



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Clearwater

on 11/05/2013

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

- Ashley Davies, Lead Reviewer and Consultant, Forefront LLC
- Andrew Coble, Vice President of Prevention, Youth and Family Alternatives
- Jennifer Calame, Counseling Services Supervisor, Family Counseling Program
- Karen Mersinger, Quality Improvement Specialist, Sarasota YMCA



Quality Improvement Review

Family Resources-Clearwater - 11/05/2013

Lead Reviewer: Ashley Davies

Latrice Covington, Contract Manager, Office of Prevention and Victim Services

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input 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 type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 7 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 6 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 5 Youth | 6 Direct Care Staff | 4 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 checked="" 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 checked="" 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 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 agency is preparing to open a LGBT shelter for foster youth.

All staff have completed Trauma Informed Care training.

The shelter has been in a transition period over the last couple months prior to the Quality Improvement review. The position of the Case Manager had been vacant for a little over a month, until about two weeks prior to the Quality Improvement review when the position was filled. Also the Residential Supervisor was new to the position and started in September 2013. During the months of August and September 2013 the shelter was going through a transition with trying to hire a new Residential Supervisor and Case Manager, as a result various staff members had to perform different roles, in addition to their own, in order to provide the services of the Residential Supervisor and Case Manager positions.

The shelter recently received news the C.E.O. of the agency is retiring and a new C.E.O. is on board to begin mid January 2014.

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. The programs share the position of Vice President. Each location has a licensed clinician, Shelter Director, Residential and Non-Residential counselors, Residential staff members and Outreach staff. A centralized Human Resources and Fiscal departments handle all personnel and financial matters. Each sites' clinician reviews and oversees all counseling and mental health services provided to youth and families delivered at their respective location. The agency assigns the daily operation and direct responsibility of each shelter to the Residential Director at each youth shelter. All Family Resources residential shelters have implemented uniform operating protocols for all three service locations in the areas of operations and programming for both residential and non-residential services. Other uniform protocols for all 3 locations include training and professional development. The agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency 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 agency has a clear policy and procedure of background screening requirements that includes the Department of Juvenile Justice (DJJ) screening. Staff and volunteers must also receive an eligible rating prior to employment from local law enforcement. For this indicator, seven employee files were reviewed. All files have documentation that the employees were screened prior to employment. All files also have documentation of E-Verify screening, and two or all the following screenings; driver's license, local police department and/or sheriff's office. No exemptions were required because all employees were rated eligible. One staff required and received the five-year re-screen prior to the initial hire date. The Annual Affidavit of Compliance with Good Moral Character Standards was completed and submitted to the DJJ prior to January 31st.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The agency has a concise policy and procedure in place that prohibits the use of physical abuse, profanity, threats, or intimidation and the reporting requirements if staff know, or has reasonable cause to suspect that a youth is abused, abandoned, or neglected, which was confirmed by staff surveys. Staff surveys also documented they have not witnessed any type of abuse by other staff. There have been five staff disciplinary actions within the last six months. Two were Notices of Disciplinary Action/Written Reprimand, two were Memorandums of Understanding, and one was a Counseling Memorandum. The concerns addressed were violation of policy or work rule, unsatisfactory performance, medication errors, and work schedule. The Department of Juvenile Justice Central Communications Center incidents for the past six months did not report abuse. The youth surveys document they feel safe and there has not been a need to call the abuse hotline. The abuse hotline number and youth rights are posted in the shelter. There is a grievance box located in the common area of the shelter that is accessible to the youth. There were fourteen grievances since September 2013 and none prior. Staff notes on the grievance forms do not provide information about the outcome. Some forms have the youth signature as being adequately handled by Family Resources, Inc. prior to Supervisor/Director Signature and staff notes. Therefore, it appears there is no follow-up with the youth. No graffiti was found inside or outside the facility.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has an Incident Reporting Policy that addresses incident reporting requirements. The agency's policy addresses all major requirements of the Florida Network of Youth and Family Services and the DJJ Central Communication Center (CCC) policies. The current policy was last reviewed and approved by the agency's Chief Operating Officer (COO) in September 2013. The agency's policy specifies that the shelter notifies the CCC within two hours of the incident, or within two hours of becoming aware of the incident. All reports to the CCC for the last six months were reported within the required two hour time frame.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There are policies and procedures in place for first year and ongoing training requirements that align with this indicator. The agency's training requirement for first year staff is eighty hours and forty hours for ongoing staff. A total of six staff training files were reviewed for this indicator. Three first year training files were reviewed for this indicator. One of the three first year staff has completed the first year and the other two are still within their first year. The staff completing the first year has eighty five and one half training hours and completed all required training's. One first year staff has sixty four and one half training hours, has completed all the required training's, and is on track to meet the required hours. The other staff training file has documentation of some of the required training and number of hours completed to date is not known. All three first year staff has documentation of Prison Rape Elimination Act (PREA) training. For ongoing training hours, three staff training files were reviewed; two residential and one non-residential. All ongoing training files document forty or more training hours. One residential training file has documentation of all the required training except Fire Safety Equipment. Another residential training file has documentation of all training except Fire Safety Equipment and Signs/Symptoms of Mental Health and Substance Abuse. There are individual training files maintained on each employee. The agency has an annual training plan. Of the six files reviewed, five have an annual employee training hours tracking form by initial hire date and certificates. Sign-in sheets and agendas for training's attended are kept in a separate binder.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place that outlines the process and reports that will be reviewed. There are several steps, teams, and forms used for this indicator. Each monthly every program within the agency provides the Quality Improvement person with a report that tells at a minimum the number of clients served, the length of stay, and grievances. The safety team conducts facility inspections and provides a monthly report. The residential facilities receive formal inspections twice a year and other buildings annually. There is a Quality Improvement council that meets quarterly to review the monthly data to determine any trends. The council also utilizes the Florida Network Contract Benchmark Report. The Agency conducts peer reviews where staff from one program will audit another program. The reviewer completes a Peer Review Summary that checks files for legal forms in the file, assessment present, service plan present, goals specific, supervisory review, assessment/plan timely, case notes linked to plan, case notes timely, strengths, weaknesses, and corrective action needed. There is also a Risk Management Team made up of supervisors and managers that meet quarterly. The Team reviews reports from the safety team and quarterly incidents. The team also reviews the annual report to determine any trends or concerns. Staff meetings also provide staff an opportunity to review incidents and safety concerns.



