



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

Review of Family Resources-Clearwater

on 12/02/2015

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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

### Standard 2: Intervention and Case Management

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

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

### Standard 3: Shelter Care

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

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

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

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

### Rating Definitions

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

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

### Review Team

#### Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Rodney Dailey, Senior Children Service's Counselor, Orange County Youth and Family Services

Teresa Clove, Executive Director, Thaise Educational and Exposure Tours

Cheri Pettitt, CEO, Arnette House



**Quality Improvement Review**

Family Resources-Clearwater - 12/02/2015

Lead Reviewer: Ashley Davies

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**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers          | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor                 | 1 Clinical Staff         | 2 Program Supervisors   |
| <input checked="" 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 | 4 MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 3 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                | 4 Youth Records (Closed)                                       |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 4 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**

- 5 Youth                      5 Direct Care Staff                      0 Other

**Observations During Review**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Intake                               | <input checked="" type="checkbox"/> Posting of Abuse Hotline         | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities        | <input 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"/> Discharge                                   | <input type="checkbox"/> Group                                 |
| <input type="checkbox"/> Security Video Tapes                 | <input type="checkbox"/> Treatment Team Meetings                     | <input type="checkbox"/> Meals                                 |
| <input checked="" type="checkbox"/> Medical Clinic            | <input checked="" type="checkbox"/> Social Skill Modeling by Staff   | <input type="checkbox"/> Youth Movement and Counts             |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth    |  |

**Comments**

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

[Rating Narrative](#)

## Strengths and Innovative Approaches

### Rating Narrative

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

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

In June 2015, the new Residential Supervisor began at the shelter.

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

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

The first nurse was hired and started working at the shelter in September 2015.

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

In October 2015, YDS staff were provided a three hour curriculum called Positive Youth Development 101, which is based on Motivational Interviewing and Trauma Informed Care. Curricula was developed by two DJJ Master MI Trainers and delivered in person covering three different sessions to allow for all to participate. Positive Youth Development 201 is scheduled for delivery early February 2016.

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

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

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

In November 2015, the Program Director resigned. The position was vacant at the time of the review. The licensed shelter counselor provides clinical supervision and the Residential Supervisor provides administrative supervision with the COO.

In November 2015, the Truancy Case Manager position that was housed in St. Pete was moved to Clearwater and changed to a Master's Degree counseling position to perform functions of family counseling, case management, and share in the Case Staffing coordination with the St. Pete position.

## Standard 1: Management Accountability

### Overview

#### Narrative

Family Resources, Inc. – North youth shelter, named SafePlace2B, 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 SafePlace2B, 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 department handles 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 the 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

There were three staff members hired since the last on-site review. All three employee files were reviewed to ensure a background screening was completed prior to the employee being hired. All three staff had an eligible background screening completed prior to their hire date. There were no staff requiring a 5-year re-screening during this review period.

The Annual Affidavit of Compliance was completed and submitted on January 5, 2015.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

Florida Abuse Hotline information was posted in the facility for youth to easily access the information.

The agency has a comprehensive policy that addresses each of the elements of the indicator regarding Abuse Free Environment.

The agency also has a comprehensive policy that addresses their Grievance Procedures. The Youth Handbook provides information on the Grievance Procedure, however it may need to be updated as the process is written differently than explained by staff (ie: currently completed grievance forms are to be inserted in a locked box on the wall in the shelter and in the handbook it is stated that the youth should give the form to a staff member or put it in an envelope and slide it under the Residential Supervisors door).

The Grievance forms reviewed had the client's grievance and the staff's comments, however; they did not have any information on the client's satisfaction with the resolution. All forms were addressed within the required time-frame.

Two grievances did not fully address the grievance. One grievance stated that a staff member poured bleach on the client's toothbrush and the staff notes did not address the accuracy of the statement—only that the client could have a new toothbrush. Another grievance was that a staff member was yelling and disrespectful which is a "trigger" for the client. The staff notes state that "triggers" were processed with the client.

All five staff surveyed knew the procedures to allow a youth to call the abuse hotline. All staff also reported they have never heard another staff member deny a youth access to the abuse hotline. All five staff also reported they have never heard a co-worker use inappropriate language when speaking with the youth or use threats, humiliation, or intimidation.

All five youth surveyed reported they know about the abuse hotline but have never called. All five youth reported they have not been denied access to call the abuse hotline if wanted. All the youth surveyed reported staff are respectful when speaking with the youth and they have not heard staff use inappropriate language when speaking with the youth. All five youth reported they feel safe in the shelter.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a comprehensive policy and procedure for CCC incident reporting that addresses the time-frame for reporting, however the policy does not address the process for follow-up communication.

