Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Manatee

on 06/14/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: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/Petitiion 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	Limited
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

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

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, FNYFS/FOREFRONT LLC

Raymond Ballinger, Shelter Manager, Lutheran Services Florida (Southwest Oasis)

Raylene Coe, Program Coordinator, Crosswinds Youth Services

Vernon B Pryer Jr, Regional Monitor, Department of Juvenile Justice

Persons Interviewed

- [x] Chief Executive Officer
- [ ] Executive Director
- [x] Chief Operating Officer
- [ ] Chief Financial Officer
- [x] Program Director
- [x] Program Manager
- [ ] Program Coordinator
- [x] Direct- Care Full time
- [ ] Direct-Care Part Time
- [ ] Direct-Care On- Call
- [ ] Volunteer
- [ ] Intern
- [ ] Clinical Director
- [x] Counselor Licensed
- [ ] Counselor Non- Licensed
- [x] Case Manager
- [ ] Advocate
- [x] Human Resources
- [x] Nurse

2 Case Managers
1 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
1 Food Service Personnel

2 Clinical Staff
0 Other

Documents Reviewed

- [x] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [x] Logbooks
- [x] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [x] Contract Scope of Services
- [x] Egress Plans
- [x] Fire Inspection Report
- [ ] Exposure Control Plan
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [x] Key Control Log
- [x] Fire Drill Log
- [x] Medical and Mental Health Alerts
- [x] Table of Organization
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Telephone Logs
- [ ] Supplemental Contracts
- [x] Vehicle Inspection Reports
- [x] Visitation Logs
- [x] Youth Handbook

7 # Health Records
6 # MH/SA Records
8 # Personnel Records
0 # Training Records
7 # Youth Records (Closed)
6 # Youth Records (Open)
0 # Other

Surveys

3 Youth 6 Direct Care Staff

Observations During Review

- [x] Intake
- [x] Program Activities
- [x] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [x] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [x] Discharge
- [ ] Treatment Team Meetings
- [x] Youth Movement and Counts
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [x] Group
- [x] Meals

Comments

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

No CINS Petitions were conducted or available for review.

Strengths and Innovative Approaches

Rating Narrative

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

Families Resources had many accomplishments and growth this fiscal year, including:

-successful Council On Accreditation review in January 2017 granted them re-accreditation through 2020,

-obtained and maintaining 4 Star Charity Navigator rating as an agency,

-will be the recipient of funds raised by Pride, St. Pete to secure an LGBTQ street outreach liaison in Pinellas County,

-was the recipient of the Florida Network's 2017 "Agency of the Year" award,

-met 100% of deliverables (non-res cases & care days) by end of May. This was the first time in agency history for at least the past 8 years.,

-and transformed the Manatee shelter by replacing all of the shelter carpets with wood-look laminate; replacing the old wooden fence with vinyl two-tone PVC privacy fence; replacing the refrigerator and stove; purchased all new bedroom furnishings (beds, dressers, armoire, a new sofa and a new coffee table) and painted all 6 bedrooms in kid-friendly themes for a more trauma informed approach.

Standard 1: Management Accountability

Overview

Narrative

Family Resources, Inc. – Manatee youth shelter, called SafePlace2B, and non-residential programs are located in Bradenton, Florida. Family Resources, Inc. provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The Family Resources agency primarily provides CINS/FINS services in Manatee County and nearby surrounding counties. Family Resources also operates sister North and South youth shelters (also called SafePlace2B) that are located in Clearwater and St. Petersburg, Florida respectively. These agencies service youth and families in Pinellas and other surrounding counties. Each location has assigned or has access to a licensed clinician. 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 created new positions-- Senior Director of Residential Services, Senior Director of Community Services and Senior Director of Quality Assurance. All have been hired and have been in their positions for less than 3 months. The Family Resources Manatee program conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency trainings combine staff members of each location to be trained on various core training topics.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure which was approved and signed in March 2017. The approved policy addressed all required elements of its compliance to the Department's background screening process. Additionally, the agency completes an annual affidavit of compliance with Good Moral Character and submits to the Department by January 31 of each year on all staff who were actually working during the calendar year. Furthermore, in compliance with the Department's requirement all employees, interns, volunteers are to have a re-screening every five years after the date of the initial screening.

