



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Manatee

on 02/10/2016

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
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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

Standard 2: Intervention and Case Management

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

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

Standard 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

Ramona Salazar, Program Monitor, Department of Juvenile Justice

Rhonda Rhodes, Clinical Director, Hillsborough County Children's Services

Keisha Dunn-Pettis, Quality Management Manager, Children's Home Society (Safe Harbor)



Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 5 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 19 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 4 Youth 4 Direct Care Staff 4 Other

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

In March 2015 the agency hired a new Residential Supervisor who is a Licensed Clinical Social Worker (LCSW).

Since the last on-site review the agency has opened their new Maternity Transitional Living Program and named it SafePlace2b-Too-Young Moms. The program serves eight pregnant or parenting moms and their babies. Moms must be ages 16-22 and referrals are accepted from statewide.

All paperwork for non-residential/counseling services was standardized and implemented throughout the agency.

In July and August of 2015 Family Resources was rebranded and released a new logo and website. These services were donated by an artist in NYC. SafePlace2B was trademarked. A new philosophical approach to service delivery focusing on cognitive restructuring was introduced agency-wide. Also, the new Behavioral Motivation System was implemented. The system uses a new approach reflecting goals/interventions that focuses on changing thoughts. Interventions are listed by domain and correlate to incremental steps or activities to start the change process.

In September 2015, the agency developed new job titles for Youth Care Workers (they are now called Youth Development Specialist) which was implemented to include a tiered system with a certification process that includes written exams and observations by supervisors and peers. An increase in pay is given with additional responsibilities with YDS II and YDS III.

Also in September 2015, all paperwork for shelter services was standardized and implemented throughout the agency.

In October 2015, YDS staff were provided a three-hour curriculum called Positive Youth Development 101, which is based on Motivational Interviewing and Trauma Informed Care. Curricula was developed by two DJJ Master MI Trainers and delivered in person covering three different sessions to allow for all to participate.

The agency has implemented an expanded Peer Review process to include mock QI reviews on a quarterly basis.

The Manatee SP2B shelter received the Basic Center Grant for shelter; the only site in Florida chosen.

The agency was selected for a five-year Healthy Relationships Grant serving high risk youth and young adults 15-25 to promote healthy relationships, making the right choice the first time for marriage; preventing domestic violence and unwanted or unplanned pregnancies. The program is named Safe2B You and Me.

The agency was selected for the Chosen Families Program; a program to assist adoptive families from disruption. Wrap-around services began in October 2015.

In January 2016, a local artist adopted the bedrooms in the shelter and is creating "themed" rooms.

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 Residential 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

There were fourteen employees and two volunteer intern background screenings reviewed since the last annual compliance review. Of the fourteen employees, all were rated as eligible and one was rated as eligible with charges. In addition, their program utilized two interns—one of which was rated as eligible and one was rated as eligible with charges. All background screenings were completed prior to the date of hire as required by Department and Florida Statute.

The Annual Affidavit of Good Moral Character was submitted to the Department on January 7, 2016 as required.

There were no exceptions noted for this indicator.

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. Upon hire, each staff signs a code of conduct that prohibits physical abuse, profanity, threats, or intimidation. They are also provided training on child abuse reporting as part of first year training requirements. A review of staff training files for first year training validated this practice.

During the admission process the shelter staff 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. The process is explained in the youth handbook given to the youth at admission. Youth have access to grievance forms at any time. The forms are located in a folder on a bulletin board in the dining room. The youth may also place the form in an envelope and seal it if they choose. A locked grievance box is located outside the Residential Supervisor's office and the youth place any grievances in that box. That box is checked daily by the Residential Supervisor. The shelter has had four grievances filed in the last six months. All four grievances were addressed by either the Residential Supervisor or Program Director the following day and were resolved with both the youth and staff. The youth signed the grievances indicating they were satisfied with the resolution. There were comments written by the Residential Supervisor or Program Director indicating how the grievance was resolved.

