of staff keys which was lost.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has a policy in place which addresses the training requirements for staff. This plan includes all elements required by the Florida Network and the CINS/FINS rule. Two staff training records were reviewed for the completion of first year training. Each of these two staff were found to have exceeded the eighty hour training requirement, and their hours of training completed in the first year of training were 110 and 101.5 respectively. One reviewed staff training record had no documentation to reflect them taking the course on PREA. Since they could not locate this specific training course, the staff took the course immediately to ensure this was recorded. The other reviewed staff record indicated they did not complete the courses for signs and symptoms of mental health and substance abuse or the course on PREA during their first year of employment; however, they did complete these in the week after their one year anniversary.

Four staff training records were reviewed for the completion of annual in-service training requirements. Each of the four staff exceeded the twenty-four hour requirement, and their hours ranged from forty to sixty hours of training. Three of the four records reflected all mandatory training topics had been completed. These included training on fire safety equipment, crisis intervention skills, suicide prevention, signs/symptoms of mental health and substance abuse, universal precautions, and cultural competency. Each staff was also found to have current certification in CPR and first aid. The other staff completed all required trainings with the exception of crisis intervention skills.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a clear policy regarding reporting and analyzing data. Jessica Hamilton, Residential Supervisor, was interviewed regarding the procedure. All data is collected and distributed by the non-residential Secretary. The COO, Residential Supervisor and Management Team review the data. Staff is informed about various benchmarks, incident reports, grievances as well as other types of trends in the monthly staff meeting. Staff meeting minutes were reviewed and documentation supports this. A Leadership Team for Family Resources also receives and reviews this information. Risk Management reviews all incident reports.

Any pattern or trend which is negative is discussed with management and staff. Together they deal with issues and come up with new ideas or ways to bring about a positive result.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Family Resources program provides Non-Residential Services through its Counseling staff located in Bradenton, Florida. Primary services delivered include Truancy, Marriage and Family Counseling. The Non-residential services component includes a Program Director and additional staff members that include three Family Counselors, two case managers, a Community Relations Specialist, and a Secretary. The Program Director is a Licensed Mental Health Counselor (LMHC) and is responsible for the daily operations and service delivery of the non-residential services program. 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 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 nonproductive 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.

The Family Resources Manatee non-residential program has a new format for working with truant youth in the county. Law Enforcement radios in to a Board of Education staff member located at the non-residential office when a youth is found on the streets during school hours. That person then checks school enrollment, program enrollment, and other pertinent information concerning the youth's school attendance requirements. If there is no legitimate reason for the youth to be out on the streets during school hours, Law Enforcement drops the youth off at the CERTAIN office. CERTAIN stands for Community Effort To Reduce Truancy by Addressing Individualized Needs. At that time the BOE staff talks to the youth to discern what was going on, what kept him from attending school, and determining youth's risks/needs. At that time the staff member calls the parent explaining the situation and lets them know where they can pick the youth up. If the child is in crisis, the youth can talk to one of two counselors with offices in the CERTAIN area. When the parents arrive, services are explained and an Intake is either set, completed, or declined by the parents. If the case is opened, the youth/family receives services for 60 days. At the end of that time, the counselor and family determine if they would like to continue with a case manager/counselor in the CINS/FINS program or to help with linking to other community services. This program is innovative and provides immediate services for intervention of immediate risks in which the youth is currently involved by being on the streets during school hours, as well as, providing immediate access to prevention services.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Family Resources has a written policy in place indicating there is a 24 hour/7 day a week eligibility Screening process. This policy provides the criteria for eligibility, the definition of a Child In Need of Services/Family In Need of Services (CINS/FINS), the purpose of the program, and the procedures staff should take to determine eligibility for services.

