



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources- St. Petersburg

on 11/08/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory:85.71%
Percent of indicators rated Limited:14.29%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

| | |
|---|--------------|
| 2.01 Screening and Intake | Satisfactory |
| 2.02 Needs Assessment | Satisfactory |
| 2.03 Case/Service Plan | Satisfactory |
| 2.04 Case Management 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 |
| 3.08 Video Surveillance System | Satisfactory |

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory:96.30%
Percent of indicators rated Limited:3.70%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, FOREFRONT LLC/FNYFS

Kelley Scott, Supervisor of Non-Residential, Youth and Family Alternatives

Shanna Baker, Program Manager, Thaise Educational and Exposure Tours

Toni Del Regno, Regional Monitor, Department of Juvenile Justice

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> Nurse | | |
| 3 Case Managers | 0 Maintenance Personnel | 3 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 7 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 6 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 10 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 10 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 7 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 9 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

7 Youth 4 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input checked="" 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 checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input checked="" type="checkbox"/> Searches | <input checked="" type="checkbox"/> Discharge | <input checked="" type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input checked="" type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input checked="" 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

Program has no Staff Secure, no Minor Sex Trafficking and no Case Staffing examples.

Strengths and Innovative Approaches

Rating Narrative

Family Resources is a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by Family Resources, Inc. The central office is located in Pinellas Park, Florida and shelters located in Clearwater, St. Petersburg and Bradenton, Florida. The programs serve both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The programs policies provide for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking. The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. Their mission is to inspire well-being and success in the lives of vulnerable children, youth and families through responsive quality programs and safe places. To fulfill their mission, services offered include short-term residential care, transitional living programs, counseling, community education, street outreach and after-school programs.

Since the last quality improvement visit:

-The Substance Abuse Level II monitoring was conducted in October 2016 for both SafePlace2B-North and South shelters. They received an overall 93% and have since renewed their license.

-Multiple job fairs have been held at their various residential locations over the course of the last year. In addition, they have implemented the Berke Assessment for their hiring process. This is a pre-employment test that measures personality and matched skill sets for the job requirements. The tool evaluates and helps them choose the right candidate for a position.

-Family Resources was one of two recipients of the Florida Network's Agency of the Year.

-The former COO resigned from her position on February 14, 2017. As part of the restructuring plan, Family Resources hired both a Director of Residential Services and Director of Community Services. The agency felt that these two positions will be better for continuity and structure. There is now a Sr. Director of Residential & Counseling Services.

-Additionally, a licensed mental health counselor has joined Family Resources as a Sr. Director of Quality Assurance. She utilizes both her clinical expertise and experience with contract compliance to ensure quality programming throughout the agency.

-In September 2017, they recruited two new supervisors for their counseling programs (both licensed mental health counselors).

-In September 2017, they also hosted a national Youth Care Worker Certification training at their site for 12 of their Youth Development Specialists. This was a week-long intensive training provided to them by the Runaway and Homeless Youth Training and Technical Assistance Center (RHYTTAC) through the National Safe Place Network (NSPN). This training provided the opportunity for staff to become nationally certified Youth Care Workers.

-Their St. Petersburg shelter is the recipient of the St. Petersburg Chamber of Commerce, Young Professionals project. As a result, their backyard area will get a make-over with \$8300 in donations and volunteer work by the young professionals.

-In May, a local Pinellas County funder, Juvenile Welfare Board, provided funding for the purchase of two new 12-passenger vans for their Clearwater and St. Pete shelters.

-A staff member was designated as their Ambassador for Youth. His sole purpose is to bring creative and meaningful engagement activities to enhance the lives of their youth. He will be working with all of their shelter programs.

Standard 1: Management Accountability

Overview

Narrative

The Family Resources, Inc. SafePlace2B program provides shelter and non-residential services for youth and their families in Pinellas County and Manatee County. All residential shelter staff and non-residential staff are overseen by a Senior Director. The Department of Children and Families has licensed Safe Place 2B as an emergency runaway shelter.

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

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

Family Resources, Inc. as required by law in Chapter 985.407, of the Florida Statutes and consistent with the Department of Juvenile Justice policies, has a written policy requiring a criminal history background screening be conducted on all employees, interns, mentors and volunteers with access to program youth. The screening, which includes fingerprinting, must be completed and receipt of an eligible for hire rating received, before any offer of employment is made. Concomitantly, interns, mentors and volunteers must undergo the same criminal background screening as potential employees as a condition of association with the program and/or contact with program youth. Additionally, a re-screening of each staff member, intern, mentor, and volunteer is to be completed every five years after the date of initial screening. Staff undergo additional background screenings prior to any position change or transfer from one program to another. The policy further asserts the provider's Human Resources Department will complete and submit an Annual Affidavit of Compliance with Good Moral Character to the Department of Juvenile Justice Background Screening Unit by January 31, of each year on all staff who were actively employed at a program site during the calendar year.

Family Resources, Inc. documents the implementation of the following procedures to ensure policy demands are met:

- All prospective new employees, volunteers, mentors and interns complete the entire background screening packet provided to them by the Human Resources Department
- All prospective new employees, volunteers, mentors and interns ensure all required documents and identification, including fingerprint cards are supplied and part of the packet. All forms, must be complete, signed, and, where applicable, notarized, before the packet is returned to Human Resources for submission to the Department of Juvenile Justice who will then utilize Level 2 standards in completing the screening.
- Human Resource staff submit the completed background screening packet for screening and record the receipt of the eligibility rating.
- Human Resources Department complete and submit an Annual Affidavit of Compliance with Good Moral Character to the Department of Juvenile Justice Background Screening Unit by January 31, of each year on all staff who were actively employed at a program site during the calendar year. Human Resources staff re-submit the background screening packet for each active employee, volunteer, intern and mentor to

the Department of Juvenile Justice Background Screening Unit every five years and record the screening results.

The program has hired and retained thirteen new employees since the last annual compliance review in September 2016. There were no new volunteers, interns, or mentors involved with this program since the last annual compliance review. A review of the background screenings for each of the thirteen new employees found each of the reviewed screenings were completed prior to the date of hire. All thirteen employees were rated eligible for hire; therefore, no exemptions were required. One employee was applicable for a five-year background rescreening. A review of the rescreening documentation verified the rescreening was completed in May 2017, two months prior to the ten-year date of hire anniversary. Documentation was reviewed confirming the completion/submission of the Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 4, 2017, prior to the deadline date of January 31, 2017 as required by Department of Juvenile Justice Policy.

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

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has written policy in place purposed to ensure the youth, staff, and others in the program experience an environment in which they feel safe, secure, and free from threats, harassment, and/or any form of abuse. This policy merges the enforcement of a staff Code of Conduct and mandatory reporting of any suspicion or knowledge of any kind of abuse, neglect, or abandonment to the appropriate agency, with the development and implementation of a youth grievance process and the requirement of management to respond immediately to any incidents involving any type of harassment, intimidation and or abuse involving program youth and/or staff to help ensure youth safety.

The program has staff Code of Conduct specifically prohibiting any kind of maltreatment of youth including discrimination, harassment, bullying, physical and sexual contact, as well as, excessive use of force. The Code also articulates rules regarding the provision of contraband to youth, social contact with youth for non-work-related purposes, the use of profanity or other abusive language in the presence of youth and the exploitation of the relationship with the youth for personal gain. The program requires all staff to sign an Affidavit of compliance with the Code of Conduct documenting their awareness of the Code and the expectations of them soon after employment. The Code of Conduct acknowledged by staff also reinforces the mandatory reporting of suspected or known abuse neglect, or abandonment of a youth to the Florida Abuse Hotline and, in the case of institutionalized abuse or the age of the youth, to the Central Communications Center. Program procedure documents the specific information to be reported via the Florida Abuse Hotline. Amongst other information, the names and address of the youth, parent(s)/guardian(s) or other persons responsible for the youth's welfare, the youth's age, gender, race and any sibling name(s), the nature and extent of the alleged abuse, neglect or exploitation, as well as, the identity of the abuser (if known) are to be provided. The program staff then report alleged abuse to the Department of Juvenile Justice Central Communications Center and document all reports in the youth's file. Additional procedures are required once the abuse registry determines whether the report will be investigated and if the youth will require shelter or residential services during the investigation. The program provides staff training regarding the reporting of child abuse. The program also ensures youth are aware of their right to unimpeded access to program telephones to contact the Florida Abuse Hotline to report abuse and overtly posts the Florida Abuse Hotline telephone number in the facility to ensure the youth have access to the telephone number. The program has implemented a grievance procedure for the youth, as well, to ensure youth in the program are able to grieve actions of staff and any perceived adverse conditions or circumstances related to the violation or denial of basic rights. This procedure involves the youth's completion of a grievance form, the submission of the completed form into a locked box and a review by the program or residential supervisor within seventy-two non-weekend hours. There is an appeal process if the youth is not satisfied with the supervisor's response to the grievance. All grievances and findings are maintained in a central file for the period of one year. Additional procedures are also in place

for management to effectively review and address all reported incidents of maltreatment of youth in the program including but not limited to exploitation, harassment, the use of profanity or threats in the presence of youth and all forms of abuse and or neglect, verbal, psychological, physical, and sexual. Staff also cooperate with staff from the Department of Children and Families and Department of Juvenile Justice investigators and serve as advocates for the best interest of the youth in their care.