In practice, the agency's CCC reporting and documentation were exceptional. All time-frames were met and follow-up was thorough. The appropriate staff and supervisors were notified and signed the documentation.

### 1.04 Training Requirements

Satisfactory  Limited  Failed

#### Rating Narrative

There were two employee files reviewed for first year training requirements. One of the two staff have completed their first year training period and documented 78.25 hours. All required trainings were completed. The second staff documented 42.75 hours so far for first year training; however, still had seven months left in the training cycle to receive the additional hours.

There were three staff training files reviewed for annual training requirements following their first year of employment. All three staff documented the required number of training hours completed with 44, 53, and 40 hours respectively. All required trainings, as well as, additional trainings were covered.

### 1.05 Analyzing and Reporting Information

Satisfactory  Limited  Failed

#### Rating Narrative

The agency has policy and procedures that addresses their review process. In addition to specified reviews required by this indicator, the agency also conducts quarterly mock QI reviews. Highlights of all reviews are reported in the agency internal newsletter and intranet. Documentation of outcome data review is well organized and comprehensive. It appears that the agency focuses on system and process improvement.

There was evidence of all required reviews with the exception of the quarterly review of medication management practice via Knowledge Portal or Pyxis Med-Station Reports as the agency has not utilized the system long enough (due to training issues) to produce data.

### 1.06 Client Transportation

Satisfactory  Limited  Failed

#### Rating Narrative

The agency's policy and procedures regarding Transportation specifically details how clients are to be transported with an additional passenger and when there is only one staff and one youth in the vehicle. The van log lists approved drivers of the agency vehicles. According to policy and procedure reviewed 10/15 the van logs will include approximate mileage and anticipated time of arrival, however the logs with this information were implemented during the review.

Five trips in the van log were compared with the log book—two were neither logged out nor logged in and two were logged out but not in. However, one of those called when child was dropped at the destination and one was logged out, called at drop off, and logged in. No documentation was found that the agency's supervisor or managerial personnel considers the clients' history, evaluation, and recent behavior before transport. Copies were received of all staff driver's licenses who transport youth.

### 1.07 Outreach Services

Satisfactory  Limited  Failed

#### Rating Narrative

The agency developed a policy and procedure for outreach which encompasses the elements of the indicator.

The agency has an extensive network of agencies they have agreements with to provide services for Family Resources youth. The agreements were all current and up-to-date. There is documentation that agency representatives attend Circuit 6 DJJ Coordinators Meetings and Advisory Board Meetings, as well as, other community meetings appropriate to the mission of the agency.

## 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 the SafePlace2B – Clearwater shelter. This position was vacant at the time of the review. There are two non-residential counselors and one licensed residential counselor. 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 to the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by Family Resources with shelter 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 gather together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist and resolve issues faced by the youth and their family.

### 2.01 Screening and Intake

Satisfactory                       Limited                       Failed

#### Rating Narrative

Family Resources has a written policy in place for Screening and Intake. Four non-residential and four residential case files were reviewed. The youth and parent received and signed all required forms for the screening and intake process which pertained to the available service options, rights and responsibilities of the youth and guardian, grievance procedure and the possible actions involved with the CINS/FINS services.

One case was not screened within seven days of the referral and there was no documentation in the file indicating any attempts were made. After speaking with the counselor, she indicated that she had spoken with the father within the seven day period, but that he was interested in waiting closer to the client's court date before scheduling an appointment to open the case. Unfortunately, this was not documented in the case file.

### 2.02 Needs Assessment

Satisfactory                       Limited                       Failed

#### Rating Narrative

Family Resources has a written policy in place for the Needs Assessment. Four non-residential and four residential case files were reviewed. Every file met all the required documentation. The Needs Assessments were implemented face to face within 2 to 3 days after the initial intake for the non-residential and the residential Needs Assessments were completed within 72 hours of admission. They were completed and signed by a Masters level counselor and reviewed by a supervisor.

There were two non-residential and two residential youth who had elevated suicide risks and were given an additional screening by a licensed mental health counselor. One of the youth from the non-residential program did not require additional services but the other youth agreed to and signed a safety plan and was monitored closely.