There were four youth available to take a survey. All youth reported they are able to call the abuse hotline if needed. All youth reported staff are respectful when speaking to the youth and they have never heard staff use profanity or threaten another youth. All the youth also reported they feel safe in the shelter. There were three staff members surveyed. All three staff members knew the procedures to allow a youth to report abuse to the abuse hotline. None of the staff had ever heard another co-worker deny a youth access to the abuse hotline. In addition, none of the staff had ever heard a co-worker use profanity, threats, or intimidation when speaking with the youth.

There were no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

A review of Central Communication Center (CCC) reportable incidents was reviewed for the last six months. There was one CCC incident during this review period classified as a medication error on January 22, 2016. The incident was not recorded in the facility log book as required by the shelter's policy and procedure and reviewer guidelines for this indicator. There are internal processes for non-reportable incidents which are also tracked for internal purposes. There were four internal incidents reported for the last six months—three of which were for client injuries and the fourth incident was reported as other. These internal incidents do not require log book documentation but do require management review as stated in the center's policy and procedure. A review of the internal reports include management review and are signed. The internal incident report documents the time of the incident and the time the incident was called into the CCC

hotline which was applicable to the one reported CCC incident. It should be noted that the internal incidents were reviewed by the Chief Operating Officer (COO) of Family Resources.

The CCC incident was reported within the two-hour timeframe as required.

There were no exceptions noted for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

All direct care staff whether they are full-time, part-time or on-call are required to receive a minimum of eighty hours of training for the first full year of employment and twenty-four hours of annual in-service training. Direct care staff in residential programs licensed by the Department of Children and Families (DCF) are required to have forty hours of training per year after the first year. Required trainings are outlined in the shelters and the Florida Network (FN) policies and procedures for training requirements. Training plans are used for staff and require certain trainings to be completed within a required timeframe from the date of hire. The training plans for the Case Manager, Counselor and the Youth Development Specialist I (direct care staff) has required training that must be completed within ten days of hire and annually thereafter. Training subjects falling under the Administrative Training on the plan are to be completed within thirty days of hire and program related training on the plan must be completed within the first year of employment and annually thereafter. Contract and position specific trainings are also included in the plan with no timeline for completion indicated. The plan also provides entry of any staff attending conferences or other trainings. Each position also has a training plan for the 2nd year of employment with training subjects that are required to be completed within the second or consecutive years of employment with approximate completion by October of that year.

Five staff training files and plans were reviewed. Of the five training files selected, four of the staff were hired within the last calendar year. Training hours exceeded the policy and procedure requirement of eighty hours within the first year of employment.

There was only staff training file applicable for a review of annual in-service training requirements. This staff exceeded the required forty hours of training and all required training topics were covered.

The shelter does maintain an individual training file for each staff which includes an annual training plan that tracks the number of completed training hours and dates. There are sign-in sheets, agenda and training certificates in each training file. Each agency does submit a training plan to the Florida Network, however it should be noted that the training plan does have timeline requirements for training topics to be completed within ten days and training topics to be completed within thirty days (both from the employees date of hire). There were some training topics under both categories that were either not completed or completed beyond the time-frame stated on the training plan.

Exceptions:

The agency's training plan does have timeline requirements for training topics to be completed within ten days and training topics to be completed within thirty days (both from the employees date of hire) and there were some training topics under both categories that were either not completed or completed beyond the time-frame stated on the training plan.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place for data analysis of program operations, contract requirements, risk management, internal QI reviews, detailed incident data tracking for CCC and abuse reporting, customer satisfaction surveys, outcome measures, case record reviews, and grievances. There is internal monthly data collection that is tracked on an annual basis and can be compared to previous year's data. The data collection is maintained on the agency's intranet and information can be retrieved regarding a program's performance, utilization, funding sources, and donations. The data information is also available to view on request and the reports for this site location was provided during the review.

