



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Family Resources-Clearwater

on 04/15/2015

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Limited
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory: 80.00%  
Percent of indicators rated Limited: 20.00%  
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	Limited
3.07 Special Populations	Limited

Percent of indicators rated Satisfactory: 71.43%  
Percent of indicators rated Limited: 28.57%  
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 4: Mental Health/Health Services

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

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

## Overall Rating Summary

Percent of indicators rated Satisfactory: 87.50%  
Percent of indicators rated Limited: 12.50%  
Percent of indicators rated Failed: 0.00%

### Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

### Review Team

#### Members

- Ashley Davies, Lead Reviewer and Consultant, Forefront LLC
- Danielle Husband, Program Director, Youth and Family Alternatives – RAP House
- Paul Sheffer, Regional Monitor, DJJ



## Quality Improvement Review

Family Resources-Clearwater - 04/15/2015

Lead Reviewer: Ashley Davies

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Angela Patton, Program Manager/Case Manager, Thaise Educational & Exposure Tours

### Persons Interviewed

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

### Documents Reviewed

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs                       |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook             |
| <input type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 5 Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 8 Personnel Records  |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 5 Training Records/CORE  |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 3 Youth Records (Closed)                                       |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 5 Youth Records (Open)   |
| <input checked="" type="checkbox"/> Exposure Control Plan             | <input type="checkbox"/> Supplemental Contracts                      | 0 Other  |
| <input checked="" type="checkbox"/> Fire Drill Log                    | <input checked="" type="checkbox"/> Table of Organization            |  |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              |  |

### Surveys

- |         |                     |         |
|---------|---------------------|---------|
| 4 Youth | 6 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

### Observations During Review

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

### Comments

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

Rating Narrative

## **Strengths and Innovative Approaches**

### Rating Narrative

The shelter hired a new Program Director who had been in the position for approximately three weeks prior to the review. The position of the Residential Supervisor was still vacant at the time of the review. The previous Residential Supervisor left the agency approximately two month's prior to the review.

The agency has opened a Maternity Group Home on April 1, 2015 that has eight beds.

## Standard 1: Management Accountability

### Overview

#### Narrative

Family Resources, Inc. – North youth shelter named Safe Place 2B and non-residential programs are located in Clearwater, Florida. Family Resources, Inc. provides services through a direct local service provider contract with the Florida Network of Youth and Family Services. The Family Resources agency primarily provides CINS/FINS services in Pinellas County and nearby surrounding counties. Family Resources also operates sister youth shelters, also called Safe Place 2B, that are located in St. Petersburg and in Bradenton, Florida. These agencies service youth and families in Pinellas, Manatee and other surrounding counties. Each location has a licensed clinician, Shelter Director, Residential and Non-Residential counselors, Residential staff members and Outreach staff. A centralized Human Resources and Fiscal departments handle all personnel and financial matters. Each sites' clinician reviews and oversees all counseling and mental health services provided to youth and families delivered at their respective location. The agency assigns the daily operation and direct responsibility of each shelter to the Residential Director at each youth shelter. All Family Resources residential shelters have implemented uniform operating protocols for all three service locations in the areas of operations and programming for both residential and non-residential services. Other uniform protocols for all three locations include training and professional development. The agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency training's combine staff members of each location to be trained on various core training topics. This report focuses on the services associated with the North Shelter.

### 1.01 Background Screening

Satisfactory                       Limited                       Failed

#### Rating Narrative

The program has a policy and procedure in place to address background screening requirements, which was reviewed in October of 2014. The Program hired eight new staff since the last annual compliance review. Seven of the new employees were screened prior to beginning work with a rating of eligible or eligible with charges. The other staff member began work seven days prior to their screening having been completed. The program had no staff eligible for five-year rescreening. The program also had an incident on January 26, 2015 in which a PRN staff member worked without a current background screening. They had not worked at the shelter for over a three month period. Upon discovery this was immediately reported to the Central Communications Center (CCC). The program submitted their Annual Affidavit of Good Moral Character to the Department's Background Screening Unit on January 5, 2015, meeting the annual requirement.