The program provided a blank copy of the Code of Conduct for review. The seven-page document references a variety of behavioral expectations staff are to meet as a condition of their employment, some of which are not related to the provision of an abuse-free environment. However, the reviewed Code of Conduct clearly outlined prohibition of many types of maltreatment of youth such as verbal/physical/sexual abuse and other behaviors which have the potential for causing emotional/psychological harm to the youth such as exploitation, breach of confidentiality, and engaging in behavior reflective of a conflict of interest. The document also states alleged violations of the Code of Conduct will be investigated and, if founded, shall result in appropriate discipline including termination of employment. All staff are required to sign an Affidavit of Compliance with the Code of Conduct as evidenced by a review of two randomly selected affidavits, both of which were signed by staff within weeks of their date of hire.

Reviewed documentation indicated the staff educate youth regarding their right to report any kind of abuse they experience and the procedures to report abuse during the intake process. Additionally, this information is also documented in the Youth Handbook provided to each youth for their reference while accessing services in the program. During the tour of the program site which included, both, the shelter and the outpatient counseling offices, it was observed the program conspicuously posts the Florida Abuse Hotline number in each of the two main lobbies youth and their families visit for each service, as well as, in the main living area of the shelter. Each of the surveyed staff indicated they are aware of the requirement to report suspected or known abuse and each of the respondents further indicated they have been trained how to report abuse. Accordingly, all but one of the ten reviewed staff training files indicated the staff had completed training regarding child abuse reporting in the first months of hire. The exception was a staff person who failed to complete many of the required trainings and then resigned within three months of hire.

Additionally, program practice is to document and record all abuse reports on incident forms. There is no other collective record/log maintained regarding abuse calls made from the program, as all calls are individually documented in a youth's file. Consistent with staff reports stating there have been no calls to the Florida Abuse Hotline from the program in the past six months, a review of incident reports completed in the past six months documented no calls to the Florida Abuse Hotline.

The program has a written grievance policy and procedure in place to ensure any client can exercise their right to initiate and address for youth to share their concerns with staff. A review of orientation documentation reflected staff inform and educate youth of the process and this information is provided to the youth in their copy of the Youth Handbook. During the facility tour, locked grievance form boxes were observed in the youth living area (for the shelter) and in the main lobby (for outpatient counseling) readily accessible to youth where youth can submit their grievance/feedback regarding any perception their rights have been violated. Program practice then requires the program supervisor to check both boxes daily, with the exception of weekends/holidays, (only he has key). The supervisor then reviews, and addresses the youth grievances in a timely manner.

A review of the grievance binder contained a total of six grievances filed since the beginning of fiscal year 2017-2018. All six reviewed grievance forms originated from youth admitted to the shelter program and related to peer conflicts. Each grievance was addressed in a timely manner, (four within one calendar day and two within three business days). However, because there were no times of submission, review, or mediation documented on the grievance form, the reviewer was unable to discern whether the mediation occurred within the seventy-two hour time frame required in the program policy.

During this review, administrative staff advised there have been no incidents alleging the emotional, physical or sexual abuse of a youth, or other staff misconduct including threats or intimidation of youth, the use of excessive force, or staff use of profanity in the presence of youth which would require the

immediate attention of management. Congruently, a review of reports to the Central Communications Center in the past six months indicates the occurrence no such incidents. Thus, there was no documentation to review regarding management's response to such allegations.

There were no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There are written policies in place which asserts a reporting process for incidents that may pose a risk or liability to the organization or its clients. This process will assist in the identification of problems and document trends and corrective actions taken to minimize future risk. Per policy, notification to senior management is to occur when a critical incident occurs. The policy lists critical incidents as a significant injury to a youth or staff, death of a youth, youth on youth sexual abuse, youth arrest for a felony charge, a missing youth, a suicide attempt by a youth, as well as, employee misconduct or arrest. Also listed is any incident which would have a high likelihood of media attention or agency liability. There is a formal, written risk management system in place for identifying and addressing significant change in the number or severity of incidents. This includes but is not limited to: use of force (by staff and shift), youth on youth battery and/or assaults, staff misconduct with youth and allegations against staff.

There is also a policy stating the provider complies with the DJJ policy 8000 "Central Communications Center" (CCC) on incident reporting. The CCC will be notified as soon as possible, but no longer than two hours after reportable incident occurs, or within two hours of the program learning of the incident.

All staff who have direct knowledge of an incident that constitutes a risk to the organization and/or clients must complete an Incident Report and must report the incident within one hour of occurrence to the appropriate senior staff member and within two hours to the CCC. Follow-up will be provided to the CCC assigned staff with requested information until they indicate the case is being recommended for closure. The procedure lists numerous types of activities which would require incident reporting to include program disruption, escape/abscond incidents, medical incidents, mental health and substance abuse incidents, complaints against staff incidents and youth behavior incidents such as felonious activities.

The program documented eight incident reports during the six months of this review period and contacted the Central Communications Center (CCC) related to six reportable incidents. A review of the eight incident reports indicated all incident report forms were fully completed by the pertinent staff including reviews by the supervisor, the senior director and the risk management staff. Two of the eight incident reports, both related to youth behavior incidents did not meet the criteria warranting a report to the CCC. The remaining six incident reports did meet the criteria reporting to the CCC and a corresponding CCC report was reviewed with each of these incident reports.

The six reportable incidents occurring within the past six months included one incident related to program disruption, three incidents related to medication errors and two incidents related to youth behavior. A review of documentation indicates three of the six CCC reportable incidents were reported to the CCC within the required time two-hour time frame. In all applicable cases, the program completed all follow-up tasks and submitted all requested documents as required by the CCC. Two of the six CCC reportable incidents were detailed in the program logbook on the date/time of the incident as required. A review of incident reports verified that in four of five CCC reported instances, the program completed an incident report. Each of the completed incident reports was signed by the senior staff.

Exceptions:

There was one reportable incident, which involved the discovery of contraband in a youth's room, which was not reported to the CCC by staff until the program supervisor was informed of the incident two days later. Upon notification of the contraband, the shift supervisor contacted the CCC. The staff who failed to report the discovery of contraband at the time of discovery experienced disciplinary action and retraining.

Another reportable incident which involved a medication error (missed dosage) was not reported to the CCC until two days later because the nurse chose to e-mail staff regarding the missed dosage rather than to report it directly at the time and/or to contact the CCC regarding the missed dosage. Subsequently, the CCC was not contacted within two hours after staff gained knowledge of the reportable incident. Rather, the call to the CCC to report the medication error was thirty-seven minutes late. The incident report documents the nurse experienced a disciplinary action and was retrained on medication distribution procedures consequent to this incident.

A third reportable incident, also related to a medication error, was reported to the CCC past the required two-hour time frame. The incident was reported thirty-eight minutes late after the staff gained knowledge of the incident at 9:00 a.m. but did not contact the CCC until 11:39 a.m. The incident report documents all staff will be retrained on medication distribution procedures consequent to this incident.

Four of six CCC reportable incidents were not documented in the program logbook. One of these incidents was called in to the CCC by the supervisor who was at home at the time without access to the electronic log book. The other incidents appear to be oversights by the staff who called in the CCC reports.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures to ensure staff are appropriately trained to conduct all job position duties and trained in all required areas to meet the standards of the Department of Juvenile Justice for CINS/FINS providers. The Departmental standards were modified for fiscal year 2017-2018 and the program subsequently modified their policies and procedures to match for all new hires starting on or after July 1, 2017. These new standards require specific trainings (i.e. orientation, managing aggressive behavior, suicide prevention, child abuse reporting and universal precautions among others), to be completed in the first 120 days of hire and a total of eighty hours completed during the first calendar year of employment. All training requirements are based on the individual staff's date of hire. After the first year of employment, each staff are required to complete a minimum of forty hours of training each year. Training is to be completed annually in suicide prevention and human trafficking, and every two years regarding Prison Rape Elimination Act course number 110 (PREA) and fire safety. Furthermore, staff are to remain certified in cardiopulmonary resuscitation and first aid throughout their employment.