### 2.03 Case/Service Plan

Satisfactory                       Limited                       Failed

#### Rating Narrative

Family Resources has a written policy in place for the Case/Service Plan. Four non-residential and four residential case files were reviewed. The eight Case/Service Plans were developed based on the information gathered during the Needs Assessment, Screening and Intake. Each Case/Service Plan had several goals; date that the plan was implemented; addresses the frequency, location, person responsible, and target date of completion; actual date of completion if complete; and signatures of the child, parent, counselor and supervisor.

One residential file did not have the parent signature on the Case/Service Plan. The Residential Supervisor and Counselor advised that the parent was not involved with the child's service plan due to receiving counseling services through the Non-Residential Program. The standard states that the client, parent, counselor and supervisor are to sign the Case/Service Plan. Best practice would be to follow the standard and require the client, parent, counselor, and supervisor to sign it.

The Case/Service Plans were reviewed every 30, 60 and 90 days as required when applicable. Some of the clients were discharged before the Case/Service Plan reviews were due to be completed.

One Case/Service was not developed within the seven working day period following the completion of the Need Assessment, but was three days late. There was no justification given by the counselor or no documentation in the case file as to the reason for not completing the Service Plan in the allotted time-frame.



## 2.04 Case Management and Service Delivery

Satisfactory  Limited  Failed

### Rating Narrative

Family Resources has a written policy in place for Case Management and Service Delivery. Four non-residential and four residential case files were reviewed. There were no issues to address on this indicator. All guidelines were being followed. A counselor was assigned to each client and ensured that services were delivered to the client and parent.

Outside referrals were made as needed and case termination and follow-up services were being completed.

## 2.05 Counseling Services

Satisfactory  Limited  Failed

### Rating Narrative

Family Resources has a written policy in place for Counseling Services. Four non-residential and four residential case files were reviewed. There were no issues to address on this indicator. All guidelines were met. The client and parent were receiving counseling services through the residential or through the non-residential program. One family was receiving counseling through both programs. The client was being seen by a counselor at the Shelter while the parent was receiving counseling through the non-residential program. The counseling services reflect the needs that were addressed in the Needs Assessment and Case/Service Plan.

Each case file was individualized, adhered to the confidentiality policy, progress notes were in chronological order and the clinical supervisor reviewed and signed the case files as required.

## 2.06 Adjudication/Petition Process

Satisfactory  Limited  Failed

### Rating Narrative

The agency has a policy and procedure that addresses each element of this indicator including required time-frames for each step in the adjudication/petition process. The agency had only one case staffing case that began in December 2014. There is a new Case Manager handling this case. It is apparent that the family/youth is receiving quality services and that the new Case Manager is completing all paperwork required by the court. The documentation is confusing and some not available that shows that the parent has been notified within required time-frame of Case Staffings. The committee members were notified no less than five days from the last Case Staffing. The committee has the required attendees plus some additional community services. A new Case Plan was developed and provided to parent.

## 2.07 Youth Records

Satisfactory  Limited  Failed

### Rating Narrative

Family Resources has a written policy in place for the Youth Records. Four non-residential and four residential case files were reviewed. There were no issues to address on this indicator. All guidelines were met. All files were marked confidential, neat, and orderly. The agency has purchased a portable opaque file container that has the capability to lock. It is used to transport the files to other locations as needed. The youth files are accessible only to the program staff as reported by the CEO, Shelter Supervisor, and Counselors.

## 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 SafePlace2B 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, twelve Youth Development Specialists, a Cook, and an Executive Assistant. The position of Program Director had been vacant for approximately one month prior to the review.

The Residential Supervisor oversees the day-to-day operations of the youth shelter. The residential program's Counselor is an 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 many family services offered by Family Resources.

### 3.01 Shelter Environment

Satisfactory  Limited  Failed

#### Rating Narrative

The Facility appears to be very clean and well-kept needing very little repair, both inside and out. The Program has annual inspections in place for Fire, Department of Health Group Care and the Child Care Food Program. All Inspections are current and up-to-date. The Facility also provided monthly fire drills in addition to quarterly emergency drills. However, all of the emergency drills only consisted of tornado drills.

Since August of 2015, there has been a total of sixteen combined fire and emergency drills. The majority of the drills (nine) were completed on the morning shifts, three on the evening shift, and four on the night shift.

The Facility appears very secure with limited access both in and out controlled by the program staff. Each staff member has ID badges in conjunction with their keys that maintain the safety and security of the program. In addition, the program is equipped with a security camera system within the residential portion of the facility which monitors daily routines and activities of the youth and staff.

The program has a detailed color coded daily schedule for the youth which consist of recreational, social, and educational activities, as well as, faith-based activities.