### 1.02 Provision of an Abuse Free Environment

Satisfactory                       Limited                       Failed

#### Rating Narrative

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

Upon hire, each staff signs a code of conduct that prohibits physical abuse, profanity, threats, or intimidation. The program also provides training for child abuse reporting as part of their first year staff training plan.

### 1.03 Incident Reporting

Satisfactory                       Limited                       Failed

Rating Narrative

Family Resource has a detailed policy and procedure which includes all of the incident reporting requirements found in DJJ Central Communications Center (CCC) policy and the Florida Network of Youth and Family Services CINS/FINS policy and procedure manual. The shelter had twelve CCC reports during the past six months. Four of these reports were called in after the two hour reporting requirement. It appears the former program supervisor implemented a practice in which staff were not allowed to call the CCC without their approval.

### 1.04 Training Requirements

Satisfactory                       Limited                       Failed

Rating Narrative

The shelter has a policy in place which addresses the training requirements for staff. This plan includes all elements required by the Florida Network of Youth and Family Services CINS/FINS policy and procedure manual. Two staff training records were reviewed for the completion of first year training. Each of these two staff were found to have met the eighty hour training requirement. Neither of the reviewed training files had documentation reflecting completion of training on the Prison Rape Elimination Act (PREA). One of the records was also missing documentation of training for abuse reporting procedures during their first year of employment.

Two staff training records were reviewed for the completion of annual in-service training requirements. Each of the two staff met the forty hour requirement. Each of the reviewed files reflected all mandatory training topics had been completed. These included training on fire safety equipment and suicide prevention. Each staff was also found to have current certification in CPR and first aid.

### 1.05 Analyzing and Reporting Information

Satisfactory                       Limited                       Failed

Rating Narrative

The program has a policy and procedure to ensure the quality of services and a focus on meeting the needs of the youth they serve. The shelter enters data from their youth into NETMIS, as well as other databases which assist in tracking how the youth in the program are served. The program director also composes a monthly report of relevant program data which is forwarded to the Chief Operating Officer (COO) for review. Each Monday, Family Resources holds a meeting with their program directors of each shelter to analyze the data which has been collected and issues which are occurring in each shelter. Family Resources also has a process in which a peer conducts a random review of records each quarter. This review looks at all elements of program documentation to include: intake, assessment, service plans, case notes, consents, case closures, and supervisory review documentation. Customer satisfaction surveys are completed with each youth upon discharge. Outcome data is also tracked by the Florida Network and this information is forwarded to the COO for review on a monthly basis. Family Resources holds weekly senior meadership meetings. This team will focus on trends or risk management issues identified in the outcome data, in addition to customer satisfactioun data, to make improvements and to assist in the implementation of new procedures on at least a quarterly basis.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

The Family Resources agency provides non-residential counseling services through its North Family Counseling Center located in Clearwater, Florida. The non-residential services include Truancy, Marriage and Family Counseling, and Family Counseling. Family Resources non-residential program has one Program Director who also provides direction to other family help programs. There is one non-residential counselor who has a MA. Safe Place 2B Residential Shelter has a Residential Director, who is a LMHC. Centralized Intake Services are evidenced throughout all charts reviewed. The Family Resources non-residential program distributes a "Reference Guide for Clients" handbook to each parent/guardian or family. It clearly states the Rights and Responsibilities, Grievance Policy, Consent to Treatment, and Discharge Policy. The language used is appropriate for many levels of education parents might possess. The non-residential program also provides each family with the FLN "A Guide to CINS/FINS Services for Parents". This provides the options and process through which parents can find the help needed for truant, runaway and/or ungovernable youth.

Screenings are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. A case plan is developed for each client. In addition, home visits are conducted on a case-by-case basis to offer support the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by Family Resources with shelter or residential care as a viable option for youth that need additional support services. The non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist resolve issues faced by the youth and their family.