The program maintains the previous training requirements policy, reviewed/approved in March, 2017 for all staff hired prior to July 1, 2017.

Specialized suicide-risk assessment training (twenty hours) and supervised experience is required for non-licensed clinical staff who work in shelter/residential programs under the supervision of a licensed mental health clinician. There must be written confirmation by the licensed clinician, indicating the non-licensed staff has completed the required supervised assessments and training in the non-licensed clinician's training file on a specific form before the non-licensed staff can be authorized to solely conduct suicide risk assessments.

Each CINS/FINS provider is required to maintain a training file, individualized for each staff specific to their position and training requirements. Maintained in this file should be a tracking sheet documenting the training requirements completed, as well as, training certificates, training rosters and agendas for each of training attended.

Staff training services are scheduled throughout the year and may be provided by the Florida Network, local community resources and various local provider personnel approved to deliver training. Furthermore, each staff is enrolled in the Department of Juvenile Justice provided SkillPro Learning Management System, a computer-based network of training courses.

During this annual compliance review, it was evident the program maintains an individual training file for each staff person. A total of ten staff training files were reviewed. Additionally, the SkillPro records of each

of the staff who's training files were selected for review were also obtained. A review of the employee roster indicates only one direct care staff has been hired since the start of the fiscal year 2017-2018. Thus, only one file selected for review pertained to a staff hired since July 1, 2017. Four of the reviewed files pertained to staff hired within the past calendar year. The five remaining files were of staff who have been employed for more than year and included the longest employed staff who was hired in July 2007.

The first page of the file is a tracking form which lists all the training requirements for the staff based on policy in place during the staff's date of hire. Designed to track the employee's progress in completing these trainings, reminding staff to complete the trainings and maintenance of these tracking logs and the other documentation in the training file is the responsibility of the program supervisor. All but one file, the file relating to the staff hired in July 2017, contained this training plan/tracking form.

All the training files included copies of training certificates indicating completion of instructor-led courses, most corresponding to a training on the tracking log; though inclusion of the required sign in sheets and syllabi describing training content was not a demonstrated practice in any of the reviewed files. There were also courses checked off on the tracking log as completed though there was no certificate or documentation verifying completion, particularly related to orientation training.

There appeared to be a systemic absence of documentation other than the training plan regarding the completion of CPR/First Aid training in all ten reviewed training files, however, the program supervisor was able to produce, in a piecemeal fashion, all the missing CPR training certification documents by the end of the review. Even so, two of these certifications were in CPR and CPR/AED only, indicating two of the staff hired within the past calendar year was still lacking training/certification in first aid. The administrative staff have indicated they are developing a training coordinator position to assume all responsibility for training and documentation of training which will surely facilitate record-keeping and encouragement of the staff to continue trainings.

The four reviewed files pertaining to staff hired within the past calendar year before the start of the fiscal year 2017-2018 reflected three direct care staff and one nurse. Each of these files indicated completion of program orientation, suicide prevention signs and symptoms of mental health and substance abuse disorders, confidentiality, trauma informed care, child abuse reporting, and PREA, as well as, cultural diversity and universal precautions. Three of four records indicated completion of youth development, CINS/FINS core training, fire safety equipment and sexual harassment. None of the reviewed records reflecting staff hired in the past calendar year indicated completion of training regarding the behavior management system in the program or the security requirements and procedures, constitutional issues relating to care and custody and Title IV-E expectations, as of the week of the review (all requirements of the policy in place at each of the staff's date of hire). None of these four reviewed training files have yet achieved the one year milestone at which eight hours of training were required to be completed. All four are on track to meet the requirements on time.

Five of the reviewed training files pertained to staff who had been employed at the program for more than one year including one hired in 2007, one hired in 2008, two in 2015, and one in 2016. Each of these staff completed numerous trainings consistent with the requirements of the training policy before the fiscal year 2017-2018. All but one staff completed more than the required forty hours of training, with one staff, completing thirty-seven hours of training according to documentation in her file, including fifteen hours of SkillPro coursework. One staff completed only part one of the required two-part training in SkillPro and failed to repeat the PREA course prior to the two-year time frame required by the Department and program policy. Neither did this staff complete any training regarding mental health and substance abuse signs and symptoms in reviewed year.

Two non-licensed staff were applicable for the requirement of twenty hours of specialized suicide-risk assessment training and supervised experience. Each of their reviewed training files contained written confirmation on the Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form signed by the licensed clinician, indicating the non-licensed staff has completed the five required supervised assessments and training.

Exceptions:

Inclusion of the required sign in sheets and syllabi describing training content was not a demonstrated practice in any of the reviewed files.

The one reviewed staff training file applicable to the revised standards for Fiscal Year 2017-2018, who had been employed for approximately ninety days at the time of the review, lacked a training plan. Furthermore, this staff failed to complete any of the required instructor led trainings other than medication distribution for non-licensed staff, required SkillPro trainings, and CPR/First Aid training. This employee resigned a week prior to this annual compliance review, however, he was just thirty days shy of the one hundred twenty-day time frame for completion of numerous mandated trainings.

One of five staff training file reviewed for annual training was documented as having completed thirty-seven hours of training, including fifteen hours of SkillPro coursework for the calendar year 2016, three hours shy of the required forty hours.

One staff has not completed PREA since October 15, 2015. This course is to be completed once every two years.

One staff training file does not document completion of fire safety training course in the past two years. Notably, this relates to a long-term employee and not all her records are in the file, making it impossible to discern when/if she has completed this training.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy which states the importance of gathering and processing of information regarding the population they serve, the community needs, the logistics regarding the provision of services, and the effectiveness of the services, as well as, input from a variety of sources including the youth, their families, and community members to ensure appropriate decision-making and effective, strategic planning. Therefore, the Performance and Quality Improvement Plan (PQI), which encompasses a variety of information gathering and reporting processes have been developed and implemented to access and analyze pertinent information regarding program performance and quality of services. This information is then analyzed and put into report form, on a regular basis and then communicated to the program staff, the management staff, and the Board of Directors for discussion and decision-making. Included in these reports are monthly reports of relevant program data, quarterly Incident/Accident and Grievance reports, the Annual Report for each program and quarterly case record (peer reviews) where aggregate data is compiled and reported.

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

The program provided a pertinent sample of aggregate data, summarized in detailed graphs for review. Also reviewed was a copy of the last quarterly report and the last annual report. A review of documentation provided by the program verifies the consistent collection and analysis of various data to identify program patterns and trends, program strengths and weaknesses and to enhance decision making to maintain and improve the quality of services provided by the program. There is an agency-wide workbook where information is stored and communicated.

Reviewed documentation indicates reports are completed monthly regarding a variety of data including, but not limited to the daily census, admissions, length of stay, the provision of family counseling services, program incidents, accidents and grievances, as well as, youth and family satisfaction survey results. Monthly review of NetMIS data reports is also completed by the program director.

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

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

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

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy requiring all agency vehicles used to transport youth are inspected for safety and mechanical problems at least annually by a certified mechanic. All repairs made to the transport vehicles are to be documented and maintained at the program site. Written policy further requires each youth transport vehicle be equipped with a first aid kit, a fire extinguisher, a seat belt cutter and a window punch, as well as, anchored seat belts for each passenger.

Focused on youth and staff safety and security in all situations when a youth is transported by program staff, the written transportation policy addresses on avoidance of circumstances of real or perceived harm to any individual, as well, as allegations of impropriety regarding any individual. The program policy asserts it is best practice to have a third party (approved volunteer, intern, agency staff or another youth), present in the vehicle when transporting a single client and the associated procedures detail how to operate under the conditions of best practice, while also addressing transport situations when a third party is unavailable. Additionally, documentation regarding the transport is incorporated into the written policy which ensures each transport is conducted by specific staff drivers who have been screened to ensure they have a valid Florida Driver's Operators License and a safe driving record. The policy requires the staff maintain a Vehicle Mileage Log for the transport vehicle to document the date, time and the destination of the trip, the occupants of the vehicle, the starting/ending mileage and the anticipated time of arrival/actual time of arrival.

Specific vehicles, equipped with securely anchored seatbelts are designated for youth transport. Program procedure mandates staff are to ensure safety inspections are conducted on the designated vehicle on a regular basis and if a potential mechanical/safety issue is suspected or identified, staff will notify the program supervisor. The program supervisor will then ensure the vehicle is inspected by a licensed mechanic. All receipts related to vehicle repair and/or maintenance will be documented in the vehicle log and retained by the program. Program procedure also dictates all policy required safety equipment (a first aid kit, a fire extinguisher, a seat belt cutter and a window punch), will be available to the driver prior to each transport.