Youth data collection includes information regarding length of stay, charge history, placements, denials, groups, off-site activities, grievances, respite care, treatment sessions, etc. This list is not inclusive of all the data collected by this agency but does provide a snapshot of the trending data collected and how the information is disseminated to program staff, corporate and funders. There are also monthly report cards which provides data analysis and information regarding each shelter through the agencies NetMIS reporting process. Monthly data collection can be requested for month to month, quarter to quarter or annual comparisons for any of the data obtained for each shelter. There are monthly risk management meetings to review and discuss trending data for each shelter. These meetings are held via GoTo Webinars for each site location and the data is reviewed and discussed. The meeting minutes provides information on who attended, items discussed and issues and/or concerns.

There were no exceptions noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

There is a shelter and Florida Network policy and procedure in place providing staff with procedures for the transportation of youth in order to avoid situations that put either youth or staff at risk, guard against allegations, and to prevent inappropriate conduct by youth or staff. The shelter strives to improve practices which includes constant communication between transports to the Residential Supervisor whenever there is a single youth transport with staff, regardless of gender. There is documentation in the shelter's log book when a single youth is transported to and from school. There is evidence that the Residential Supervisor is aware and approves single client transports through logbook documented entries, log book review, and comments and/or feedback and through communication via phone from transporting staff. In addition, there is a list of agency approved drivers based on the staff's work performance, driving history and adherence to the code of conduct as it relates to maintaining professional boundaries between staff and youth. The list provides those staff listed agency and shelter approval to transport a single client.

The agency vehicle policy requires inspection by a certified mechanic at least once a year and that documentation of all repairs are kept on-site in a separate binder. Staff are responsible for

reporting any mechanical issues and having the vehicle serviced at the earliest opportunity. The policy further states that the agency vehicle must be equipped with a first aid kit, fire extinguisher, seat belt cutter and window punch and seat belts must be functional. These are observed and located in the agency's transportation vehicle. The vehicle inspection log and vehicle maintenance documentation was reviewed. The last vehicle inspection was completed in July 2015. In addition, there is documentation for routine maintenance completed in September 2015, November 2015 and January 2016.

There were no exceptions noted for this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

Program has a policy which is in-line with Florida Network policy and procedure as it relates to outreach services and community involvement. The program participates in local DJJ and Council meetings. Agency also maintains written agreements with community partners that include services provided and a detailed outline of the referral process. Program procedure calls for staff obtaining copies of the meeting minutes to provide to leadership.

For the review, the program provided a binder with a calendar of 2015-2016 Community Outreach Meetings. The calendar is very detailed and includes the name of the meeting, purpose of the meeting, contact person, day of meeting, time of meeting, location and name of staff attending. Evidence of attendance is in fact supported by copies of the agenda and minutes. Meetings attended include: DJJ Advisory Board Meetings, DJJ Coordinator Meetings, Coalition Against Trafficking Meeting, Homeless Leadership Board Meeting, and Substance Abuse Advisory Board Meeting.

In addition, the program's Interagency Agreements are organized in a binder and are current; valid August 2015-August 2017. There are 14 areas that the program has signed agreements with other agencies for and include: Mental Health, Afterschool Programs/Community Centers, Behavioral/Law Enforcement, Health, Counseling Services and Supervised Visitation.

There were no exceptions noted for this indicator.

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. The Program Director is a Licensed Clinical Social Worker (LCSW) and is responsible for the daily operations and service delivery of the non-residential services program. Screenings are conducted by Youth Development Specialists and Counselors twenty-four hours a day, seven days a week. A case plan is developed for each client. In addition, home visits are conducted on a case by case basis to offer support to the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, family and individual counseling is offered by Family Resources with shelter care as a viable option for youth that need additional support services.

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

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy in place indicating that there is a 24 hour/7 day a week eligibility screening process. This policy provides a criteria for eligibility, the definition of Child in Need of Services/Families in Need of Services (CINS/FINS), the purpose of the program, and the procedures to be performed to determine eligibility for services.