### 2.01 Screening and Intake

Satisfactory                       Limited                       Failed

#### Rating Narrative

A total of six files were reviewed, three non-residential files and three residential files. All files indicated that contact was made with the family within seven calendar days from the date of the referral. The parents and clients are given the CINS/FINS services brochure, which describe case staffing committee, CINS petition process, and CINS adjudication, at the time of intake. Consent to treatment, client rights and responsibilities, and notice to privacy practices are also given to the client and parents. The parents and clients sign the form acknowledging they received the information. All six files that were reviewed had signed documentation from the client and parent that they received the information at intake.

### 2.02 Needs Assessment

Satisfactory                       Limited                       Failed

#### Rating Narrative

According to policy, a needs assessment must be initiated within 72 hours of admission for shelter youth and completed within two to three face to face contacts for non-residential care. In five of the six files reviewed the needs assessment was completed within the time frame. In one residential file the youth was admitted on 3/7/15 and the needs assessment was not initiated until 3/12/15. There was no documentation in the case notes for the delay. All need assessments were completed by a Bachelor's or Master's level staff member and signed by a supervisor. Out of the six files reviewed, two needs assessments indicated an elevated suicide risk level. Both of those clients were referred for an assessment by a licensed mental health professional.

### 2.03 Case/Service Plan

Satisfactory                       Limited                       Failed

#### Rating Narrative

There were three non-residential files and three residential files reviewed. All the case plans in the files were developed within seven working days of the needs assessment. All service plans were individualized and needs were prioritized according to the needs assessment. In the three non-residential files, service plans that were reviewed did not include the location of service, target completion dates or the date the plan was initiated. Verbiage "time frames" need to reflect what the standard is looking for (frequency, target date) and be more specific. Objectives were not measurable, for example, "12 sessions" could be noted as "1x/wk for 12 weeks". The three shelter files included all requirements on the service plans, including, measurable goals, target dates, and date initiated.

Service plans are to be reviewed every 30 days with the parent (if available), if not it should be documented in the progress notes. In two of the non-residential files there were no 30 day reviews. One file noted a 60 and 90 day review done. The shelter files were not applicable here as the youth were discharged prior to the 30 day review.

All initial service plans reviewed were signed by the youth, parent, counselor, and supervisor.

### **2.04 Case Management and Service Delivery**

Satisfactory

Limited

Failed

#### Rating Narrative

There were three non-residential files and three residential files reviewed. All files were assigned to a counselor/case manager and it was documented. Referrals were identified for each client as needed and the case worker coordinated service plan implementation. Progress notes in each of the files indicated the family's progress in services and case monitoring. Families were being referred for additional services as needed. No referrals for case staffings were needed. No clients had a court hearing or related appointment for the staff to accompany the family on.

No documentation in the files that case termination follow-ups have been done. Program Director reports that their secretary is doing them and they are reported in NETMIS.

### **2.05 Counseling Services**

Satisfactory

Limited

Failed

#### Rating Narrative

There were three non-residential files and three residential files reviewed. All six files documented counseling services in accordance with the Case/Service Plan to the youth and families. All files documented that the youth were receiving individual/family counseling and group counseling (shelter care) per standard. All files indicated that the youths presenting problems are identified in the needs assessment and on the service plan. Case notes are maintained for all counseling services provided and documents the progress of the youth.

Two of the non-residential files indicated supervisor reviews of the case records and staff performance. It was unable to be determined if this process is on-going and consistently being done. The intake forms are signed by a supervisor when the case is initially opened; however, there was no documentation in four of the files that any other supervisor review was done. Recommendation would be to have a supervisor progress note that documents monthly that the file was reviewed by a supervisor. The non-residential files have a CINS/FINS File Organization check list that has a supervisor review section; however, it was not signed in one of the non-residential files. Would be beneficial to use this form in residential files.

Program Director provided the registered intern supervision log for the non-residential case manager; however, that review is different from the case file review.

### **2.06 Adjudication/Petition Process**

Satisfactory

Limited

Failed

Rating Narrative

There were three Non-Residential reviewed. Each of the cases showed proper notification of the CINS Case Staffing to the parent/guardian and Case Staffing Committee. There were no emergency case staffings noted. The Case Staffing Committee consisted of representatives for Family Resources, Pinellas County School District, Law Enforcement, County Attorney, and MentalHealth/Substance Abuse Agencies. There was adequate documentation of the CINS process and follow up. The Case/Service Plans were not updated with Case Staffings recommendations as the goals were already in the Case/ Service Plans.