Reviewed program procedures do not specifically address how it determines how administrative staff determine the driver's license status of a staff member or whether a staff is eligible to become a designated driver, nor are there requirements as to adherence to safe driving, such as speed, unplanned stops, or compliance with seatbelt laws. However, the procedures do detail a transport process wherein a

designated staff driver transports a single youth when a third-party is not present. It is clearly stated a program director must be made aware of prior to a trip being conducted with a single youth regardless of the gender of the staff and/or the youth. A single youth can be transported without a third party after careful consideration of the youth's previous evaluations, history, personality, recent behavior and length of stay, as well as, the driver's work performance and history and length of employment, all of which may indicate whether inappropriate behavior may occur by either party on the transport. Additionally, a trip plan must be completed prior to the transport and then, the staff must check in by telephone the program staff at specified times. The residential supervisor will communicate with staff via log book entry or the white board, which youth are appropriate for single transport.

Another optional safeguard in place for a staff when transporting a youth without a third party is the audio witness accessed when a driver calls the program and maintains an open line on the telephone while making the transport. This safeguard is required if a single youth must be transported prior to the residential supervisor being on site to determine if the youth is appropriate for single transport. The procedures also stipulate a Trip Plan/Vehicle Mileage Log is maintained in the vehicle and what information will be documented regarding every transport made in the vehicle.

The program recently received a donation of a brand new 2017 Ford Transit 358 Wagon. Inspection of this vehicle indicated it is a twelve-passenger van with securely anchored seat belts. Inside the van was a fire extinguisher and a first aid kit, as well as, an auto safety kit which contained a variety of items of benefit in case of emergency including reflectors, jumper cables, an air compressor, and a tow cable. The window punch and seat belt cutter are maintained on the keychain rather than in the vehicle.

The program director indicated he inspects the vehicle at least once weekly, however, these inspections are not documented. The annual inspection is not yet due; however, one oil change has been completed and the receipt maintained. Monitor observed there is a tire pressure light on in the dashboard, but the program director insisted this appears to be a sensitive gauge, as he recently ensured the tire pressure was within the safety limits. A Vehicle Mileage Log was in the vehicle and noted to document the following information regarding each transport: Date, time of departure, time of arrival, driver's initials, youth initials, destination/purpose of travel, estimated mileage of trip, actual starting and ending mileage, number of occupants, and supervisory approval from, if applicable.

Though not articulated in program policy or procedure, the program has developed and maintains a roster of staff authorized to drive during a transport. The reviewed roster listed twenty-five staff members, although at least one of these staff has recently resigned. Monitor observed a copy of every applicant's driving record is obtained during the background screening process and one staff who had a history of driving suspensions was not on the roster as an authorized driver. During the review, the human resource department provided documentation of a random sample of three staff driving records checks demonstrating annual checks are conducted to ensure each authorized driver's license remains valid and the record reflects a safe driving record. Also noted when conducting a review of training records, each authorized driver on the roster has completed training regarding the transportation policies and procedures.

A review of the facility logbook indicates the program supervisor reviews youth information and determines if a particular youth is appropriate for single staff transport. He then documents his findings in the program logbook to ensure staff are able to differentiate which youth can be transported at a 1:1 ratio. There is documentation in the logbook indicating the supervisor has consented to single youth transports and he is aware the transports are taking place.

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

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

Family Resources have a written policy and procedure that address the elements of indicator 1.07. The

policy was last updated on 03/05/10. This Florida Youth and Family service provider encourages and offer preventative and outreach services to the members of the communities they serve. Family Resources offer informational and educational CINS/FINS services to youth and families, alcohol and drug treatment, adolescent behavior, parenting classes, youth education issues and information.

The provider's procedure requires outreach services which will be designated to lead staff to coordinate and provide services to communities, audiences, individuals, and group with a particular customer focus. Family Resources staff are to attend the meetings and will obtain copies of the minutes to the meetings to supply to agency leadership. Staff representing the agency will provide verification of attendance at DJJ Board and Council Meetings.

There were four events that was observed. One was the Manatee County Juvenile Justice Board meeting on 8/17/17. Minutes were provided and there is verification that shows a representative of the agency attended the meeting. For the PJAC Advisory meeting on 10/27/17, there were minutes provided and there was verification that a representative attended the meeting. For the PJAC Partners meeting on 9/21/17, there were minutes provided and there was verification of a representative of the agency attended the meeting. For the event, Safe Place to be in the Community, at the Enoch Davis Center on 6/12/17, minutes were not applicable for this event. There is verification that a representative of the agency attended the event.

The agency provides outreach services to the families within the community. The referral process – if a client needs further services they are referred out to other agencies within the community that fit their needs.

The program has written agreements with other community partnerships/agencies. Family Resources have interagency agreements where they agree to work with the children and families in the program and communities. Family Resources refer clients out to outside agencies and evidence of the referrals are on the left side of the clients' file.

There was a master sheet of outreach activities but the sheet with the activities and dates didn't coincide with the evidence of the outreach forms in the files. The Senior Director mentioned that sometimes the staff aren't able to bring back proof of minutes because they are the ones facilitating the outreach/meetings.

Exception:

There was a Master sheet documenting all outreach activities. A random selection of the outreach activities and its dates was conducted to verify evidence of completed outreach services. The dates of the selected activities couldn't be located in the binder.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Family Resources, Inc.'s SafePlace 2B South Campus in St. Petersburg is contracted through Florida Network to provide CINS/FINS non-residential and residential counseling services for youth and their families in Pinellas County and neighboring counties. The program provides an intake and screening process twenty-four hours a day seven days a week. The program consists of trained staff that are available to discuss the needs of the family and the youth.

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

Non-residential services within the program include individual and family counseling. Non-residential services counselors provide case management services for truant and ungovernable youth while also linking youth and families to community resources. The non-residential component also encompasses the Case Staffing Committee. This is a statutorily mandated committee that develops a service treatment plan for truant youth, ungovernable youth and runaway youth when all other interventions have been exhausted or upon the request of the parent/guardian of the youth. The Case Staffing Committee can also recommend the filing of a CINS Petition with the Court as needed. The non-residential component consists of one full time Master's level therapist and one full time licensed supervisor, who oversees the Residential counselor as well.

2.01 Screening and Intake

Satisfactory
 Limited
 Failed

Rating Narrative

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

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

A census roster for youth served in the past six months was requested of residential and non-residential youth of which four from each program were randomly selected.

There were four non-residential files that was reviewed; two opened and two closed. Of the four files, one open file was a day late for the seven day time frame on the screening. All other files were in compliance. The four files were also reviewed for documentation that the following items were received in writing by the youth and the youth's parent or guardian. Of the four files, all were in compliance. The four files also provided documentation of the possible CINS/FINS stages (Case Staffing Committee, CINS Petition and CINS Adjudication), and grievance procedures. Of the four files all were in compliance with the indicator.

There were four residential files that were reviewed; two opened and two closed. Of the four files all were compliant within the seven day time frame of completion. The four files were also reviewed for documentation that the following items were received in writing by the youth and the youth's parent or guardian. Of the four files, all were in compliance. The four files also provided documentation of the possible CINS/FINS stages (Case Staffing Committee, CINS Petition and CINS Adjudication), and grievance procedures. Of the four files, all were in compliance with the indicator. Residential youth and their parent/guardian are provided with a Youth Handbook which details the expectations of the program services and appropriate behavior with the shelter.

Exception:

One non-residential open file was a day late for the seven day time frame on the screening.

2.02 Needs Assessment

Satisfactory
 Limited
 Failed

Rating Narrative

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

The policy is implemented by the following procedures: the assessment must be completed within 72 hours of admission in residential and non-residential should be completed within 2-3 face to face contacts with youth. Within either component of the program if a suicide assessment is necessary, the assessment must be conducted immediately following the intake form by a Master's level in the non-residential program and a licensed clinical staff member in the residential program. Each assessment must then be reviewed and signed by a clinical supervisor.

A census roster for youth served in the past 6 months was requested for residential and non-residential youth of which four from each program were randomly selected.

There were four non-residential files reviewed: two were open and two were closed. Of the four all of the files were compliant regarding assessment completed within the necessary time frame of 2-3 face to face contacts. Of the four files one was identified as a risk of suicide to which an Assessment of Suicide Risk was conducted by Master's level staff and reviewed and signed by licensed staff.