There were three non-residential charts reviewed, two open and one cclosed. The NETMIS Screening form is used for eligibility screening in this program. Eligibility requirements stated in the agency policy and obtained on the NETMIS form coordinate together to provide a strong screening process. If a parent/guardian calls in staff are trained to complete the screening process at that time. If a written referral is received by mail or fax, a designated, trained staff makes three attempts to complete the screening within seven days. If the parent is reached, the NETMIS screening form is completed. If parent is not reached, the referral source is notified, who then determines whether to contact the family to respond to the screening call or if another referral avenue will be taken. At the time eligibility is determined an intake appointment is set.

There were three non-residential charts reviewed, two open and one closed. All three non-residential charts had NETMIS Eligibility Screening forms completed.

The agency has a written policy for the Intake process that provides an outlined process for youth eligible for the CINS/FINS services, this includes: immediate needs, risk factors, and presenting problems. If the youth is not eligible for services, at least three referral sources are provided. If shelter services are determined, the youth is placed in the residential program with family sessions offered. Per written policy, at the time of intake, each youth and parent/guardian receive a copy of the "Rights and Responsibilities", including the grievance policy, and available services, as well as, the FLN publication describing the case staffing, CINS petition, and CINS adjudication process. All three non-residential charts reviewed provided a written "Rights and Responsibilities" form stating service options, Rights as a Client, including the grievance process, and Responsibilities as a Client. All three non-residential charts had signatures on this form from the youth, parent/guardian, and staff, as well as, date signed.

There were three residential files reviewed, one open and two closed. The agency policy for Screening and Intake was followed in all three residential files. Screenings were completed face-to-face at time of intake. All paperwork required by the indicator was signed by the parents/guardians and in the file.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is an agency written policy for 2.02 Needs Assessment stating when, within 72 hours for residential or two to three face-to-face sessions for non-residential, and who, Bachelor's or Master's level staff, will complete the Needs Assessment, which will be signed by a supervisor. Staff procedures also are included to provide the information gathered in the Needs Assessment/Pyschosocial assessment.

All three non-residential charts reviewed had a Needs Assessment. Two were completed within the first face-to-face office visit and one was completed within two face-to-face sessions. All three non-residential intakes were completed and signed by a Bachelor's or Master's level staff.

Three residential files were reviewed, one open and two closed. The agency policy for Screening and Intake was followed in all three residential files. Screenings were completed face-to-face at time of intake. All paperwork required by indicator was signed by the parents/guardians and in file.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This agency has a written policy indicating Case/Service plans will be developed within seven working days of the completion of the Needs Assessment. The procedure to be followed is clearly outlined for staff.

All three non-residential charts reviewed had Case/Service Plans which were completed within seven working days, and actually completed at time of first face-to-face session. All three non-residential Case/Service Plans had individualized and parent/family goals which met the needs identified in the Needs Assessment. Service type, frequency, and location were noted in all three non-residential plans. All goals also documented persons responsible and signature of parents. One chart had target and completion dates for youth, but parents goals did not have target or completion dates. Counselors signed at the time the plan was developed and the supervisor signed well within the 30 days, usually within less than one week's time.

Three residential files were review and found all had Case/Service Plans completed. Two were completed on the date of intake with one showing contradictory dates. Counselor logs show counselor discussed (initiated) the Case Plan on 11/30/14 and called mother concerning the Case Plan. However, date initiated on the Case Plan form stated 12/03/14. All charts reviewed consistently had supervisor's signatures well before the 30 days. This evidence shows close supervison of the Case Plans.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This agency has a written policy that indicates all non-residential families are provided with an inclusive referral list of services in the community. This list is presented to the family during the intake process. This referral form is fluid in the fact that as individual or family needs are assessed, the counselors provide an actual referral form, phone number, and contact name, and/or make the contact for the family to the referral source. This is documented on a inclusive referral list. Referrals to other sources not on the list are added at the bottom providing the correct contact information, along with a referral form, if needed, by the receiving source.

All three non-residential charts had documentation of the Inclusive Referral form with referrals indicated on it, referral forms and releases of information for specific referrals provided, and documentation in counselor's notes.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy pertaining to the counseling services. It states there will be counseling services in regard to the Case/Service Plans. Programs provide individual, family counseling, and groups to meet the needs of the youth.