**2.07 Youth Records**

Satisfactory

Limited

Failed

Rating Narrative

There were three non-residential files and three residential files reviewed. All three non-residential files and the two closed residential files were marked with confidential on the outside of the folder. The open residential file was not marked "confidential." It is suggested that the tabs be replaced in the file as they are unreadable. The files are located in a file cabinet, which remains locked and the door is also locked. The files are neat and in order. Staff can easily access the information in the file. A suggestion is to stamp the word confidential on both sides (front and back) of the files.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

Family Resources, Inc. provides residential CINS/FINS services through a contract with the Florida Network of Youth and Family Services. The North Safe Place 2B shelter is located in Clearwater, Florida. At the time of this Quality Improvement review, the program was staffed with a Residential Director, Shelter Counselor, a Case Manager, nine Youth Care Workers, a non-residential Counselor, a cook, and a Secretary. The position of Residential Supervisor had been vacant for approximately two months prior to the review. The current Residential Director had only been in the position for approximately three weeks prior to the review. The shelter also had a Case Manager position vacant and five Youth Care Worker positions vacant.

The Residential Director who is a Licensed Mental Health Counselor (LMHC) oversees the day-to-day operations of the youth shelter. In addition the residential program's Counselor is also a LMHC. The shelter provides a "Client Handbook" to each youth upon admittance. Beyond that, each parent sits with the youth while staff goes through the handbook so both youth and parent will know what the expectations are while the youth is in the shelter. Parents and/or guardians also receive, at that time, a brochure, "Strong Families Are the Cornerstone of Our Community". All forms are signed by parent/guardians and youth showing an understanding of these. This identifies and explains the many family services offered by Family Resources.

### 3.01 Shelter Environment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The shelter environment was observed and furnishings appeared to be clean and in good repair. The youth are provided an area in the shelter for group meetings and recreation time and an area to complete homework. The shelter has four bed rooms with three beds each. Each bed room includes an interior bathroom for the youth assigned to the bed room to use. The rooms were neat with no obvious signs of graffiti or other damage. Each bed had a blanket and sheets that were provided to the youth to use.

The shelter has a schedule for daily programming and activities for the youth. The shelter also has an outdoor area where the youth can enjoy being outside and enjoy physical recreation.

The Residential Director shared the youth are able to complete art projects and a yoga instructor comes to work out with the youth in the shelter. The youth can also earn access to the "Gold Room" with enhanced activities for the youth to enjoy.

### 3.02 Program Orientation

Satisfactory                       Limited                       Failed

#### Rating Narrative

There were six files reviewed for the Program Orientation Standard. All six files met the requirements of the standard. The exception noted is there is no documentation within the file that the youth received a copy of the Client Handbook. Verbal confirmation was received from three staff members that the youth are provided a handbook upon admission and that it is reviewed by the Youth Care Workers during the orientation process.

### 3.03 Youth Room Assignment

Satisfactory                       Limited                       Failed

#### Rating Narrative

There were four files reviewed for this standard. Family Resources, Inc. utilizes the CINS/FINS Intake Form as the tool to assist in determining appropriate room assignment for a youth upon admission to the shelter. The CINS/FINS intake form was completed for each of the four youth at the time of intake.

The CINS/FINS Intake form asks the staff to review and assess the youth's history to determine if there are any reasons for special room assignments. This includes the youth's age, weight, history of mental health issues, history of violence, etc.

Exceptions to this indicator include that all four of the files reviewed did not include a supervisory signature on the form as required on the form. Additionally, in the space provided for the staff to include more details about the youth related to past history, behavior and affect during the intake process or current needs, all four files stated "Age Appropriate" but no further details to assist in the room assignment process.