There were four residential files reviewed: two were open and two were closed. Of the four all of the files all were compliant regarding assessment completed within the necessary time frame of 72 hours. All needs assessments were completed by Bachelor's or Master's level staff. Of the four files, one was identified as a risk of suicide to which an Assessment of Suicide Risk was conducted by Master's level staff and reviewed and signed by licensed staff.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

Satisfactory
 Limited
 Failed

Rating Narrative

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

The policy is implemented by the following procedures: the case/service plan is to be developed within 7 working days of the completion of the needs assessment with the youth and the family. The plan is developed based on the information that is ascertained from the screening, the intake, and the needs assessment. It is ideal for the youth and the family to be involved in the development of the plan. Each plan will include but not be limited to the following: specific child needs that have been identified, realistic

time frames of completion of the goals, and specific service and treatment that is to be provided to the youth. The Case/Service Plan must have the signatures of all parties responsible in facilitating the plan as well as the date the plane was initiated. If the youth or parent/guardian is unwilling to sign the case/service plan the information will be documented in the plan and the progress notes.

A census roster for youth served in the past six months was requested of residential and non-residential youth of which four from each program were randomly selected.

There were four non-residential files reviewed; two were open and two were closed. Of the four, one was found to be out of compliance with developing the Case/Service Plan within 7 days. One closed file did not have the actual completion date notated. Three files were out of compliance with 30 day period reviews.

There were four residential files reviewed; two were open and two were closed. Of the four all were in compliance with developing the Case/Service Plan within 7 days. Of the four files all were in compliance for 30 day period reviews.

Exception:

Three non-residential files, one open and two closed, were out of compliance regarding 30 day reviews. Case/Service Plan was not reviewed and signed within the time frame. It should be noted that the agency has implemented weekly Treatment Team meetings to review all open non-residential files. The agency currently conducts weekly Treatment Team meetings to review all open residential files.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

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

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

A census roster for youth served in the past six months was requested of residential and non-residential youth of which four from each program were randomly selected.

There were four non-residential files reviewed: two opened and two closed. Of the four files all were provided with sufficient case management and service delivery according to the needs identified of the youth and the family. All youth were monitored appropriately and counselors/case managers provided efficient support and care to the youth and the family. The closed files reviewed included appropriate follow up protocol. Of the four files one closed file did not have progress notes updated appropriately. All other files contained progress notes that also reflected entries in the service log.

There were four residential files reviewed: two opened and two closed. Of the four files, all were provided with sufficient case management and service delivery according to the needs identified of the youth and the family. All youth were monitored appropriately and counselors/case managers provided efficient

support and care to the youth and the family. The closed files reviewed included appropriate follow up protocol. All sessions documented appropriately in all files.

Exception:

One closed residential file did not have the progress notes updated appropriately.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

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

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

Non-residential counseling includes but is not limited to crisis intervention, assessment and screening of the youth as well as individual, family and group counseling. The non-residential program also accepts referrals from school guidance counselors, school resource officers, local law enforcement agencies, Department of Juvenile Justice, and any other concerned adult (family or friend) within the youth's life. Referrals can also be accepted from the youth themselves.

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

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

A census roster for youth served in the past six months was requested of residential and non-residential youth of which four from each program were randomly selected.

There were four non-residential files reviewed. In all four files, counseling services were continuously provided to the youth and the family based on the findings of the initial screening and needs assessment completed. Of the four files, three did not have updated Case/Service Plan reviews. All files were reviewed and signed by supervisor.

There were four residential files reviewed. In all four files, counseling services were continuously provided to the youth and the family based on the finding of the initial screening and needs assessment completed. The youth's presenting needs were identified and addressed in individual sessions with the youth and the family as outlined in the case plan and the progress notes of each youth. All files were in compliance, reviewed and signed by supervisor.

All counseling sessions met the criteria set in the Indicator. It should be noted that posted schedules of

group counseling sessions are in the living room area of the shelter visible for all youth to view.

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

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

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

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

The committee is comprised of representatives from local community agencies: Department of Juvenile Justice, Pinellas County School Staff (youth's school), State Attorney's Office, local law enforcement agencies, various mental health, educational and social services along with any other individual recommended by the youth or the family. The committee recommends services and treatment to the case manager/ counselor to implement with the youth and the family. The committee will also have the final decision on filing a CINS/FINS petition in court when the counselor/case manager makes the recommendation. The counselor/case manager will provide the youth and the family a written report detailing the recommendations of the Case Staffing Committee and the decision whether a petition will be filed in court (if necessary).

A census roster for youth served in the past six months was requested of residential and non-residential youth of which four from each program were randomly selected.

There were four non-residential files reviewed; no file was denoted a CCS youth at this location.

There were four residential files reviewed: no file was denoted a CCS referral youth at this location.

Program residential director stated that Case Staffing Committees are performed out of the Clearwater Office. There are no CCS youth at this location.

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

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

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place to maintain client records in a manner that protects the confidentiality of the youths records.

Client records are placed in a secure area or contained in a locked file cabinet under the supervision of a staff member. Files can be removed for staff access but has to be replaced by the end of day. Files are to be kept in a secure area at all times and not left unattended at any time. When recording information in the youth's file it should be done in a private location. Original records should not be removed from the

property for the exception of transporting the files to court or another program site. All records should be retained accordingly to approved agencies. The protocol of destruction of the youths' file shall be witnessed and attested to in writing.

Client records are placed in a secure area or contained in a locked file cabinet under the supervision of a staff member. Files can be removed for staff access but has to be replaced by the end of day. Files are to be kept in a secure area at all times and not left unattended at any time. When recording information in the youths file it should be done in a private location. Original records should not be removed from the property for the exception of transporting the files to court or another program site. All records should be retained accordingly to approved agencies. The protocol of destruction of the youths fill shall be witnessed and attested to in writing.

Exception:

One of the six closed files was not marked confidential.

Standard 3: Shelter Care

Overview

Rating Narrative

The SafePlace2B is a youth shelter located in St. Petersburg that is licensed to serve the Department of Children and Families (DCF) and Children in Needs of Services/Family in Needs of Services (CINS/FINS). At the time of the Quality Improvement, there were no DCF youth residing at the shelter. The agency has not admitted any DCF youth since July 1st, 2017. Therefore, the DCF license was expired, and the agency is working on renewing the permit in November 2017. There were 9 CINS/FINS youth residing at the shelter at the time of review. The agency operates 24 hours, 7 days a week and serves both residential and non-residential youth. The provider serves special populations such as Domestic Violence and DJJ respite youth. For the last six months, the provider did not have any youth admitted as a Staff Secure. The agency recently received funding to renovate and remodel the facility, and they are in the process of proceeding with the renovation this month. The female and male youth rooms were assigned on the opposite side, and there was a total of four bedrooms-- three beds each with an individual bed, linens, and pillows. The youth do not perform any meal preparation; however, youth do complete independent living skills by completing chores.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has written policies and procedures in place and compliance with the Florida Network contract. The policy was last reviewed and signed by the Chief Executive Director in March 2017.

The Residential Supervisor or designee will conduct weekly inspections of the physical plant ensuring that the supervisor or designee will attend to those areas needing attention. The Residential Supervisor or a designee maintains a log to note those areas in need on a weekly basis. The Residential Supervisor manages the schedule for inspections such as fire, pest control, and ground maintenance. Staff will post daily youth activities that are accessible to youth. Youth are to be provided an opportunity to participate in faith-based activities.

Furnishings are in good repair, and the program is free of insect infestation. The agency is receiving funding to renovate and remodel the basketball area as well as some of the paintings that need to be done this month. Bathrooms and shower areas were clean and functional. There were no graffiti on walls, doors, or windows. Lighting is adequate for tasks performed. Agency's vehicles were equipped with safety equipment including first aid kit, fire extinguisher, glass breaker, seat belt cutter. However, one of the vans did not have a flashlight in the vehicle. Ten of the staff members' vehicles were inspected. One out of ten vehicle's doors was left unlocked. Detailed egress plans of the facility, grievance forms were posted in the facility. While reviewing the grievance binder, there was only one observable form could be reviewed. The initial grievance was completed on 8/19/17, and it was reviewed on 8/23/17. The procedure indicates that the grievance form is to be reviewed within 72 hours.

Youth have a safe, lockable place to keep personal belongings. Family Resources does not allow the youth to bring any electronic devices. If needed, all of the youth's valuables items are secured in a safe box, and only staff are allowed to access. The program completes fire drill every month within two minutes, and it is to be conducted every shift. The agency appeared to complete fire drill on a monthly basis on every shift. However, there was one month, September; the drill was only done on 2nd shift.