All three non-residential charts had documentation showing all youth were provided with appointments set for individual and family counseling. The counseling notes by the counselors indicated the sessions were in response to youth's presenting issues by psychosocial assessments and case/service plans. The youth's progress was documented and there was evidence there is a review process. One youth and family never kept another appointment w/ counselor after Intake and Case Plan. However, the counselor met with the youth and parent at Teen Court each time, working to engage the family back to services. There was evidence of strong follow-up and commitment by counselor.

Three residential files were reviewed. All three files had complete, dated, and well documented counseling notes that report individual and family counseling. Counselors show support for youth in the shelter to facilitate their success. Counseling documentation is clear and concise, typed and easily read.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This agency has a policy documenting the Case Staffing process if needed. Due to the new CERTAIN PROGRAM being a "current" at-need service, there is not as much need for the Case Staffing service.

One non-residential chart was reviewed for the Adjudication/Petition Process. This was a new case which was initiated by the Teen Court. The counselor has opened the case and will attend the first Case Staffing with the family. This is an on-going process at this time.

Three residential files were reviewed with none having Adjudication or Petitions. There is a policy for such needs and was indicated in one open file in non-residential.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

All three non-residential charts that were reviewed were marked confidential, kept in a secure, locked room in a locked file cabinet with other open and recently closed files. Designated staff have keys to said files.

There were three residential files reviewed, one open and two closed. The two closed were clearly marked with red confidential stamps. The one open file had confidential on the side of the binder in black and is not as easily seen. A white sticker with red confidential on the front and back of open binders would be helpful.

Standard 3: Shelter Care

Overview

Rating Narrative

Family Resources Manatee program provides residential CINS/FINS services through a contract with the Florida Network of Youth and Family Services. The Manatee SafePlace2B shelter is located in Bradenton, Florida. At the time of this Quality Improvement review, the residential program is staffed with a Residential Supervisor, a Counselor, a Case Manager, twelve Youth Care Workers, a part-time cook, and an Administrative Assistant. There was one part-time male Youth Care Worker position that was vacant. The Residential Supervisor oversees the day-to-day operations of the youth shelter. The program provides group sessions to clients a minimum of five days a week on various topics that address issues including substance abuse prevention, anger management, effective communication, leadership skill building and many others. The agency utilizes a behavior management system that is also used in its other residential programs.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Disaster Preparedness Plan in place that meets the requirements of the Florida Network.

All fire inspections appear to be within compliance. The fire inspection report has been completed within the year. The fire prevention plan is in compliance. There were no concerns with the fire safety and sprinkler systems. This agency did a great job of documenting all fire drills for the year. They complete at least one drill per month. There were some incidents where staff did not complete in less than two minutes. The staff received feedback and improvement was documented. Also, make sure you are completing emergency care drills on all shifts. Those documented only were only for 1st and 2nd shifts.

This agency did well with reporting and documenting the mock emergency drills each quarter. The facility was equipped with a knife-for-life. The first aid kits were fully stocked. I observed wire cutters and bio-hazard waste disposal bin(s). All annual inspections appeared to be up-to-date. No concerns with sprinklers, alarm system and kitchen overhead hood. The Department of Health inspection was up-to-date. The menus were posted; however, they don't appear to be up-to-date. Recommendation would be for menus to be updated.

DCF Child Care License was placed out front. There were no concerns in the area of debris. Everything appeared to be operational. All doors appeared to be secure. There were maps of the facility placed throughout the building. Abuse Hotline information was made accessible to the youth. All surveillance cameras appeared to be operational. When asked how long they keep recordings the supervisor informed the interviewer they check cameras every two weeks. All staff doors were locked. Agency vehicles were equipped with first aid kit, fire extinguisher, flash light, glass breaker, seat belt cutter, and air bag deflator. Staff informed the interviewer that they were not allowed to transport youth in their private vehicles. There were no concerns with interior lighting. No graffiti was located within the building. All furniture appeared to be in order. Note: There was bed bug cups placed under each leg of each bed. There are also bed bug sheets for each bed. All beds were equipped with the right fixings. There was a number on the side of the door identifying bedrooms. There was also a bed for handicapped youth. There was no evidence of hazardous unauthorized metal/foreign objects. All areas appeared to be clean. I observed no mildew. Everything seemed to be in working order. No concerns with the MSDS. The book was reviewed. The washer and dryer were in working order.