### **3.04 Log Books**

Satisfactory                       Limited                       Failed

#### Rating Narrative

The shelter maintains a bound logbook and also a Shift Exchange Information form for each shift. In addition staff also complete a shift summary note for each youth. The Shift Exchange Information form documented all youth on medication, allergies and alerts each shift. The form also documented any new intakes or discharges. Any other important information relating to the shift is also documented on this form. This form is signed by the outgoing supervisor and the oncoming supervisor each shift. More detailed information about each specific youth's day is documented in the youth's shift summary note completed for each youth, each shift. The information documented in the logbook was brief and most of the time more detailed information could be found on the Shift Exchange Information form or in the specific youth's shift summary note.

Most safety and security issues are being documented on the Shift Exchange Information form. Incidents are being documented in the logbook; however, the information is limited and not detailed, entry would document a youth was arrested but did not document reasons why, staff members involved were not documented, and follow-up instructions or care was not documented for youth returning from hospital visits. Recording errors were not always handled appropriately and were scratched out rather than struck through with a single line and initialed. Supervision counts were documented numerous times throughout each day. There were many blank lines observed throughout the logbook that were not crossed out and initialed.

All staff were not consistently documenting a review of the logbook for the previous two shifts. There were two specific staff members who consistently documented a review when working; however, other staff members did not. It was difficult to tell when weekly supervisor reviews of the logbook were occurring. The Shelter Director would review the logbook and initial the top of each page but did not make an actual entry in the logbook with the date and time.

### **3.05 Behavior Management Strategies**

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has a written policy related to the Behavior Management System and the process is explained to youth during their orientation process. The agency utilizes a program where the youth are encouraged to make positive choices to earn privileges and work to avoid being overly punitive with the youth. The process includes an Orientation Phase, Bronze Level, Silver Level and Gold Level. The youth are encouraged to assess their own behavior and request an increase to their current level.

Review of training files showed that the employees receive training during their orientation phase on the Behavior Enhancement System the shelter utilizes. Grievances were reviewed and the supervisor addressed youth concerns related to staff that were being perceived as unfair to the youth in the shelter.

### **3.06 Staffing and Youth Supervision**

Satisfactory

Limited

Failed

Rating Narrative

Family Resources, Inc. has a policy related to Staffing and Youth Supervision. The agency policy states that a male and female staff member will be present on each shift, daily. The agency acknowledges that currently they are not able to meet this requirement, as they currently have more female employees than male employees. However, the agency does have a process in place to advertise for vacant positions and places advertisements on public job search engine sites and their own agency website.

The agency generally utilizes two staff during the midnight shift (11 PM to 7 AM). However, it was noted there were a couple of shifts in the last 90 days where only one employee was present for the shift.

The agency provides the employees with a typed staff schedule that is completed monthly. The agency requires an employee speak to the supervisor in the event that a shift needs to be changed and the agency maintains a recall roster of employees in the event an employee is absent from work for a shift. The agency policy also requires an employee from the previous shift be held over until coverage can be found if an employee does not arrive for a scheduled shift.

The agency does maintain a video surveillance system within the shelter. The system appears to be working correctly and contained 18 days worth of footage that could be reviewed.

The agency maintains a policy related to supervision which states staff will observe youth at least every 15 minutes when the youth is in the sleeping room. During a review of bed checks, it was determined the youth can go to bed as early as 8 PM at night when they are new to the shelter. However, the current bed check sheet being utilized by the agency does not start documentation of checks until 11:15 PM. The agency staff reported they have not been documenting checks from 8 PM to 11:15 PM or after 7 AM, as the sheet being used includes space to document between 11:15 PM through 7 AM.

Video was reviewed for two separate nights, 4/5/15-4/6/15 and 4/11/15-4/12/15. During the review of the time period of 1 AM to 2:30 AM on 4/6/15, it was determined the 1 AM check was completed late (1:08 AM), the check completed at 1:28 AM was notated to have been completed by staff AM but was completed by staff SM, the check completed at 2:12 AM was notated to have been completed by staff AM but was completed by staff SM, the check completed at 2:28 AM was notated to have been completed by staff AM but was completed by staff SM. It was also noted that the bed check form used by the agency has prepopulated times every 15 minutes and prepopulated times that it took to complete the checks. Per the Standard, the bed checks and documentation are to be completed in real time.