The agency is up to date with annual fire inspection. There were seven fire extinguishers, and the last inspection was done in August 2017. The agency has a current satisfactory group care inspection report form from the Department of Health, and its expiration date is 9/30/18. The last inspection report was completed on 10/24/17. During the review, the agency's DCF Child Care License was expired as of 11/2/17. Due to the agency not serving DCF youth since July of 2017, the DCF has not re-issued the

license. However, the program had proof that they had contacted the DCF and they will be coming out to renew the license on 11/21/17. While reviewing the youth's activity calendar, there was no indication that the youth were offered to attend faith-related activities on the board. However, the orientation booklet indicates that the youth have the opportunity to do so if they desire.

Exceptions:

One out of ten vehicles was not locked at the time of the review.

There was one grievance form completed during this year, and the form was completed on 8/18/17. However, the follow up was done on 8/23/17, not meeting the 72 hours follow up requirement.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedures in place where a youth is given an opportunity to learn about the program and through an orientation. The youth receives the orientation packet and signed and dated within 24 hours of admission.

The provider's procedure requires that all new clients receive orientation packet within 24 hours of admission to the program. A review of youth orientation packet covers program philosophy, goals, services, and expectations, search policy, daily program, and the review of youth's rights and the grievance procedures and contraband policy.

A sample of six files were randomly selected and reviewed: 3 open and 3 closed residential youth files. Youth received a handbook during intake or within 24 hours. The Youth Handbook consists of program policies and guidelines, disciplinary action for violation of program rules, grievance procedures, emergency/disaster plans, contraband rules, physical/facility layout map, room assignment, abuse hotline number, dress code, and daily activities. The Youth's Handbook describes how disciplinary action would be conducted. Youth who receives a disciplinary action is to be placed on "Ownership" level and required to complete the "Ownership" paperwork for youth to be accountable for their actions and reflect on their behaviors. The suicide alert system is noted in the youth's file and alert board upon intake.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency does have a written policy and procedure to determine a youth's room assignment.

The agency's procedure requires the room assignment to be determined based on the information gathered during intake, youth's referral behaviors, initial collateral contacts, and initial interactions with and observations of the youth. Some of the pertinent information are suicide risk, perceived maturity, level of aggression and proclivity for violence, past involvement in aggressive and/or predatory behavior, sexual misconduct, gender, age, the presence of medical, mental, or physical disabilities, gang affiliation, attitude upon admission. Clients who are determined special attention for safety reasons will be assigned appropriately. No other staff member than the supervisor can assign youth room arrangement.

A sample of six files were randomly selected and reviewed: three open and three closed residential youth files. All six files had the room assignment based on the information collected during intake. Room assignments are noted in the youth's file, alert board, and the log book. Youth who are placed on Constant sight and sound monitoring is noted during assessment and assigned to "couch" which this enables the staff to monitor the youth closely. Out of six files, only one of them was placed on special

monitoring due to his suicide risk history and was assigned a room called “couch.”

The agency has an alert system which is color-coded to note whether a youth is placed on a higher monitoring status, elevated supervision or to indicate whether the youth has referral behaviors of substance abuse, medical issues, mental health issues, etc. Based on client’s referral behaviors, the agency refers them to obtain other resources from various programs such as career counseling, mental counseling, substance abuse, etc. Out of (6) six files, one of the referral forms was signed only by the parent. In addition, one of the client’s file did not have the referral form in the file.

Exceptions:

Out of six files, one of the files had only parent signature to acknowledge that the agency made the referral.

Out of six files, one of the client's files did not have the referral form in the file.

3.04 Log Books

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy and procedure to ensure that daily activities, guidelines, and entries in their paper log book.

The agency shall maintain a chronological account of all events. At a minimum, documented in the log books are unusual occurrences, problems, and emergency situations. All entries are legibly written in ink and include client plans, medication-related information about youth, a statement providing pertinent information. Entries which could impact the security and safety of the program may be highlighted. All recording errors are struck through with a single line, and staff must initial the correction. The word “error” may be written by the recording and the use of whiteout is prohibited.

Oncoming YDS and program supervisor will review the logbook at least two previous shifts to become aware of any unusual occurrences. Residential Supervisor shall review and sign the permanent log weekly and indicate the dates reviewed and note in the logbook as to any corrections, recommendations and follow up required.

Safety and security issues such as CSS monitoring and medical related information are documented in the log book. Resident counts are documented in the log book. Supervisor regularly reviewed the log book, dated and signed. Entries are made in ink without erasures, and the use of whiteout is prohibited. Any recommendations or follow up required are written in the book and signed by the supervisor. The agency did not have any youth leaving campus for over the night home visit with the guardian in the past six months. Youth are encouraged to do visitation on campus or go off campus for a few hours and return to the facility. On the procedure, the errors are to be struck through with a clear line with staff initial and the word “error” may be written by the recording if space permits.

Exceptions:

Errors were often corrected with scribble, and some of the recording errors were not struck through with a clear line.

The policy must reference new practice. The agency implemented the electronic logbook since August 2017. However, there was no procedure written in their policy.

3.05 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a written policy and procedure to ensure that a consistent and fair system of privileges and consequences are used. The agency uses the Behavior Management System (BMS) which is designed to provide an opportunity for youth to earn rewards and consequences issued for their behaviors.

The agency utilizes the Behavior Management System (BMS) which is called Advancing Youth Development (AYD). The AYD system consists of three different phases (Orientation, Citizenship, and Leadership). This system is designed to promote youth to display positive behaviors as well as providing ongoing feedback to youth to fulfill program expectations. The behavioral management is explained upon youth's admission, and it is written in the youth's handbook.

The program has a written description of the BMS, and it is explained during program orientation. Youth receives the youth's handbook and sign off on admission. The AYD system consists of three different phases (orientation, citizenship, and leadership). Youth is placed on orientation level for 24 hours upon admission. Then youth can earn up to be placed on be on citizenship level in which youth can start earning monetary rewards. The highest level is called leadership which the youth gets to earn a maximum amount of money daily. The incentives are displayed in the common area which gives motivation for youth as they can visually see the desired items they want. On every Thursday, youth have an opportunity to buy off the items.

The youth are graded in the seven areas each day to earn privileges. Clear expectations are written in the AYD system in the youth handbook. A youth who is in assessment period does not earn any monetary rewards until the youth moves up the higher level. If youth disrupts the program, not following program rules, not respecting staff, then the youth is to revert to an "Ownership" level. At this level, youth must work on paperwork, which is designed for youth to be accountable and reflect on behaviors that help them to make the necessary corrections. The youth are given a form called Behavior Grading Sheet daily and staff rates youth's behaviors on every seven areas (morning hygiene, school attendance, group attendance, after dinner chores, bedtime hygiene, respect, and safety).

Staff are trained in the theory and practice of administering the AYD system. A new hire shadows and receives training on the AYD system for at least three shifts. During an interview with the shelter supervisor, it was found that staff members are provided with feedback and evaluation of staff regarding their use of BMS system informally. There was no evidence that staff were receiving feedback in regards to their use of the system. However, there were two incidents observed during staff meetings that the agency reviews the BMS system.

Exception:

There was no evidence that the staff were receiving training or feedback in regarding their use of BMS system as this was done informally. However, the supervisor reviewed Behavior Management Technique in two out of six staff meetings.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure to ensure that the agency is meeting the requirements set by the Florida Network. The agency has a policy indicating that adequate staffing is provided to ensure the safety of youth and staff.

The agency shall maintain two staff, one male and one female at all times, during awake and sleep time. During times of critical staff shortages, direct care staff may be the same gender if the supervisor can demonstrate a continued effort to hire the right combination of staff gender for shifts. If a direct care staff fails to relieve the worker on the previous shift, they will be expected to contact the supervisor and stay on site until a replacement is found. Staff will observe youth at least 15 minutes during sleep time or any other events such as illness or restriction.

The agency serves a maximum of 12 youth. On each shift, the agency maintains minimum staffing ratios

as required by Florida Administrative Code and contract. There are at least one female and one male staff on each shift. At this time, the agency is looking to fill in one male staff and two part-time male staff, and the agency's hiring manager marketed for these positions. Due to a shortage of male staff, female staff are covering at least 3-4 times a week at this time. The agency has been posting these positions since September. Due to a high turn-over rate, it appears that the agency is consistently posting for the position for male staff. It was found that many of the shifts were covered by same gender (female). But the agency is putting their best effort to fill these positions and hire part-time male staff.