It was observed that the grievance folder was located on the wall. The staff interviewed had adequate knowledge of the grievance process. Daily Activities were posted on the board. The staff interviewed had adequate knowledge of daily activities.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were five youth files reviewed, three closed and two open. All youth received an adequate orientation within a 24 hour period. All areas of the orientation checklist appeared to meet criteria that the Florida Network was looking for. There were no exceptions found with any files. Whatever disciplinary action that took place was explained in documentation. It appears that the staff have a good grasp of how to explain the grievance procedure. There are facility maps that were placed on walls throughout the facility.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

All five files reviewed appeared the youth's classification correlated with the board and intake files. The colored tabs matched what was in the files and on the alert board. There appears to be a good system in place. There were no exceptions in this area. The doors also had room numbers that labeled the rooms.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Logbooks were reviewed and safety and security issues appeared to be documented appropriately. All fire and emergency drills were documented in the logbooks. They were also color coded correctly. It was observed that the supervisor and staff were reviewing the logbook in a timely manner. Visitation and home visits were documented and color coded. There was no white-out or erasing in the logbooks. There were some recording errors that were only crossed out with no date or initial next to them.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Behavior Management System appears to be very detailed and can be easily be understood by youth. The system appears to be very rewarding if youth are willing to put forth efforts in the program. The consequences appear to be in compliance with Florida Network standards. There is adequate written feedback showing the progress or regress of the youth's behaviors. This is completed on a daily basis. The form observed gives a good measurement of the youth's behaviors. The staff was interviewed and was able to explain the Behavior Management System in detail. The staff appeared to have vast knowledge of the system.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

This Program has a clear policy for staffing and youth supervision that complies with DJJ policy. Staff schedules are posted in the hallway. Schedules were reviewed from July - present. There was one overnight shift where only one staff was on duty. Due to the Shelter only being licensed for twelve (12) the one staff member to 12 youth was in compliance. Forty (40) shifts had only one gender of staff on duty. The Residential Supervisor explained that she has been trying to hire males but is having difficulty staffing males on all shifts.

Bed checks were provided for November 24th through the present originally. Four (4) days in the end of November and beginning of December had times when there were lapses in time significantly greater than the 15 minutes required. The Residential Supervisor explained that there were issues with the "gun" that records the time. They found it was not always recording the bed check on the computer. They devised a plan to have one staff sit at the computer while the other staff does the bed checks and alert them if the time was not recorded. Older bed check sheets were requested and the checks were correct. The "gun" for electronic recording is not working presently so they are recording the bed checks manually again. All other checks were done within the designated fifteen (15) minute time frame.

There is a book at the staff desk with names and phone numbers of staff to be called if additional coverage is needed.

The Shelter has a surveillance system which is monitored in the Residential Manager's office. The cameras provide a clear view of all common areas of the Shelter as well as the outside perimeter. The Residential Supervisor has the ability to change the view or zoom in on specific areas. The system provides backup for 10-12 days depending on amount of activity recorded.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a well documented policy regarding special populations: Staff Secure, Domestic Violence Respite and Probation Respite youth that complies with the DJJ standards. The Program did not have any Staff Secure, DV Respite or Probation Respite in the past year.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Family Resources Manatee program provides screening, counseling and mental health assessment services. The Family Resources Manatee agency has direct care 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's 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 the residential youth shelter. The Family Resources Manatee program 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, 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. At the time of this onsite Quality Improvement review, the agency has two staff members that are licensed clinicians. These staff members are involved in the review of all residential clients that screen positive for suicide risk. 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 agency has written policy in place for Healthcare Admission Screening that was last reviewed in October 2014. A general health screening is conducted during the admission process by the staff member completing the intake. The staff uses the CINS/FINS intake form (Page 2) to assess youth for any current medical illnesses, chronic medical conditions or any recent injuries or accidents. The staff also determine at this time if the youth is currently taking any prescribed or over the counter medications. If the staff determine that the youth has any existing specific medical issues that need to be addressed they then conduct a medical follow up with the program manager, the parent or guardian and/or licensed medical personnel as indicated. Information regarding the youth's medical conditions or needs may be entered into the medical mental health alert system to facilitate the communication process between staff. Information is also written in the program log book and communicated verbally from shift to shift during the formal shift change process.