There were three open and two closed non-residential files reviewed. All five files reviewed were screened for eligibility within seven days of the referral, by a trained professional, utilizing the NetMis Screening form. In each file reviewed, the parents and youth received a listing of available service options, their rights and responsibilities, the Parent/Guardian Brochure, and grievance procedures, as acknowledged by their signatures.

There were two open and one closed residential files reviewed. All files were screened according to agency policies. All of the appropriate forms were used and the youth and families were provided with information about their placement within the shelter, the program, and their rights and responsibilities.

There were no exceptions noted for this indicator.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy which states a Need Assessment must be initiated within 72 hours of admission for residential services and 2-3 face to face sessions for non-residential services. The Needs Assessment must be completed by a trained employee with a minimum of a bachelor's degree. The Needs Assessment must be reviewed and approved by a supervisor. The policy also addresses what information must be included in the Needs Assessment.

There were three open and two closed non-residential files reviewed. All files revealed that Needs Assessments had been completed within 2-3 sessions by a Bachelor or Master's level staff. The Supervisor had reviewed and approved the files per the agency's guidelines. In one file the youth had previous suicidal ideations and, according to agency policy, the Supervisor was consulted and a safety plan was developed. The youth did not require any type of elevated supervision.

There were two open and one closed residential files reviewed. The Needs Assessments were completed within 72 hours of the time of intake. They were completed by a Bachelor or Master's level staff and reviewed and approved by the Supervisor. In two of the files the youth answered yes to questions on the risk assessment. The staff followed policy by completing the Suicide Risk Assessment in each case and reporting the results to the Licensed Clinical Social Worker (LCSW). The LCSW stepped the youth down to elevated status. The LCSW reported that youth will remain on elevated status throughout their stay.

All of the files reviewed included a Youth Self-Assessment and the information was included in the Needs Assessment. The inclusion of this information made the Needs Assessment comprehensive and client-centered.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy indicating that the Case/Services Plans will be developed within seven working days of the completion of the Needs Assessment. The procedure to be followed

is outlined for staff.

There were three open and two closed non-residential files reviewed. All Case Plans were initiated the day the Needs Assessments were completed. All plans were individualized according to needs of the youth and included all parties. In two files the youth received group services only and their case plans did not reflect target or completion dates. Case reviews were completed every thirty days.

There were two open and one closed residential files reviewed. Only two of the three files were applicable for a Case Plan, the third youth had not been in the shelter long enough to require a Case Plan to be completed. The Case Plans like were initiated on the same day that the Needs Assessments were completed. They were individualized and reflective of needs of the youth. Both Case Plans documented target dates for completion. All files revealed inclusion of all relevant parties in the care planning process and implementation.

Exceptions:

In two non-residential files reviewed the youth received group services only and their case plans did not reflect target or completion dates.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency has a policy stating there will be coordination of services and support for the families. Each family is given a list of referrals at intake. The Counselor/Case Managers work closely with the youth and families to assist them in resolving issues and utilizing linkages as appropriate.

There were three open and two closed non-residential files reviewed. In all cases a Counselor was assigned. The Counselors coordinated the services and provided support to the youth and families. Follow-up contact was initiated in every case if the youth and/or family missed an appointment. In two cases, multiple efforts were made in an attempt to engage the families.

There were two open and one closed residential files reviewed. In all cases, a Counselor and/or Case Manager was assigned. It was evident that the Counselor and/or Case Manager work very closely with the youth and family while coordinating services and providing support.

There were no exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy in place stating individual, family, and group services will be provided to meet the needs of the youth and families.

There were three open and two closed non-residential files reviewed. All of them had set appointments for individual, family, or group therapy. In two of the files review the youth were receiving individual and group therapy in response to the Needs Assessment. The youth's progress was noted in the counseling notes and there was evidence that the cases were reviewed by the youth, parent, counselor, and supervisor.

There were two open and one closed residential files reviewed. The counseling addressed the needs of the youth as evidenced by the content of the Needs Assessment. Counseling sessions in one file were offered to a mother who could not come into the office showing the flexibility of service provision. There was evidence that the progress was reviewed by the youth, parent, counselor, and supervisor.