Program staff schedule is provided by the shelter supervisor, and it is posted in a place visible to staff. There was a roster that includes contact numbers to reach these staff when additional coverage is needed. There were at least ten on-call staff on the roster, and these staff mainly covers on the weekend. The full-time employees are scheduled from Monday through Friday. In the case the shift is not covered, shelter supervisor contacts the on-call staff members to cover. In the case the on-call staff may not report to work on time, the shelter supervisor fills in the spot until on-call arrives at the site. Agency is equipped with functional cameras and well positioned in the common area. The staff does check every 15 minutes for the most of the part while youth are sleeping. The agency ensured to use the real-time when recording the bed check. However, there were a few incidents in which the check was done more than 15 minutes.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy in place for Special Services Population which was revised on 07/01/15. Special population services include staff secure services, services to Domestic Violence Respite and services for Probation Respite. Staff secure shelter services are designed to serve court ordered youth who have been held in contempt for continued running away or are locked out of their home due to history of conflict and/or ungovernable behavior.

Staff secure shelter services is an intervention serviced focused on youth and families who may be experiencing severe conflict or have a history of family issues that have not been resolved. The goal of staff secure services is to provide one-to-one intensive individualized services for a longer period for the youth and family. Youth who are eligible for staff secure placement must be adjudicated as a CINS/FINS youth, they can receive services for up to 90 days with a possible 30-day extension.

Family Resources has a policy in place but they do not service Staff Secure youth and they do not service youth with Domestic Minor sex trafficking. They service clients within the Domestic Violence Respite and Probation Respite programs.

Probation Respite: The agency has applicable probation respite policies and procedures in place. The agency has had a total of six (6) cases within the last 6 months. Six of the six files reviewed for respite referrals came from DJJ probation and were all referred while under the eligibility status of being on probation with adjudication. Four (4) of the six cases have evidence that the Florida Network of Youth and Family Services (FNYFS) was contacted for approval prior to admission for probation respite placements. Two (2) of the 6 cases did not have an email in the file. One (1) of the 6 files stated the length of stay at the shelter was 21 days. The other five (5) cases did not state the length of stay, these cases were domestic violence cases. Six of the 6 cases stated the length of stay at the shelter was no longer than 14 to 30 days. There is evidence of case management and counseling needs being considered in three (3) of the 6 cases. The length of stay in the shelter for youth in the other 3 cases was not long enough to implement a service goal plan. In 6 of the 6 cases, the services that were provided to probation respite youth were consistent with all other general CINS/FINS program requirements.

Domestic Violence: The agency has applicable Domestic Violence Respite policies and procedures in place. The agency has had cases in the last six months. In five (5) of the six (6) cases, the youth were admitted to Domestic Violence (DV) placement and had a pending DV charge and evidence of being

screened by JAC/detention, but did not meet criteria for DJJ secure detention. One (1) of the 6 cases were probation not DV. Six of the 6 youth did not exceed 21 days in the program. Three out of the 6 youth were discharged from the program within 48 hours so there was no documentation to show transition to CINS/FINS programs. Three (3) of the youth refused after care. Three of the 6 youth case plans in the case files reflect goals. Three of the 6 youth left the program before the goals could be implemented. Services provided to domestic violence respite youth were consistent with all other general CINS/FINS program requirements in 5 of the 6 youth, the other youth was probation.

There were no exceptions to this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure to ensure that the agency is meeting the requirements set by the Florida Network to ensure safety of all youth, staff and visitors.

The agency shall have cameras in the interior and exterior to cover general locations of the shelter.

Cameras are not to be placed in private areas such as bathrooms or sleeping quarters. The recorded video is stored for a minimum of 30 days and stored in a separate storage for a length of time needed to complete investigation. Only designated staff are trained to handle the equipment and monitor footage in an ethical manner. Supervisory review of video is conducted bi-weekly and documented to assess the activities of the facility. The cameras have the ability to record date, time and location, and back-up capabilities that enable cameras to operate during power outage.

There is a written notice that is posted on the premises for the purpose of security. Cameras are in the interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. The system can capture and retain video photographic images including facial recognition and are stored for a minimum of 30 days. The agency has a back-up server which operates during a power outage. The supervisor reviews the video and note in the logbook. Out of three days sampled, it appeared that staff were completing at least 15-minute bed check. However, one of the staff appeared to be motionless for a period of time.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SafePlace2B St. Petersburg youth shelter provides screening, counseling, and mental health assessment services. 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 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, 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

Family Resources have a policy in place for health care admissions screening of the youth in the program. The program performs a preliminary physical health screening for each youth at the time of admission to the shelter. If present during the scheduled working hours, the agency nurse will conduct the health screening. If the nurse isn't present during admission of a youth, a non-health care staff may perform this screening. The nurse has five days to review the screening if not available during admission of the youth. The screening will include current medications, allergies, existing (acute and chronic) medical conditions, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty moving, observation for presence of scars, tattoos, or other skin markings. Family Resources ensure medical care for the youth admitted with chronic medical conditions. Family Resources provides all client unimpeded access to emergency medical care at all times. Staff documents the presence of any of the following conditions and will provide appropriate medical follow up as needed.

During admission, the staff will conduct an in-depth health screening through the completion of the CINS/FINS intake assessment form. If there is a significant medical issue the client will be referred to their physician, emergency room or to the public health care department. Program staff may consult with the agency medical consultant for general and specific guidance regarding ongoing care. Family Resources have procedures in place if there is a medical emergency at the program. All direct care staff will receive training. There is a procedure in place for completing the CINS intake assessment form. There are two same sex staff members as the youth that observe the youth for any rashes or health problems. If a client has a health concern, they are to consult with a staff member. All medical referrals will be documented on a daily log.

There were six cases observed-- two open and four closed. Four out of the six cases reported youth being on medication. Four out of the six youth have existing (acute and chronic) medical conditions. One out of the six youth have allergies. None of the youth files observed reported having any recent injuries or illness. Five of the six youth don't have any evidence of illness, injury, pain or physical distress, difficulty moving. One of the youth have pain when playing sports. One of the six youth have presence of skin markings. The

other five don't have any markings.

Six of the six youth don't have diabetes, not pregnant, don't have a seizure disorder nor cardiac disorder. Two of the six youth have asthma and take medication. Six out of the six youth don't have tuberculosis, hemophilia (bleeding disorders) nor do they have head injuries, occurring during the previous 2 weeks. Six of the six youth when needed the parent is involved with the coordination and scheduling of follow-up medical appointments. Three of the youth medical referrals are documented on a daily log. The other three youth don't have a medical daily log.

Exception:

For one of the youth during the initial intake session it was documented that the youth isn't on any medication. A few days later the client started to take medication which wasn't documented on the medical daily log, nor was it noted in the staff case notes that the client was taking medication.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Suicide Prevention called the Comprehensive Master Plan for Suicide Prevention and Response – Pinellas 4.02B. The number series 4.02B refers to all Family Resources shelters that provide services. The agency has had no major changes in the policy for the current fiscal year. The agency's Comprehensive Master Plan for Suicide Prevention and Response – Pinellas policy was last reviewed, signed and approved by the agency's Chief Executive Officer in June 2017. A review of the policy indicates that the policy includes provisions for mental health and substance services, suicide prevention procedures, mental health crisis intervention and emergency response. The policy includes provision pertaining to both Residential and Non-Residential Services.

The agency's procedures require the organization to have measures in place to address youth admitted to the program that have a past or existing presence of suicide risk. The agency's procedures address Initial Mental Health and Substance Abuse; Suicide Risk Screening and Referral for Assessment; Clinical Assessment of Youth on Sight and Sound Supervision; Levels of Supervision (1 to 1, Constant Sight and Sound Supervision, Elevated Support, Standard Supervision); On-Going Staff Evaluation of Suicide Risk Behaviors; Notification of Agency Official; Outside Authorities and Parent/Guardians; Needs Assessment; Mental Health Alert Process; and Non-Residential Services. The policy Residential and Non-Residential Services include Training; Referral and Collaboration; Authorization to Transport for Emergency Mental Health or Substance Abuse Services/Law Enforcement Transport; Notification of Management, On-Call Staff, Outside Authorities, Parents, Guardians of Mental Health or Substance Abuse Emergency.

The agency has a section in the policy that focuses on the procedures for Documentation of Mental Health Crisis or Emergency Situation. The agency requires that staff members be prepared to write a detailed incident report prior to the close of the end of the shift. The report must include signs and all relative symptoms that the youth was exhibiting, assessment procedures taken and results, other staff activities taken, notifications, and resolution of the problem. The written incident report must be produced within 24 hours of the incident. Collateral documentation must be documented in the client's file and include all measures taken to address the situation, referral made and the resolution of the crisis. The agency does not use an evaluation of imminent danger or suicide risk probability scale instrument. The agency completes the screen and automatically places youth on constant sight sound if the youth meets any of the six (6) suicide risks questions on the CINS/FINS Intake Form.