A review of two open and three closed residential files indicated that in all five cases a health care admission screening was conducted by staff during the intake process. All five files documented healthcare admission screening was completed using the CINS/FINS Intake Assessment form. None of the youth required any follow-up medical appointments; however, the agency has a process in place to contact the youth's guardian if needed. One youth was admitted with a fractured jaw; however, there were no follow-up doctors' appointments needed. There were two youth who documented taking medications and this information was in the youth's file and in the shelter logbook.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Comprehensive Master Plan for Suicide Prevention and Response in place. The plan was last reviewed on September 8, 2014. The plan states that each youth will be screened for suicide risk by the six suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to questions two and three, the youth is considered to be at high risk of suicide and must be placed on One-to-One supervision and referred for Baker Act. If the youth answers "yes" to questions 1, 4, 5, or 6 on the Intake Form then the youth is determined to be at moderate risk for suicide. The youth will be placed on sight and sound supervision until a full suicide risk assessment is completed. The assessment will be done within twenty-four hours during the weekdays or within seventy-two hours if over the weekend.

There are four different levels of supervision used in the shelter. One-to-One Supervision, 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 three files reviewed for youth placed on suicide precautions. All three youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. All three youth were immediately placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. All three files documented the assessment was completed within twenty-four hours by a masters level counselor. All the assessments contained documentation of a consultation with the LMHC by telephone. All three youth were placed on elevated supervision, with sharps restrictions, after consulting with the LMHC. There were fifteen observations maintained the entire time the youth were on sight and sound supervision. There were detailed shift notes in each file documenting when the youth was placed on sight and sound supervision and the reasons why, and when the youth was stepped down to elevated supervision. All three files also documented the youth's room assignment as the couch until the youth was stepped down to elevated supervision, then the room assignment was updated to an actual room and bed. 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, on the Shift Exchange of Information Form, and in the youth's file.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place to address medication procedures recently reviewed and updated in October 2014. The policy addresses storage, inventory and verification procedures, over-the-counter medications, disposal, and incident reporting. The policy addresses requirements outlined in the DJJ Health Services Manual. The shelter provided documentation of all staff who are trained to help youth in self-administering medication.

Observations of medication storage revealed medications are stored in a locked room, in a double-locked medication cart. In addition, the key to get into the locked room is stored in a separate area in a locked key box. There are two cameras recording the medication administration area. One camera is pointing directly at the medication cart and the other camera is pointing down the hall. This helps ensure youth are receiving their medications as required and helps with any investigations needed to be conducted due to medication errors. Oral and topical medications are stored in separate, labeled, drawers. At the time of the review, the shelter had no youth currently on any topical medications and only one youth receiving oral medications. There is a small refrigerator located in the same locked room as the medication cart for any medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration. The shelter does not provide over-the-counter medications, unless the youth comes in with it and has a doctor's order, so they did not have a stock of over-the-counter medications.

The shelter keeps a small supply of sharps in a locked cabinet, in a locked box. The supply includes four pairs of scissors and razors that the youth bring in to use. A detailed inventory of the sharps in conducted each time a youth enters or leaves the shelter and brings in new razors or disposes of old razors. As a result the inventory of the sharps ends up being conducted more than once a week. Youth are required to sign-out and sign-in razors when they need to use them. If a youth is on sharps restrictions they are not allowed to use a razor.