The review of bed checks completed on the shift of 4/11/15-4/12/15 determined bed checks were not completed at 1:30 AM, 1:45 AM, 2 AM or at 2:15 AM. There were bed checks completed at 2:24 AM, 2:32 AM, 2:47 AM and 3:02. The form used by the agency employees documented that bed checks were completed at 1:30 AM, 1:45 AM, 2 AM, 2:15 AM, 2:30 AM, 2:45 AM and 3 AM. After review of the video footage, the agency contacted the CCC and made a report related to the discovery of the falsification of the bed checks.

### 3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure to address staff secure youth. The policy addresses the orientation procedures, assessment and service planning, enhanced supervision and security, parental involvement, and collaborative aftercare. One applicable file was available for review. A review of the court order and supporting documentation found this youth met the eligibility criteria. The documentation in the file validated the program completed an orientation with the youth and parent on the day of admission. The counselor completed a needs assessment five days after the admission, which was two days after the seventy-two hour requirement. The file also contained a plan of services which was created and signed by the counselor and youth ten days after their admission, which was three days after the seven day requirement. The program provided staff secure supervision logs which designated the staff responsible for providing enhanced supervision on each shift. The documentation reflected only one staff member completing the log each day. This resulted in multiple shifts with no staff member being designated to be responsible for the youth. This information was also not found in the daily shift notes as required. The reviewed documentation found the program was involving the parent, when applicable. Program policy 3.07 for staff secure shelter states they will maintain a minimum staffing ration of one staff to six youth, day and night; however, a review of bed check logs during this youth's stay found five nights when only one staff member worked the overnight shift with more than six youth present. This youth has not been discharged so no documentation is available for review regarding any collaborative aftercare practice; however, this is addressed in the program's policy and procedure.

Four files were reviewed for Special Populations-Domestic Violence Respite. All four files had evidence of the youth being arrested for Domestic Violence and the agency submitting the documentation to The Florida Network of Youth and Family Services for approval for the Domestic Violence Respite. Three of the youth had treatment goals developed during their respite at the shelter and the goals were related to family

conflict issues.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The Family Resources agency provides screening, counseling and mental health assessment services. The Residential Director is a Licensed Mental Health Counselor (LMHC) and one Safe Place 2B Counselor is also a LMHC. The Family Resources agency has staff members that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The agency also uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter. The Family Resources agency assists in the delivery of medication to all youth admitted to the residential youth shelter. The agency operates a detailed medication distribution system. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury. The agency has a full complement of staff of both male and female staff members across all three work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training.

### 4.01 Healthcare Admission Screening

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has a comprehensive policy and procedure addressing the requirements in both the indicator and the Florida Network policy and procedure. A total of five open files were reviewed for this indicator. Upon intake the agency utilizes the CINS/FINS Intake form as its health screening instrument and a "Client Description Sheet" to describe any observations of scars, tattoos, or markings along with the youth picture and demographics. This was completed in all five files on the date of intake. None of the files reviewed documented any medical issues during the health screening process. None of the files required any follow-up medical care; however, the agency has procedures in place if it is needed.

### 4.02 Suicide Prevention

Satisfactory                       Limited                       Failed

#### Rating Narrative

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

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

There were three files reviewed for youth placed on suicide precautions. All three youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. All three youth were immediately placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. All three files documented the assessment was completed within twenty-four hours by a Licensed Mental Health Counselor (LMHC). All three youth were placed on standard supervision. There were thirty minute observations maintained the entire time the youth were on sight and sound supervision.

There was no documentation in the logbook of youth on suicide precautions or changes in supervision levels.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy for medications. The policy was last reviewed by the agency's Chief Operating Officer in September 2013. The policy has detailed procedures for storage of medication, inventory and verification of medication, delivery or assisting in self-administration of medication, over-the-counter medications, disposal of medications and incident reporting relating to medication errors. This policy covers the requirements for medication distribution in accordance with the DJJ Health Services Manual.

All staff employed at the shelter are trained to assist in the delivery of medication and have access to medication.