A review of the Suicide Prevention indicator was conducted onsite during the Quality Improvement review. The agency has a total of four (4) employees that are Licensed Clinicians. All clinician licenses are active and in effect. Specifically, a total of six (6) client files were reviewed to assess the agency's adherence to the requirements of this indicator. The 6 files reviewed consisted of two (2) open and four (4) closed client files. A review of the randomly selected files revealed that the files generally adhered to the requirements

of the indicator. Specifically, a total 6 client files had evidence of a completed risk screening that was completed during the admission or over the telephone prior to admission. All 6 files have evidence of executing the suicide risk screening process utilizing the risk screening section contained in the CINS/FINS Intake Form. Each of these forms were found in each client's file and completed by a trained staff person and reviewed and signed by the supervisor.

A total of five of the six cases had evidence of past or present risks identified by answering yes to 1 or more of 6 suicide risk screening questions on the CINS/FINS Intake Form. All 6 client files had documentation indicating they had been placed on constant site and sound supervision as required. Actual client observation logs indicate that observation times were documented every 15 minutes or less on a Red observation log. The log captures the name, time of observation, mood/behavior and initials of the staff person that is conducting the observation.

Each youth placed on supervision had evidence of completed needs assessment. Each client's file was completed by a master's level counselor that had evidence of completing the Assessment training under the supervision of a Licensed Clinician. At the time of the review, each Assessment had evidence that it had been reviewed and signed by a Licensed Clinician. The clinicians document their credential directly on each assessment with the date and time of consultation verifying the decision to sustain the constant sight and sound status or to indicate a change to step down the level to a lower level of Elevated Supervision. All cases had evidence of documentation of changes to step youth down in four areas that included Assessment; Progress Note; Client Observation Log Form; and in the Program Log Book.

Exception:

One (1) of the six (6) client cases documented being placed on Constant Sight and Sound did not have evidence of the youth being removed from sight and sound status in the log book.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

A review of the policy indicates that the Family Resources agency has a policy that meets the general requirements of this Medication indicator. The policy was last reviewed in March 2017. The policy includes provisions staff to be trained on Medication distribution. The policy references preparation for the agency to provide inventory, storage, security, distribution, documentation, verification, training, and disposal.

Agency policy requires procedures to ensure that all residents accepted by the program receive medication as required during the duration of their shelter stay. Agency procedures require all staff to be aware of the steps to perform medication distribution to residents in the program. The agency has a medication distribution training for staff members. This medication distribution training is delivered during the orientation and on boarding process when an employee is hired by the agency. The medication distribution training is primarily delivered by the agency's registered nurse. The agency has a list of all staff authorized to distribute medication to residents accepted into the program during their shelter stay. The agency has a requirement that all medications be stored in the Pyxis MedStation 4000 machine. The agency has a policy that requires that all medications be counted on a daily basis. Narcotics and/or controlled medications must be counted on every shift. Agency policy also requires verification of medications when a youth is accepted into the program.

The agency has a list of all staff that are authorized to distribute medication across all three work shifts. The agency has a total of two registered nurses. The registered nurses are the primary staff persons that delivers medication distribution training to the rest of the staff. The nurse does distribute medications when they are on shift.

Each nurse works part time during the week.

A review conducted on site of the agency's medication practice was conducted by a quality improvement peer reviewer. The reviewer found that all medications are stored in the Pyxis MedStation 4000 medication cabinet. This cabinet is not accessible to residents unless they are accompanied by an authorized staff. At the time of this review, all medications including OTC's were stored in the medication cabinet. The agency does have more than two super users and exceed the minimum in order to operate the Pyxis MedStation on site.

The agency houses the MedStation in the secure room behind the youth care worker control desk. The room is secure as required. Youth cannot access the room unless they are with a staff person. The agency houses its sharps in a locked cabinet that is accessible only to authorized staff persons. The agency has sharps that include razors and scissors. At the time of this review, the agency had a total of six razors and four pairs of scissors. The sharps are counted three times per day.

The agency has a medication distribution log that is used to document the process in which agency members assist in giving each resident their prescribed medication. Agency's medication distribution log is legal sized and color-coded. The distribution log is also there to find that the agency is completing the MedStation verification process during the admission stage.

Agency does have a medication refrigerator that is set at the proper temperature settings and it is locked as required.

The agency is completing inventory shift to shift counts on all controlled medications. These shift to shift counts are done three times a day. Other perpetual inventory is conducted one time per week or when distributed.

All over the counter medications are counted one time per week by the registered nurse. Over the counter medication is also documented when it is given.

A review of the client files of residents currently on medication was conducted to determine the accuracy and completion of medication distribution process during the current shelter stay. The reviewer also observed medication pass while on site. The reviewer observed inventory of medication access to the Pyxis MedStation 4000 cabinet and actual distribution to residents. The reviewer found no exceptions with the onsite protocol storage, inventory and distribution to residents on medication observed while on site.

An assessment of Medication Discrepancies process and execution was also conducted. A review of the agency's execution of producing medication management reports from the Knowledge Portal was also requested on site. Monthly Reporting on site from the knowledge portal was not found.

The agency generally notifies parents and guardians when a residents' medication supplies are at seven days or less. The agency's disposal process includes a 30-day wait, three attempts to contact, and disposal with the nurse and a witness.

Exceptions:

The agency is required to complete discrepancies prior to the close of each work shift. The agency is currently clearing discrepancies in 24-28 hours.

The agency is not producing monthly reports generated by the Pyxis Med-Station via Knowledge Portal or Pyxis Med-Station Reports.

The agency's sharp count should reflect a razor count of six razors in the sharps container. The current count only documents four (4) razors in the sharps container.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy called medical and mental health alert process that requires the agency to make information discovered during the health intake screening process available to staff regarding the medical or mental health conditions of the client. The policy was reviewed by the agency's chief executive officer in March 2017. The policy meets the general requirements of the indicator.

The agency is required to maintain a system that indicates an alert identification for monitoring during the resident shelter stay. Agency is required to use a series of color-coded notifications of the clients health and/or mental health status during their shelter stay. The color-coded system includes red for constant and sound; yellow for elevated support; green for mental health; blue for substance abuse; purple for sharks restrictions; black for medical issues; orange for medications; and pink for allergies. These color-coded dots are to be placed on the spine of a strip outside of the three ring binder. Conditions such as mental health, diabetes, asthma, seizures, severe allergies, and other conditions are examples of what should be documented.

A review of a total of six (6) client files was conducted to assess the agency's adherence to the medical and mental health alert process indicator. A total of 6 client files included an indicator for a medical/mental health behavior or food allergies condition. All 6 resident client files were correctly screened and marked on the program's alert system. All the alerts included the proper color coding concerning either medications, mental health, or behavior issues. The agency's staff members are provided information and instructions as required to screen, identify and notify all required parties of client with medical, mental health, behavior or food alerts.

Exception:

One of the six files did not contain evidence of an orange sticker notification indicating that the child's original status of not being on medication had changed. The client file was not updated as required per the medical mental health alert.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has an Episodic Emergency policy titled by the same name. The policy was last reviewed in March 2017. The policy includes provisions staff to be trained on certain safety and medical emergency situations. The policy references preparation for the agency to provide immediate on-site first aid and emergency care in case of injury, acute illness, suicide or homicide in all facilities. A general review of this policy was conducted by the peer assigned to evaluate this indicator resulted in it meeting the basis requirements of this indicator.

The agency's procedure includes measures to ensure all staff members are trained and certified in first aid and CPR procedures within 90 days of hire. All staff members must document all incidents that involve youth receiving medical attention on or off site. All incidents are required to be documented on a standardized incident reporting form. Incidents forms must be filed in the official agency incident binder and logged by date of occurrence.

The agency has first aid equipment that is available at all times in the facility. First aid kits are checked by the supervisor and/or the Registered Nurse (RN) on a monthly basis. All staff members are required to complete a series of emergency training during their orientation process that include CPR, First Aid, fire safety, Universal Precautions, and others. The agency also requires that all direct care staff members that work in the shelter facility to participate in fire drills, as well as mock emergency drills on a routine basis.

There is evidence that there are a total of five first aid inventory checks since May of 2017. The agency has safety equipment that includes four (4) first aid kits in the building, 1 pair knife for life, 1 pair of wire cutters and automated defibrillator. The agency has evidence of first aid kits in the transportation van.

The agency maintains an Episodic/Emergency Incident Binder to document all incidents. Incidents are documented and then placed in the binder in chronological order.

Exception:

One client case that was documented in the Episodic and Emergency Incident Binder was not documented in the agency's Program Log Book.