There were no exceptions noted for this indicator.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency has an extensive policy and procedure for the Case Staffing Process. There was one file referred to the Case Staffing Committee in the last six months. The youth and family were presented to the Case Staffing Committee by the Family Resources Counselor in an effort to provide additional services to the family. All appropriate committee members were present. They convened and were able to make recommendations regarding additional services for the family. The parent was provided with these recommendations in writing.

A schedule of monthly meeting and committee members was provided. Documentation was provided for any meetings that did not occur.

There were no exceptions noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy regarding the handling of youth records. All youth records (open and closed) were clearly marked "confidential". They were double locked in a room and in file cabinets with appropriate staff having the keys for access. Those youth records that were transported to the site of the review were transported according to the guidelines set by the Florida Network and the agency.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The 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, nine Youth Development Specialist, a Case Manager, and a part-time cook. 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 Environment

Satisfactory

Limited

Failed

Rating Narrative

The program's disaster plan is onsite, current, and is located in a bin on the wall near the front, kitchen, and rear exits. The Fire Inspection report was completed within the last year. Fire inspection plan is in compliance. No concerns with regards to fire safety and sprinkler systems.

Fire drills were conducted monthly on each shift, for the last six months.

Emergency care drills were conducted monthly. A binder includes all emergency care procedure hand-outs and is easily accessible to staff for use.

The Group Home Inspection was current and satisfactory. The Department of Health (DOH) food inspection report was current and satisfactory and menus were posted. The food storage area was well kept, clean, and food was organized neatly.

The child care license was posted at the front of the facility.

The exterior of the facility was free from debris. It was a welcoming environment with rocking chairs on the porch and the use of solar lighting. Dumpster and garbage cans were covered. Maps of the facility are throughout the building, including youth rooms.

The grievance procedure was posted in dining area with forms and envelopes for youth. The box for submission was located by the Residential Supervisor's office. The number for abuse hotline was located in dining area and in the lobby. The number for DJJ Incident reporting was also on a cork board in the dining area.

Interior lighting was operational. Furniture was in good condition. Facility was free of graffiti. Youth rooms are undergoing a facelift. All rooms will have a theme. Room 3's theme is "World Traveler" and includes a map and compass with motivational words (also handicap equipped room). Room 4 is the "Music Room" and is under construction but does have music notes on the wall.

Youth rooms were clean (including bathroom and sheets). All beds were made, floor clear, and room number identified on each door with hearts (theme for Valentine's Day). No hazardous materials were found or unauthorized objects. Each youth room included shelter rules, client rights, disaster plan, evacuation plan, and curfew, posted on the wall.

Daily activities were posted. Groups are done daily by Counselors and shelter staff. Tutoring is offered by the school district staff twice a week. Faith-based activities were offered weekly and clearly documented on the activities wall.

The MSDS binder was reviewed. It was well organized with tabs for each chemical. The Washer/dryer was in working order. The laundry room was clean. There was no lint behind the dryer.

There were no exceptions noted for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

There were five residential files reviewed for Program Orientation. Orientation was provided within 24 hours, as evidenced by the Orientation Checklist in each file signed by youth. The orientation check list consisted of all the required elements.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

There were five residential files reviewed for Room Assignments. All files contained the necessary documentation indicating that all youth were assigned rooms upon entering the shelter and completing their Intake Process.

Room assignments in the file matched the alert board located in the dayroom. Alerts documented on each file were also documented on the alert board. Each door is marked with a room number (also matching the alert board).

There were no exceptions noted for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a logbook policy. Throughout the review, staff adhered to this policy and obtained the logbook for documentation of routine activities. The policy reads the use of white-out is prohibited and it was not found to be in use. All entries were brief and legible and included the signature of the person making the entry. The log book is highlighted with different colors to reflect vital information or occurrences regarding the youth in the program. There was very detailed documentation and consistent use of the color codes. At noon daily, staff do a web search (national weather) for the temperature and heat index to plan outings accordingly. Errors in log entries are documented in accordance with program policy. There was documentation the Residential Supervisor was reviewing the logbook at least weekly. A stamp with "Reviewed by with date" is used to easily show when each one of these reviews occurs. There were also entries of staff members reviewing the logbook for the previous two shifts.