The agency's procedure requires all prospective employees, interns, volunteers to receive a clear background screening before any services are performed and agency offers the applicant a job. The policy also addresses 5-year rescreening in its Background Screening Process. Upon each employees, volunteers, mentors, and interns fifth year of employment a re-screening must be completed.

The provider had (11) eleven hires in twelve months. Review of each applicable personnel file found an eligible background screening rating was received prior to each employee being hired. Review of the provider's documentation found the Affidavit of Compliance with Level Two Screening Standards was submitted to Background Screening Unit on January 4, 2017, prior to the required deadline of January 30, 2017.

The provider's policy regarding its Background Screening Process also included the required five -year rescreening process. There were two staff applicable for a five-year background rescreening during the annual compliance review period. Both employees received their 5-year re-screening at least ten days prior their required due date.

There were no noted exceptions for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedure which was reviewed approved and signed in March 2017 by the President and CEO for Provision of an Abuse Free Environment. The policy ensures an environment is maintained in which youth, staff and others feel safe, secure and not threatened by any form of abuse or harassment. The policy states staff are required to adhere to a code of conduct that forbids staff from using physical abuse, profanity, threats or intimidation. Management will take immediate action to address incidents of physical and/or psychological; abuse, verbal intimidation, use of profanity, and/or excessive use of force.

The policy also addresses agency requirements to report all allegations and suspicious of abuse, neglect and exploitation immediately to the Department of Children and Families (DCF) as mandated by F.S Chapter 415, and F.S 39.201. Additionally, the policy states youth shall have immediate, unimpeded access to a telephone to self-report abuse at all times. The telephone number and procedures for making a call to the Florida Child Abuse Hotline shall be prominently posted in all facilities serving youth and families at all times. The policy states management will address all complaints/grievance documents.

The agency's procedure requires any and all persons who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other must report such knowledge or suspicion to the Florida Abuse Hotline. The programs grievance process allow youth to grieve staff and conditions or circumstances related to the violation or denial of basic rights. The code of conduct details the expectations for ethical and professional behavior including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety. The program will take immediate action to address incidents of physical and/or psychological; abuse, verbal intimidation, use of profanity, and/or excessive use of force.

The policy also addresses agency requirements to report all allegations and suspicious of abuse, neglect and exploitation immediately to the Department of Children and Families (DCF) as mandated by F.S Chapter 415, and F.S 39.201. Additionally, the policy states youth shall have immediate, unimpeded access to a telephone to self-report abuse at all times. The telephone number and procedures for making a call to the Florida Child Abuse Hotline shall be prominently posted in all facilities serving youth and families at all times. Management addresses all complaints/grievance documents.

Tour of the program found postings of the Florida Abuse Hotline and directions for youth, throughout the facility. In addition, the grievance box was observed throughout the facility. Review of the staff training records confirmed staff are trained on child abuse reporting techniques and the grievance process. A review of staff personnel file documented staff signed the code of conduct.

Random conversation with direct care staff on duty confirmed direct care workers don't handle the complaint/grievance document unless assistance requested by youth. All grievance is handled by the management staff. A review of the agency grievance log book found six grievances all submitted the same day for the same reason. All youth were grieving of not being able to lay down on the shelter sofa during school hours. All were addressed within forty-eight hours of submission and resolved by the residential supervisor during the required timeframe. The program maintains a three ring binder with an accurate record of all child abuse hot-line calls.

There were no noted exceptions for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedure which was reviewed, approved and signed in March 2017 by the President and CEO for reporting incidents to the Department's Central Communication Center (CCC) and the Florida Abuse Registry. It is also the policy of Family Resources, Inc to comply with the Department of Juvenile Justice Policy 8000 Central Communications Center on incident reporting.

The agency policy contains procedures which all direct staff who have direct knowledge of an incident that constitutes a risk to the organization or its clients must complete an incident report. Management in concert with the Department has identified a list of incidents and activities that must be reported due to the fact of the level of liability threat to the organization must be reported soon as possible to senior management. The Department's Central Communication Center policy clearly outlines certain events or incidents must be reported within two hours of knowledge of the incident and/or of the incident. The CCC has a list of reportable incidents which is kept with the policy for staff to review and use as a reference. The agency policy contains procedures which all direct staff be trained on reporting procedures upon hire.