### 3.02 Program Orientation

Satisfactory  Limited  Failed

#### Rating Narrative

The Program has policy and procedures in place regarding youth being oriented into the program. All four files reviewed contained a thorough orientation to the program in which all youth and staff sign off on upon completion. All four of the files had the orientation completed on the same day they entered the program.

The orientation check list consists of all the required elements.

Based on the review of the files it appears that the youth and staff are very familiar with program rules and expectations.

### 3.03 Youth Room Assignment

Satisfactory  Limited  Failed

#### Rating Narrative

A review of four youth files revealed that the program has a policy and practice in place regarding room assignments. Each youth is assigned his or her room based on several different factors including but not limited to: age, gender, criminal history, mental health history, violent history, sexual aggression, disabilities, and suicide risk. All four files contained the required documents pertaining to youth room assignment.

Even though the youth have roommates, there is ample space within their assigned rooms for comfort, privacy, and security.

### 3.04 Log Books

Satisfactory  Limited  Failed

#### Rating Narrative

The program has a log book in place to track dates, times, and events that occur within the facility. Important events are also highlighted with different colors. The QI Indicator indicates that all

documentation should be legible and the person documenting should sign his or her name upon completing the entry. The Program Manager or designee is also required to document their review of the Log Book. While this is done on a consistent basis and according to the indicator, it was also recommended that directives and feedback be documented by the Program Manager as well.

In addition, it is difficult to determine who is documenting in the log book due to several different writing styles. A best practice for this particular issue may be for each staff member to print his or her name with a signature to follow in the front of the log book.

### 3.05 Behavior Management Strategies

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency developed a new Behavior Management System in July 2015. They have a policy and procedure for Behavior Management that details the programs commitment to a system that respects where the youth is at behaviorally and emotionally. The system is designed to motivate youth to make changes in their behavior and outlines the stages of change a youth is in.

The Youth Handbook specifically explains the Behavior Management System, the elements of the system, and each level a child can achieve. Each level has well-defined expectations and privileges. An information board in the shelter clearly identifies the level each youth is on and the date they achieved the level. The staff has a positive attitude about the new system and report that it has been successful so far.

### 3.06 Staffing and Youth Supervision

Satisfactory                       Limited                       Failed

#### Rating Narrative

The Program has policy, practice, and documentation in place for Staffing and Supervision. A review of staff schedules, log books, and client files revealed that the program maintains the appropriate staff to client ratio at all times on each shift. In addition, there is one staff member of each gender on each shift.

The Supervisor also has a hold over roster of staff members which has phone numbers in case overtime hours are needed. Staff schedules are posted in the residential area for the staff to view at all times.

The youth are monitored every fifteen minutes when in their rooms during sleep hours and are not allowed in their rooms without staff's permission during awake hours. In addition, the program has security cameras to monitor client movement.

### 3.07 Special Populations

Satisfactory                       Limited                       Failed

#### Rating Narrative

The Program has policy and practice in place pertaining to Special Population youth. During this review, there were no Staff Secure youth to be reviewed. However, there were three Domestic Violence youth files reviewed and all contained the necessary documentation according to the policy and indicator.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The Family Resources agency provides screening, counseling and mental health assessment services. The residential Counselor is a Licensed Mental Health Counselor (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. 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 and utilizes the Pyxis Med-Station 4000 Medication Cabinet. The agency provides medication distribution training, CPR, first aid, fire safety, emergency drills and exercises, and training on suicide prevention, observation and intervention techniques to all direct care staff members. 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.

### 4.01 Healthcare Admission Screening

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has a comprehensive policy and procedure on Healthcare Admission Screening addressing the requirements in both the indicator and the Florida Network policy and procedure manual which was last reviewed in October 2015. A total of four open files were reviewed for this indicator. Upon intake the agency utilizes the CINS/FINS Intake form as its health screening instrument and a "Youth Description Sheet" to describe any observations of scars, tattoos, or markings along with the youth picture and demographics. This was completed in all four 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 in October 2015. 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 four files reviewed for youth placed on suicide precautions. All four youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. One of the four youth were immediately placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. There was documentation in the remaining three files that the Assessment of Suicide Risk was completed immediately following intake by the Licensed Mental Health Counselor (LMHC) and the youth were placed on standard supervision. The remaining file documented the assessment was completed within twenty-four hours by the LMHC. The youth was placed on standard supervision and thirty-minute observations maintained the entire time the youth was on sight and sound supervision.