Quality Improvement Review

Family Resources-Clearwater - 11/05/2013

Lead Reviewer: Ashley Davies

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, and is a Registered Mental Health Counselor Intern. Safe Place 2B Residential Shelter has a Residential Supervisor, 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

There were four residential and four non-residential files reviewed. The initial screening appeared to occur typically within twenty-four hours, above the standard of within seven calendar days. The intake packet includes rights and responsibilities of youth and parents/guardian, available service options, as well as informed consents. The intake packet also documents grievance procedures. These standards were met for all files.

One file reviewed did not document a green mental health/substance abuse alert even though information in the file indicated the youth had a history, and presenting mental health issues. The supervisor explained that youth had a psychiatric evaluation scheduled to determine the youth's mental health status. The substance use section of the intake form was not filled out in one file reviewed and the file did contain information that the youth had experimental history. The CINS/FINS intake form was not signed by the supervisor in two residential files and two non-residential files reviewed.

Two residential files and four non-residential files did not contain documentation that youth and parent/guardians were informed of possible actions through involvement with CINS/FINS services. The residential files had a Voluntary Placement Agreement that documents the CINS/FINS brochure is provided to the parent. For non-residential, there is a reference guide given to parents that notes truant cases may not be able to voluntarily withdraw from services due to Florida State Statutes. This was provided to parents, but it does not meet the full standard of possible actions.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

There were four residential and four non-residential files reviewed. The psychosocial assessments were completed within the time frame for the all the residential and non-residential files. The assessments were completed by master's level staff and signed by the supervisor. The assessments contained the elements required by the Florida Network's Policy and Procedure Manual for CINS/FINS.