Review of staff training files found documentation supporting agency staff were trained on the Departments of Children and Family and the Central Communication Center reporting requirements. Review of the (CCC) data base for the past six (6) months, found six events reportable incidents submitted to the CCC. One of six incidents found the CCC was notified within the required timeframe of two hours. Five of the six reported events were closed as information only. One event was closed with substantiated findings for failure to report on four staff. Management responded to the substantiated finding by disciplining the staff.

A review of the agency child abuse report log found documentation of seven alleged calls to the abuse registry. They were not all accepted. However, four were accepted. The report contains the name of child, address of the child and date of birth of child and a brief detail of the allegation. The report also identifies the name of the operator and whether the call was accepted or not. Further review of each allegation made confirmed there were no complaints against agency staff nor any abuse allegations made.

The program maintains a three ring binder for internal incident reports. A review of the of the aforementioned binder found six incident reports, each contained supervisor actions and comments. Further review of the binder found the agency tracks each incident by month.

There were no noted exceptions for this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Family Resources Inc. has a policy in place that addresses this indicator. All full time staff that work in direct and continuing contact with youth are required to have 80 hours of training in the first year of employment. Thereafter will require employees to maintain at least 40 hours of training annually.

The agency has designed the Individual Training Plan form that specifically outlines the required training areas to meet the standards set by the Department of Juvenile Justice for CINS/FINS providers.

Training during the first year of employment shall include the agency orientation, required mandatory, in-service and annual training. The agency first year training includes all the required Florida Network training and staff after the first year will receive ongoing required training of forty (40) hours. All training is based on the staff hire date.

During this review, a total of ten (10) files were reviewed--five (5) first year employees and five (5) ongoing training. The first year staff reviewed were four (4) direct care staff and one (1) case manager.

All four (4) direct care staff have met all required training within their first 120 days of employment. All have over 40 hours of training completed.

One (1) case manager training file was reviewed. The staff has over 30 hours of training.

Observed in the case manager file was is no completion of the CPR/First Aid (scheduled for June 27th), program orientation (scheduled for June 20th), managing aggressive behavior and cultural humility. However, the staff member is still within the 120 days of employment.

Reviewed five (5) ongoing training files. All staff have well over 40 hours of training.

One file indicated a staff member will need to complete the managing aggressive behavior and PREA before the end of their evaluation date.

The agency also has a training plan in place. There is an orientation agenda and a first year quick reference guide which outlines required training for the agency contracts.

Exception:

One of the five files reviewed the staff did not complete the CPR/First Aid training in the 120 days of employment. This staff is scheduled for training on June 27th.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency values the provision of quality services to youth and families. They believe that the decisions the organization makes in order to maintain and improve the quality of our services must be based upon input from consumers, staff and the community, as well as reliable data regarding their service population, community needs, the provision of their services, and the effectiveness of those services. That information is utilized not only in improving current services, but also in the development of the agency's Strategic Plan.

To ensure quality of services and a focus on performance and quality improvement (PQI), the agency has put into place a variety of processes that work together toward achieving those goals. These interface for program, management, and Board of Director level discussions and decision-making. The PQI processes are reviewed on an annual basis to ensure they maintain their effectiveness.

Each program in the agency composes a monthly report of relevant program data which is sent to the Chief Operating Officer by the 10th of the next month. The COO reviews these as well as the monthly NetMIS data reports.

Case record reviews are conducted quarterly in all programs in the first month following the end of a quarter. Peer review team members may not review their own program files. Reviewers utilize a standard form and aggregate the data for a summary report.

There is a policy and procedure in place. The agency reviews the trends, incidents, data reports, and etc. daily, weekly, monthly and quarterly.

Family Resources risk management/safety team which consists of the senior management staff, HR, QA meets quarterly to discuss incident reports trends, benchmarks, ways to improve overall, serving more DV and Respite population, review data for overall numbers, how to incorporate changes and move with the

trends, staffing and training needs. This information is disseminated to the staff by the supervisors via email, agency intranet or during monthly meetings. They also make sure to celebrate when the agency reach milestones.

The residential supervisors and senior director meets every 2 weeks to discuss and the COO and management team meets once a month to discuss the various data, overall trends and goals of the agency.

The data is kept on the agency intranet (FamilyNet).

Minutes of the meetings were provided along with the staff that were in attendance and topic discussed.

There were no exceptions noted for this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedure which was reviewed, approved and signed in March 2017 by the President and CEO regarding transporting youth to ensure safety and security.