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

Controlled medications are locked in a cabinet behind two locks. The shelter maintains a legal-sized Medication Distribution Binder. The shelter does not distribute over-the-counter medication unless they are permitted by the parent/guardian. In addition, no youth on prescribed medications are permitted to take OTC's unless verified and approved to be taken with these medications by a pharmacist.

The shelter had six sharps in a box in a locked cabinet inaccessible to the youth. The sharps were, six pairs of scissors and no razors. The shelter usually has a supply of razors; however, at the time of the review they were out. All sharps were inventoried each shift for the last six months.

At the time of the on-site review there three CINS/FINS youth on medications. These three files were reviewed to verify the medication administration process. In two of the files the Medication Verification Form was completed, with documentation of consultation with a pharmacist, for all medications administered. The third file documented the form was completed with the parent; however, did not document verification with a pharmacist. A Medication Distribution Log (MDL) was maintained for each medication that listed the youth's name, date of birth, allergies, staff initials on the MDL, youth initials on the MDL, full name and signature of each staff member administering medication, and the full name and signature of youth receiving the medication. One file contained the pharmacy generated form with side effect information. One file did not document any side effect information for two of the three medications prescribed. The third file did not document any side effect information for either one of the medications the youth was taking. All medications in the three files reviewed were given as prescribed. All medications were inventoried each shift and initialed by two staff members. This was documented on all MDL's reviewed.

The shelter has had five incidents in the last six months, reported to the CCC, relating to medication errors. Of the five incidents, four of those were due to missed doses of medication. In two of the four incidents the pharmacist was contacted and reported there would be so harmful side effects in going ahead and giving the youth the medication. Both Youth received the medication; however, it was given late. In the other two case of the missed doses of medication the youth did not receive the medication at all. The last CCC report involved a youth receiving an incorrect dose of medication for three days. The youth was receiving ½ a pill and should have been receiving 1 ½ pills. The pharmacist was contacted in this case and reported there would be no harmful side effects and to resume giving the youth 1 ½ pills at the next scheduled time. There was documentation in three of the five above cases that the staff member(s) involved received some form of written reprimand or re-training. In one of the remaining two cases the staff resigned and in the last case there was no documentation at the time of the review of corrective action taken.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place for Medical and Mental Health Alert Process last reviewed and updated in October 2014. There is one alert board located in the dayroom for staff to review. The alert system consists of color-coded dots with each colored dot representing a different alert. There are six different colors used for alerts, green is a mental health or substance abuse alert, blue indicates the youth is on one-to-one

supervision, red indicates the youth is on sight and sound supervision, purple indicates the youth is on sharps restriction, black is a medical issue or allergy, and orange indicates the youth is on medication. The applicable color-coded dot is placed on youth's file for each alert the youth is on. The color-coded dot is also placed next to the youth's name on the alert board. Alerts are also documented on the Shift Exchange Information form and in the youth's initial shift summary note.

A total of five open files were reviewed for adherence to this indicator. All files reviewed had an alert that was appropriate to their screening and assessment results. All alerts documented in the youth's file corresponded with the alerts documented on the alert board. Two youth documented the youth was on medications and the alert was documented on the alert board; however, the applicable color-coded sticker was not placed on the outside cover of the youth's file. The applicable alerts were documented on the Shift Exchange Information form and on the youth's initial shift summary note. Any food allergies or dietary alerts are also documented in the kitchen.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a policy in place on Episodic/Emergency Care last reviewed in October 2014. The shelter maintains an Episodic Log, The shelter maintains an Episodic Log, which documents all instances of first aid care. There were three instances of off-site emergency medical care documented in the last six months. In all three instances the youth's parent/guardian was notified, as well as, the CCC. In all three cases the youth were transported by ambulance to the local hospital. All three cases were documented on an incident report and in the logbook. Information documented in the logbook was limited and only including the youth going and returning from the hospital. However, documentation on the youth's shift summary note from the applicable day included much more detailed information on the incident.

The shelter had fully stocked first aid kits, as well as, a knife for life and wire cutters easily accessible by staff. Staff training files documented staff were trained in emergency procedures, including first aid and CPR, with the exception of one staff whose first aid and CPR had expired March 30, 2015.