There were no exceptions noted for this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program has a Behavior Motivation System which is explained during orientation and is a part of the Youth Handbook. The system includes rewards, privileges, and consequences as warranted.

There is a Leadership Board where youth can reach different levels based on their compliance in the following areas: Morning Hygiene, School Attendance, Group Attendance, Bedtime Hygiene, Respect, and Safety.

This is a part of the youth's daily living and teaches about accountability and that consequences don't just have to be "negative" but can be positive. Discussion around this occurs daily. The policy outlines a step-by-step process when violations do occur.

There is an Ownership Form used to allow youth to acknowledge when they have done something inappropriate and come up with a plan to make better choices (Ownership of Actions).

A Youth Development Specialist was interviewed about this process and was able to provide clear and concise guidance on the program's system—that this system promotes kids to do better. The money earned allows the children to shop at the shelter store and youth are also able to communicate things they'd like to see be made available.

There is also an Awesome Board which allows for staff and youth to recognize one another for doing something awesome.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Staffing and Youth Supervision. The staff schedule is posted on a cork board near the front lobby and is easily visible. There is also a Shift Coverage Form that staff must fill out if they are having another staff member cover their shift. This form must be signed off on by the individual who is covering the shift. A staff list with phone numbers is located at the staff work desk in case additional coverage is needed. Staff schedules reviewed for the last six months revealed all shifts were covered with the appropriate number of staff and in most cases a male and female staff member were always on duty. It was reported by the Residential Supervisor that there have been significant issues with hiring male staff. To date there has been one "possible" viable applicant whose application she will be reviewing.

The site has a surveillance system that is located at the staff desk and also in the Residential Supervisor's office. The new camera system outlines the number of days that recording is available for and allows for viewing of coverage for the last thirty days. There is a clear picture of activities and clear view of common areas and the outside. Zoom-in capability is available in the Residential Supervisor's camera.

Camera view of bed checks was provided for January 28, 2016 and February 8, 2016. Two hour time increments were reviewed. Bed checks occurred on average every fourteen to fifteen minutes.

There were no exceptions noted for this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The program has a detailed policy regarding Special Populations. Policies exist for Staff Secure Shelter, Domestic Minor Sex Trafficking, Domestic Violence (DV) Respite, and Probation Respite. The Residential Supervisor advised that with the exception of Domestic Violence, for the past six months they did not serve any of the aforementioned special population categories.

At the time of the review, the program had two DV cases. Both cases were processed following the Florida Network and program guidelines. Detailed notes were found in both the log book and progress notes.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SafePlace2B Manatee youth shelter provides screening, counseling, and mental health assessment services. The Program Director and Residential Supervisor are Licensed Clinical Social Workers (LCSW). The shelter has staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both the residential and non-residential CINS/FINS programs.

The shelter provides risk screening and identification methods to detect youth referred to their program with mental health and health related risks. Specifically, the shelter utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth's past mental health status, as well as, their current status. The shelter also screens for the presence of acute health issues and the shelter's ability to address these existing health issues. The shelter uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in the residential youth shelter.

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

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Healthcare Admission Screening that was last reviewed and updated in October 2015. The admission process includes an in-depth screening through the completion of the CINS Intake Assessment Form. If there is any concern that a physical condition merits screening or it is apparent that there is a major health care issue, the youth will be immediately referred to their physician, emergency room, or the public health care department. If any of these conditions exist staff will contact the parent/guardian to obtain information about pending appointments with medical professionals, current medication, general precautions and how to proceed in the case of an emergency. Program staff may also consult with the agency medical consultant for general and specific guidance regarding on-going care and precautions related to these medical conditions if unable to obtain such information from the treating physician.