Even though one youth denied suicidal ideation, staff placed the youth on sight and sound supervision until he was evaluated by a Licensed Mental Health Counselor (LMHC) because he had jumped out of a car recently, resulting in hospitalization. A full suicide screening was conducted and the youth was taken off sight and sound. This demonstrated concern with safety, not just the requirements.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Four residential files were reviewed. Service plans identified needs and goals, type of service and location, person(s) responsible, target dates for completion, and date the plan was initiated. Service Plans were signed by all available parties. Two plans did not have parent signatures, but there was a reasonable explanation indicated in the file. The service plans did not identify frequency services were to be provided.

Four non-residential files were reviewed. Service plans identified needs and goals, specific services provided, frequency, location and provider, person(s) responsible, target dates, and date the plan was initiated. Service plan objectives were specific and measurable. One file documented the thirty day review was done by counselor only, because the family did not show. The sixty day review was late and the family did not show. The ninety day review was completed early with participation by the family. On another service plan, the parent signature was not documented, but there was a note that it was reviewed with the parent by phone. The thirty day review was done by the counselor and youth and the sixty day review was not documented. Another file did not document the service plan was signed by the parent, however; there was a note a copy was given to the step-mother for the father to sign and return. The thirty day review was done by counselor and youth.

Overall, there appeared to be effort to engage the parent in the service planning and documentation when the parent was not available to sign. The files contained a tracking form for the thirty, sixty, and ninety day reviews.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

There were four residential and four non-residential files reviewed. Each case was assigned a counselor to ensure delivery of services through direct provision or referral. The Referral for Services form appeared to be consistently used by residential and non-residential services to coordinate referrals as appropriate. Two files were closed and included a discharge summary. For the residential program, shift notes support involvement in activities like crafts and batting cages. Trauma Informed Care practice was demonstrated when a youth was allowed to eat at a later time. Another day, staff noted the youth had an upcoming birthday.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There were four residential files and four non-residential files reviewed. Case files reflected coordination between presenting problems, psychosocial assessments, service plans, case management, and follow up. Individual files appeared maintained and seemed to adhere to confidentiality laws. They were marked confidential and there was tracking form for release of information. Case notes were located in the files. The non-residential files have a place for the supervisor to track quarterly reviews. Services offered by the shelter included group, individual, and family counseling. Services offered by the non-residential program included individual and family counseling, and case management. One residential file contained Team Consultation Notes that provided supporting documentation of the on-going internal process, in addition to, the needs assessment and service plan review.

One residential file had identified a frequency of weekly family sessions on the service plan, however; only one session had been held in three weeks. There was no other sessions documented on the session log. The counselor explained that the father is homeless and this has been a barrier to family sessions. It is suggested that the frequency be revised if there are consistent barriers.

In each file, case notes support the goals developed in the service plan. The counselor used individualized techniques, such as youth interest in sports figures, to encourage progress.

There were minor inconsistencies such as a session marked as individual while noting that the youth and mother were present. A session log is used for tracking. One counseling session was not on the log.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

There were three youth files reviewed for the Case Staffing Committee (CSC) process. The youth were staffed and reviewed by the CSC. None resulted in an adjudication of CINS. The CSC binder was organized well. Documentation shows notification to the family and committee. Committee members sign a confidentiality agreement. The CSC committee has included the State Attorney's Office, SEDNET provider, law enforcement, and substance abuse representative. The recommendations are sent to the family with letters dated the same day as the CSC, which is above the standard of within seven working days.

Service plans were written prior to the case staffing committee to address the areas of need. It is suggested that the program consider clearer documentation of a review of the plan as a result of the case staffing committee. The supervisor pointed out that the areas to be addressed typically do not change.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency maintains a comprehensive policy and procedure on youth records to include proper storage and handling of both active and closed files.

A total of fifteen youth files both open and closed were observed throughout the review. All were clearly marked confidential. In addition, the files were maintained in a neat fashion and information was easily retrieved. The agency maintains files on site in a locking cabinet in a secure room in the residential portion of the building.