At the time of the review there was one youth in shelter on medications, this youth's file, as well as, four additional closed files were reviewed to verify the medication administration process. All five files contained a medication verification form that was completed and documented all medications the youth was taking. All five files contained a cover sheet with the Medication Distribution Logs (MDLs) that documented the youth's name, date of birth, admission date, all medications with time to be given, any approved over-the-counter medications, and a picture of the youth. Each MDL reviewed documented the youth's name, date of birth, allergies, side effects, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. Each MDL also documented a weekly review by the residential supervisor. All five files documented medications were given at the time specified or within the one hour time frame before or after the time specified. All perpetual inventory with running balances was maintained on each MDL, as well as, shift-to-shift inventories. Each file also contained a print-out, for each medication, of side effects from different websites.

The shelter has had nine incidents reported to the CCC since July 2014, with the most recent incidents occurring January 30th and February 2nd. Out of the nine incidents reviewed five incident were due to the youth receiving medication late. The medication was given outside the hour window grace period. In all cases the pharmacy was notified and confirmed it was okay to go ahead and give the medication. All staff involved in the above incidents received a written warning and one staff member was terminated. There were two CCC reports involving youth receiving incorrect dosage of medication. In one instance the youth was to receive a half pill and instead received one and a half pills. In the second instance the youth received one pill instead of two pills. The staff involved in both of these incidents received a written warning and training. Another CCC report reviewed involved a youth "cheeking" a medication and then giving the medication to a roommate. Staff involved in this incident were retrained on the medication administration policy and received a written warning. The last and most recent incident involved a missed dose of medication. In this instance the pharmacist could not be reached to determine if the youth could still receive the medication so the youth never received the medication.

The Residential Supervisor reported various processes put into place to avoid medication errors, such as alarm clocks at the staff work area, medication times written on the alert board, notes left for staff, changing night time medication pass to 9pm instead of 8pm to avoid any unnecessary distractions that were occurring during the 8pm medication pass. However, these changes occurred in December 2014 and with the recent errors in medication distribution it appears there is still a systemic problem occurring that needs to be addressed.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a comprehensive Medical and Mental Health Alert System in place that utilizes a color coding system to identify various types of alerts. There are eight color codes that are used to categorize the medical, mental health, or security risk factors youth may present with. These risks are identified upon admission to the shelter during the initial intake process and anytime throughout the youth's stay in the shelter. All alerts are documented on an alert board located in the staff work area, in the main living area of the facility. Alerts are also documented on the spine of the youth's files and in the shelter logbook.

There were two CINS/FINS youth in the shelter at the time of the review and both youth were applicable for alerts. In comparing the alerts on the alert board, the alerts documented on the youth's file, and the alerts documented in the shelter logbook it was found that the alerts were consistent across all methods of staff notification.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has a well documented Policy for Episodic/Emergency Care which is in compliance with DJJ Standards. Four (4) youth in the reviewing period received first aid or emergency care and were listed in the Episodic Care Log. Of the two (2) receiving emergency care, one had chest pain and trouble breathing. The other was dizzy, had shortness of breath and nausea. In both cases, EMS were called. Both were transported to the hospital. Parents were notified in both cases. There was no entry in the communication log or youth log notes regarding hospital diagnosis or discharge instructions for either youth but hospital discharge papers were in each youth's file. One of the youth did receive an alert due to the hospital visit. The two (2) others recorded in the log were minor injuries requiring first aid only.

Emergency Drills are conducted monthly. Documentation of these and the critique by the Residential Supervisor is in place and signed.

All direct care staff have CPR/First Aid training. Knife for Life training is part of the Orientation Process for all staff.

First Aid Kits are in the locked closet in the common room, in the kitchen and in the van. The Residential Supervisor insures that all contents are complete and up-to-date.

Emergency information is posted in multiple areas throughout the Shelter.