A total of five open residential youth files were reviewed for the initial health screening during the intake/admission process at the shelter. The agency utilizes the CINS Intake Assessment Form that documents the assessment of a youth's general health condition and/or issues at intake. Of the five files reviewed all contained a completed CINS Intake Assessment Form.

The CINS Intake Assessment Form documented two of the five youth were on medications. Both of the files documented the names of the medications, as well as, the reasons for the medication. One youth was pre-diabetic and on a special diet, one youth was allergic to penicillin, and four youth had mental health or substance abuse issues. These were all documented on the Intake Assessment Form. None of the youth required any type of follow-up care or monitoring for their condition.

There were no exceptions noted for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Comprehensive Master Plan for Suicide Prevention and Response. The policy was last reviewed in October 2015. The policy states that each youth will be screened for suicide risk by the six suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to questions 2 and 3, the youth is considered to be at high risk of suicide and must be placed on one-to-one supervision. Staff will refer the youth for a Baker Act. If the youth answers "yes" to questions 1, 4, 5, or 6 on the CINS/FINS Intake Form then the youth is determined to be at moderate risk for suicide. The youth will be placed on sight and sound supervision until a full suicide risk assessment is completed. The assessment will be done within twenty-four hours.

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

Both the Program Director and the Residential Supervisor are Licensed Clinical Social Workers (LCSW).

There were five files reviewed for youth placed on suicide precautions. All five youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. All five youth were immediately placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. There was documentation in all files the assessment was completed within twenty-four hours by the master's level counselor. All five youth were stepped down to elevated supervision after the assessment was completed. There was documentation on the observation log sheet and in the shelter logbook when the licensed professional made the decision to reduce the supervision level.

All five files documented observations of the youth were maintained, at least every fifteen minutes, the entire time the youth were on suicide precautions. The observation log sheets were also red in color making them easily identified in the youth's file and also for staff. There was also documentation in the logbook (for all five cases) when the youth was placed on suicide precautions and when the youth was removed from precautions. 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.

There were no exceptions noted for this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medications. The agency fully implemented the Pyxis Med-Station 4000 Medication Cabinet in December 2015. The shelter utilizes a nursing agency that was providing a Registered Nurse (RN) seven days' week. However, on January 22, 2016 one of the nurse from the nursing agency was let go by the shelter due to a medication error. So as of the above date the shelter has had only one RN on-site four days a week. However, on the second day of the on-site review the Residential Supervisor reported the nursing agency sent another nurse in the night prior to shadow and work with the current nurse. This nurse did extremely well and will begin working at the shelter. The shelter is currently in the process of trying to hire a nurse who will be contracted with Family Resources, and not the nursing agency they are currently using.

All youth medication is stored in the Medication Cabinet. After the youth's information is entered into the system, a bin within the Cabinet is assigned to the youth. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Medication Cabinet have to enter a password as well as their finger print to gain access. Two staff credentials are required to complete inventories. Each medication is stored in its own separate bin within the Medication Cabinet so topical medications are always stored separately. There are four Super Users assigned for the Medication Cabinet. Staff that have access to the Cabinet have been delineated in writing and have been trained on its use. Staff are also familiar with the Knowledge Portal and reports that it can produce.

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.

All medications in the shelter are inventoried three times per day (once on each shift) by two staff members. During an inventory, the staff will log into the system and choose which medication to inventory. When the medication is chosen the appropriate drawer and bin will pop open, staff must then count the medication and enter the number into the computer system. These inventories are documented in the Medication Cabinet and also documented on the youth's Medication Distribution Log (MDL) in the shift-to-shift inventory section. All medications reviewed were inventoried as required.

Youth razors are stored in a locked box inside a locked closet located in the dayroom of the shelter. The razors are inventoried perpetually, by signing them in and out at each use, and also weekly. Other sharps located in different areas of the shelter include seven pairs of scissors, a pill cutter, and tweezers, and are inventoried each week. The inventory sheet used is very detailed and includes the item, its location in the shelter, and the quantity. The form also includes a section for any discrepancies or missing items. Their forms were reviewed and have been completed for the last six months.