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 Supervisor, Shelter Counselor, a Case Manager, a Truancy Case Manager, a CINS Case Manager, nine Youth Care Workers, an Intern Counselor, and a Secretary. The position of the Cook was vacant. The position of the Case Manager had been vacant for a little over a month, until about two weeks prior to the Quality Improvement review when the position was filled. Also the Residential Supervisor was new to the position and started in September 2013. During the months of August and September 2013 the shelter was going through a transition with trying to hire a new Residential Supervisor and Case Manager, as a result various staff members had to perform different roles, in addition to their own, in order to provide the services of the Residential Supervisor and Case Manager positions.

The Residential Supervisor 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 program has a well documented policy on shelter environment that complies with the Department of Juvenile Justice indicator 3.01. A tour of the shelter and the grounds showed the grounds to be well landscaped and maintained. Shelter Staff pointed out the water shut off out front for emergencies. A thirteen camera video surveillance system is in place and functioning. There are four bedrooms with three beds to a room. Each youth has an assigned bed with clean covered mattress, pillow, linens and comforter. Each bedroom has a sink and bathroom with shower. All areas of the room and bathroom were clean and functioning. All areas of the shelter were free from graffiti, provided adequate lighting and all furniture was in good condition. Personal belongings of youth are kept in a locked area. Shift exchange sheets and shift notes provide documentation of structured activities and recreation provided for residents. There is also a basketball court, pull up bars and fooseball table in the back yard of the Shelter. A daily schedule is posted in the common room. Shelter residents have free passes to Lowry Park Zoo, the Florida Aquarium and bowling nearby due to community partners. Residents do their homework at a table in the common room. There are books available for youth to read. There is evidence in the communication log of youth attending church. All chemicals are secured behind a locked door. Material Safety Data Sheets are available for all products located in the Shelter. All kitchen utensils in the Sharps category are kept behind two locked doors in the kitchen area. All health, fire and safety inspections are current. During my tour I was informed that the Clearwater Fire Department recently came to the Shelter to familiarize the department of the layout, fire extinguisher placement and other critical information that would be essential if the Shelter had a fire.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

This program has a well-defined policy for program orientation that is in compliance with indicator 3.02. Upon arrival at the shelter, a comprehensive orientation takes place. Youth and staff initial a form after all information is received. Several forms are in place with youth and parent signature acknowledging that they understand what is expected of them while the youth is at the shelter.

A total of ten residential files were reviewed, five open and five closed. Of the ten files reviewed, eight met all the requirements of this indicator. Two closed files reviewed did not have the questions answered or not answered completely in the room assignment area and neither file had the room assignment or bed noted.

3.03 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

A comprehensive policy is in place that complies with indicator 3.03 for room assignment. During the intake, questions are asked which enable the staff to assign a room to the youth that ensures safety for the new resident as well as those already in the program.

A total of ten files were reviewed, five open and five closed. Of these, eight files had all required information. One closed file had no information in the Bed Assignment area on the screening. One other closed file had marks in different categories but other areas were left blank and did not have a bed assignment documented.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

The program has a policy for log book documentation that complies with indicator 3.04. There is consistent documentation of resident count and daily activity in the communication log. In addition, more detailed information of the shifts, alerts and resident information is written in the shift notes and shift exchange notes.

Direct care shift indicate they have read at least two shifts previous. The supervisor reads the log every Friday and puts advisories to staff and her signature.

There was one intake listed for a youth who later that day was listed as being taken off sight and sound in the communication log but it was not noted that the youth was put on sight and sound at intake. Two errors in the log book had a line through the incorrect information but were not initialed. All other errors were consistently and correctly documented.

Suggestions to make the communications log easier to read. Make sure date is at the top of every page. Include a list in the front of the log with staff name and signatures so it is easier to track. Also, include a code for the highlighted colors in the front of the book.