Documentation was found in the logbook pertaining to the youth on suicide precautions and also changes in supervision levels.

### 4.03 Medications

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has a policy in place for medication storage, access, and inventory. At the time of the review the policy was in the process of being updated to include the new Pyxis Med-Station 4000 Medication Cabinet.

The agency had fully implemented the Pyxis Med-Station 4000 Medication Cabinet two days prior to the on-site review. All youth medication is stored in the Medication Cabinet. After the youth's information is entered into the system, a bin within the Cabinet is assigned to the youth. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Two staff credentials are required to open the drawer with the controlled medications. Staff using the Medication Cabinet have to enter a password as well as their finger print to gain access. Each medication is stored in its own separate bin within the Medication Cabinet so topical medications are always stored separately. There

are two Super Users assigned for the Medication Cabinet. Staff that have access to the Cabinet have been delineated in writing and have been trained on its use.

The shelter has a system in place for refrigeration of medication if needed. There was no medication that required refrigeration during the time of review.

All medications in the shelter are inventoried three times per day (once on each shift) by two staff members. When an inventory is completed the staff will log into the system and choose which medication to inventory. When the medication is chosen the appropriate drawer and bin will pop open. Staff must then count the medication and enter the number into the computer system. If it is a controlled medication, a second staff member must also enter their initials and finger print to verify the count. If the count is inaccurate the Medication Cabinet will produce a discrepancy. The inventory must be completed and the amount must be entered into the computer system in order to close the bin the medication is in and close the drawer. If the count is not entered, the door on the bin will not close. These inventories are documented in the Medication Cabinet and also documented on the youth's Medication Distribution Log (MDL) in the shift-to-shift inventory section. All medications reviewed were inventoried as required.

Sharps are maintained in a box in a locked cabinet inaccessible to the youth. 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.

There were two youth currently in the shelter on medication. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Medication Cabinet system. The youths' Medication Distribution Logs (MDL) reviewed documented the youth's name, date of birth, any allergies, side effects of the medication, dosage, reason, method of administration, prescribing physician, and full signatures of youth and all staff. Each MDL documented when a medication was given, staff and youth initials, and perpetual inventory with running balance. A cover sheet was located for the youth that included a picture of the youth. All MDL's reviewed for both youth documented that all medication was given at prescribed times. Both files documented side effect information and other important information about the medication was printed out from Drugs.com.

The shelter has had three incidents in the last six months (reported to the CCC) relating to medication errors. Of the three incidents, one was due to a missed dose of medication. The pharmacist was contacted and reported there would be no harmful side effects and resume with normal dose at the next scheduled time. In another case, the youth received the wrong medication—he received his night time medication in the morning. The pharmacist was contacted and reported there would be no harmful side effects and could receive the rest of his medications as scheduled. The last CCC report involved a youth receiving an incorrect dose of medication. The youth was receiving two pills—one in the daytime and one at night time. Staff gave the youth both pills at the same time. The pharmacist was contacted in this case and reported there would be no harmful side effects and to resume giving the youth the correct dose the next scheduled time. There was documentation in the three cases of corrective action taking place.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory                       Limited                       Failed

##### Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process last reviewed and updated in October 2015. 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 eight different colors used for alerts—red indicates the youth is on constant sight and sound supervision, yellow is elevated support, green is a mental health alert, blue is substance abuse, purple is sharps restriction, black indicates a medical issue, orange indicates the youth is on medication, and pink indicates allergies and/or special diet. 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.

A total of four 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. 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 on episodic/emergency care that was last reviewed in October 2015.

All staff have current training in CPR/First Aid and the use of emergency equipment (knife-for-life, wire cutters, first aid kit). There are first aid kits located in the shelter and the vehicles. Also, there is a closet located in the dining room with bulk supplies of first aid items. The contents of all first aid kits are checked weekly by staff. The knife-for-life and wire cutters are located in a cabinet located behind the staff work area in the shelter. A seatbelt cutter is located on the keychain for the vehicles.

The shelter maintains an Episodic (First Aid/Emergency) Care Log. There have been five instances of episodic care (in which a youth had to be taken off-site to the hospital) over the past six months. All incidents documented required parties were notified, including the parent/guardian, Executive Director, Residential Director, and the CCC. An internal incident report was completed for all incidents, as well as, a CCC report if required. Follow-up instructions/care were also documented.

The shelter has completed three mock drills in the last six months—one was a broken arm, one was a burn, and another was an injury resulting from a fight.