There were two youth currently in the shelter on medication. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Medication Cabinet system. The youths' Medication Distribution Logs (MDL) reviewed documented the youth's name, date of birth, any allergies, side effects of the medication, dosage, reason, method of administration, directions, prescribing physician, and full signatures of youth and all staff. Each MDL is documented when a medication is given, staff and youth initials, and a perpetual inventory is noted with a running balance. There was a cover sheet for each youth that documented a picture of the youth, the medication the youth was taking, and the time to be given. There was also a print-out of drug information including side effects, what happens if a dose is missed, and what happens in case of an overdose (from Drugs.com) for each medication the youth is taking. All MDL's reviewed for both youth documented that all medication was given at prescribed times.

The shelter has had one incident in the last six months (reported to the CCC) relating to a medication error. The error was made by the RN. The RN gave one youth another youth's medication. The two youth took the same medication; however, one youth was on a stronger dosage. So the youth who received the medication was under dosed by two milligrams. This youth also did not receive her other medication that was scheduled to be given at the same time. The other youth was not affected by the error. A staff member from the shelter discovered the error during the morning medication inventory. The RN was employed by the nursing agency and not an employee of the shelter. Family Resources reported the situation to the nursing agency immediately and that RN no longer works at the shelter. Both of the youth's parents were notified of the incident. Even though the second youth was not affected by the error, that youth had one less pill. So the parent was contacted and given that information. The pharmacist was also contacted and the incident was reported to the CCC and was successfully closed out.

There are four Super Users assigned for the Medication Cabinet. Staff that have access to the Cabinet have been delineated in writing and have been trained on its use. The staff are also familiar with the Knowledge Portal and reports that it can produce.

Exceptions:

The shelter has had one medication error in the last six months.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process (last reviewed and updated in October 2015). The alert system consists of color-coded dots with each colored dot representing a different alert. There are eight different colors used for alerts—red is constant sight and sound, yellow is elevated support, green indicates a mental health issue, blue indicates a substance abuse issue, purple is sharps restriction, black is medical issues, orange indicates the youth is on medication, and pink indicates allergies or special diet. The applicable color-coded dot is placed on the spine of the youth's file for each alert the youth is on. The color-coded dot is also placed next to the youth's name on the alert board.

There were four youth currently in the shelter applicable for alerts. All four files were reviewed and revealed alerts identified during the screening and assessment process were appropriately entered into the shelter's alert system. All four files had all the applicable color coded stickers on the spine of the file. The shelter has one alert board located in the dayroom for staff to review. At the time of the review all alerts documented on the alert board coincided with the alerts documented on the youth's file. The shelter also places a picture of the youth next to the youth's name on the alert board, so staff can easily identify all youth in the shelter. A detailed intake note is also documented in the logbook for each youth admitted to the shelter. This note includes all alerts the youth were placed on. A review of the logbook for the four current youth applicable for alerts revealed all alerts were also appropriately documented in the logbook.

There were no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on Episodic/Emergency Care that was last reviewed in October 2015.

All staff have current training in CPR/First Aid and the use of emergency equipment (knife-for-life, wire cutters, first aid kit). There is a first aid kit located in the shelter in a closet in the dayroom. In February 2016 the shelter implemented an "Approved Contents" list located inside the first aid kit. This list is reviewed and updated monthly by the Residential Supervisor. All items on the list were found inside the kit. Staff also do a monthly check of the expiration dates of all items in the kit. The knife-for-life and wire cutters are in the same closet as the first aid kit (in a locked box on the inside of the door).

The shelter has no instances of off-site emergency care since the last Quality Improvement Review. However, there were Emergency/Episodic Care Drills documented on each shift for the last three quarters. The drills consisted of a youth choking, chest pains, a bone, joint, and muscle injury, an ear injury, and a bee sting.

There were no exceptions noted for this indicator.