Rating Narrative

The program has a comprehensive policy in place that is in compliance with indicator 3.05. The Behavior Management System is designed to promote positive feedback and personal growth in a community setting. It consists of rewards, privileges, and consequences that allow the youth to participate in the request to gain levels according to the behaviors they wish to model. Staff are trained in this Behavior Management System and it is documented in their training files. Youth are given a handbook at orientation that explains the system. Supervisors monitor level requests, as well as, staff interaction and grievance forms to insure the system is being used properly. No "hands on" intervention is allowed at this program and there are no incident reports in the last six months documenting the need for physical intervention.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The program has a policy in place that is in compliance with indicator 3.06. Staffing ratios of one staff to six youth during awake hours and one staff to twelve youth during sleep times are adhered to in scheduling. Each shift has one male and one female scheduled.

The shelter has a thirteen camera video surveillance system which is well positioned in several areas and is functioning properly. The staff schedule is posted and available. Contact numbers for additional staff are kept in the front of the shift note binder.

Bed checks are completed and documented using an electronic scanner. Check are done at least every fifteen minutes while the youth are sleeping. Printouts of documentation were reviewed.

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

Th program has a policy in place that complies with indicator 3.07 regarding Special Populations. They shelter both Domestic Violence Respite youth and Staff Secure youth.

At present the Shelter has two Staff Secure youth. Both of these youth were accepted after meeting the legal requirements of F.S. 984 of being court ordered to the program. These records were reviewed. Both have been given in-depth orientations, assessments, and service planning appropriate to their circumstance. There is good documentation of parental and youth involvement in case plans and aftercare goals. Separate clipboards are kept at the staff desk in the shelter which document the one-on-one supervision with name of the staff assigned to the

individual youth and documentation of the youths location and movement. No request has been made for a written report for court proceedings regarding either of these youths' progress.

Three Domestic Violence Respite files were reviewed. All of these files are currently closed. A review of these files confirmed that all three have the required documentation of approval for Domestic Violence Respite, a pending Domestic Violence charge, and screening by a Jac/Detention Center with acknowledgement that they do not meet the criteria for secure detention.

The Case Plans for these three youth address goals focusing on aggression management, coping skills for the family, and other interventions being put into place to reduce or stop the recurrence of violence in the home. All other services provided to the youths while in this program are the same as other CINS/FINS youth requirements.

One of the files reviewed reflect the youth was at the Shelter for a period of 4 days.

One file had documentation that the youth was approved for seven days and then an additional seven days were requested and approved. The youth stayed after the fourteen day approval but it was documented on the front of the closed file that the youth was switched from Domestic Violence Respite to CINS after the fourteen days with dates for each listed.

The third file reviewed showed the youth was approved for seven days. After the approved time was completed, the youth was changed to CINS status. On the front of the closed file the dates for Domestic Violence Respite and CINS services were documented.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Family Resources agency provides screening, counseling and mental health assessment services. The Residential Supervisor 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 as noted in both the standard and the Florida Network policy and procedure. A total of five files were reviewed for this indicator, three open and two closed. Upon intake the agency utilizes the CINS/FINS Intake form as its health screening instrument. The screening is comprehensive and covers all areas noted in the standard. The agency utilizes a "Client Description Sheet" to describe any observations of scars, tattoos, or markings along with the client picture and demographics. Two of the files reviewed had no medical issues noted and the health assessment process was completed with them upon intake. One youth has asthma but did have an inhaler as documented. Three of the files reviewed had medical conditions noted but the process was completed and documented well. One youth was just released from the hospital after jumping out of a car but was being treated for open wounds on his shoulder and elbow as documented in the file. Another file did not have any current conditions noted but had a head injury noted beyond six months ago which was documented in the file with no current medical attention needed. All follow-up documentation was documented in the case notes.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a policy in place that is in accordance with the Florida Network Policy and Procedures in regards to suicide precautions and satisfies the requirements of the indicator.

The agency currently has three licensed staff to assist in the process of suicide precautions. The staff utilized are Jack Smith, LMHC, counselor; Kelly Carter-Feller, LMHC, the residential supervisor; and Nicole MacKnew, LCSW, Program Director and former supervisor at this site.

A total of six files were reviewed, one open and five closed. All six files contained a suicide risk screening during the intake process utilizing the first six questions on the CINS/FINS Intake Assessment form. Five of the six files have been confirmed as placing the youth on sight and sound verified by entries in the communication log as well as the documentation of a sight and sound sheet in the file. Of the five files containing a sight and sound sheet, all were documented according to standard within the allowable time frames. The agency uses thirty minute time frames when youth are sleeping and fifteen minute time frames during awake hours. Youth care staff signed off appropriately on the sight and sound forms and the licensed professional documented on the sight and sound as well as the log when a youth was removed from watch. All six files contained a Florida Network approved clinical assessment completed by either a licensed staff member or a staff member under the supervision of a licensed staff member.

One file contained documentation indicating that the youth had answered negatively to all suicide precaution questions upon intake, however, upon meeting with the counselor the following day, answered positively regarding past suicidal behaviors. The counselor then conducted a clinical assessment and determined to not place the youth on watch as noted through the documentation in the file.

The agency utilizes a safety contract form which details what a client would do should they start to feel like harming themselves. The form lists options for the youth in that scenario and also provides the contact information for the local mental health provider. The form is completed upon intake with the youth and was present in all of the files.

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. At the time of this review, there were no CINS/FINS youth that were on Controlled medication. 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 four sharps in a box in a locked cabinet inaccessible to the youth. The sharps were, two pairs of scissors and two razors. All four sharps were inventoried each shift for the last six months.

At the time of the on-site review there were no CINS/FINS youth on medications. A sample of three closed files was pulled to verify the medication administration process. All three files documented the Medication Verification Form was completed for all medications administered. A Medication Distribution Log (MDL) was maintained for each medication that listed the youth's name, date of birth, allergies, medication side effects and/or precautions, 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. All medications in the three closed files reviewed were given as prescribed.

The shelter has had six incidents in the last six months, reported to the CCC, relating to medication errors. Of the six incidents, four of those were due to missed being discharged and sent home with another youth's medication. The medication was returned to the shelter by the youth's mother; however, there were doses of medication, one was due to the youth receiving a medication at the incorrect time, and the last and most recent incident was due to a youth two pills missing when it was returned.

The program provided a Memorandum of Understanding/Counseling Memorandum completed on two staff for two of the aforementioned incidents. One of the memorandums also documented the staff reviewed the training video on medication developed by Christine Gurk, the Nurse Consultant with DJJ Office of Health Services. Documentation contained in the CCC reports confirmed counseling and retraining was completed with staff in three of the remaining four incidents regarding medication errors. The CCC confirmed copies of the counseling/reprimand and documentation of retraining was received and attached to the CCC report. For the final and most recent incident the Shelter Manager provided a copy of the incident report which documented verbal counseling with the staff member involved.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy and procedure to address the requirements of a medical and mental health alert process. The procedures also detail steps for staff to follow in the event of an emergency medical or mental health event.

The shelter uses a color sticker system with the following breakdown:

Green: Mental Health and Substance Abuse

Blue: One to One Supervision

Red: Sight and Sound

Purple: Sharps Restriction

Black: Medical Issues and Allergies

Orange: Medications

Five open files were reviewed for any medical/mental health alerts. Three of the files contained stickers on the outside of the file making the information easily accessible to all staff. Two of the youth did not have any need for an alert sticker. In addition, the stickers are also placed on the census board in the great room and were consistent with what was on the file. Staff that were interviewed confirmed the steps of this process and also noted that the alerts are shared with staff through the shift notes log. Sharps restrictions and sight and sounds are shared in the communication log. Food allergies are posted on a log located on a clipboard in the kitchen, one youth currently at the shelter reported food allergies at intake and it was noted accurately on

this log.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a comprehensive policy and procedure that includes instructions for staff to follow should the need for emergency care arise along with obtaining local emergency care. The procedures also contain instructions to notify parents/guardians in case of an emergency and the process for reviewing all emergency incidents.

Within the time frame of the review the shelter has had no incidents of episodic care. The shelter does maintain a binder for episodic care documentation.

A sampling of four staff files showed that staff are receiving training on emergency medical procedures during their orientation. The form is entitled "On The Job Training" and under the category of Crisis Management staff are trained on "Medical Emergencies".