The agency policy contains specific procedures for staff to follow any time a youth is transported. The procedures dictate the agency staff will communicate to staff by the end of the day via logbook entry or on the white board which youth are appropriate for single transport. Youth evaluations are utilized to determine approval for single transports. The transporting staff person will be required to call the shelter and remain on the phone with shelter staff during a transport of any youth that enters the shelters prior to the Residential Supervisor being on site to make the single transport determination.

A review of staff training files found evidence staff are trained in operating the agency vehicle. A review of agency supported information confirmed the agency reviews each staff driver's license annually. A review of the agency logbook date range March 2017-found multiple entries which confirmed the practice of staff calling the shelter when alone in a vehicle and maintaining an open line until either the transport has ended. The agency utilizes a transportation log which captures the following information:

- **Date**
- **Driver Initials**
- **Youth Initials**
- **Destination/purpose of travel**
- **Approximate mileage**
- **Number of Occupants**
- **Time leaving**
- **Starting Miles**
- **Anticipated time of arrival**
- **Actual time of arrival**
- **Ending miles**
- **Supervisory approval**

Further review of the transportation logbook date-range January 2017-present found the form not completed in its entirety. The supervisory approval section was completed five times in the six-month period reviewed.

Review of transportation log book found on two occasions during the midnight shift, staff transported one child and a review of the agency logbook did not contain evidence of approval from Supervisory staff as policy dictates.

Exceptions:

Transportation logbook date-range January 2017-present found the form not completed in its entirety.

On two occasions during the midnight shift, staff transported one child and a review of the agency logbook did not contain evidence of approval from Supervisory staff as policy dictates.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedure which was reviewed, approved and signed in March 2017 by the President and CEO regarding participation in local DJJ Board and Council meetings to ensure CINS/FINS services are represented in a coordinated approach to increasing public safety.

Family Resources, Inc staff attending the meetings will obtain copies of the minutes to the meetings and supply to agency leadership. Staff representing the agency will also provide verification of attendance at DJJ Board and Council meetings. Family Resources, Inc will provide support and accommodation for staff participating in assigned meetings.

A review of the agencies documentation found evidence of community presentations and outreach events from the last 12 months. There was documented evidence of the agency attending the local Juvenile Justice Advisory Board, and the Juvenile Justice Council. The agency maintained agendas and minutes for the last four quarters.

There were no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Family Resources program provides non-residential services through its Counseling staff located in Bradenton, Florida. Primary services delivered include Truancy, Marriage, and Family Counseling. Screenings are conducted by Youth Development Specialists and Counselors twenty-four hours a day, seven days a week. A case plan is developed for each client. In addition, home visits are conducted on a case by case basis to offer support to the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, family and individual counseling is offered by Family Resources with shelter care as a viable option for youth that need additional support services.

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

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program provided a series of policies to meet this indicator. These policies address screening and 24/7 centralized intake (2.01), as well as the grievance process (3.08); client visitation, correspondence and telephone calls (3.11); and parental notification [in the event of a youth's unplanned departure] (3.12).

The program's Eligibility Screening and Intake Assessment policy provides for centralized intake availability 24 hours a day/7 days a week and that an initial screening for eligibility must occur, preferably immediately, or within seven (7) calendar days from receipt of a referral. The program's policy establishes that a screener will conduct an initial screening upon first contact with a youth and family to determine if the program can best meet their needs and, if so, an appointment or intake is immediately arranged. External referrals are made when other service providers are better able to meet the needs identified by the screening. Notably, no reference is made in the program's Eligibility Screening and Intake Assessment policy regarding provision of crisis counseling and information, staff qualifications for the screening, or the required use of the NetMIS screening form as indicated by this Standard and the Florida Network of Youth and Family Services policy 2.00 (revised 3/5/10).

With respect to the Grievance Process, the program's policy provides that any client has the right to initiate and bring to the attention of staff any complaint, grievance, or actions (of staff or other youth), conditions or circumstances of care or treatment that are a violation of their rights and then details what the process "shall include", such as written documentation of the grievance signed by the youth, the youth's written acknowledgement of the program's response, final response to the youth concluding the issue grieved, a level process requiring 5 working day response at each level, and maintenance of all materials for a year.

The program has established a Visitation/Correspondence/Telephone Calls policy which provides that youth in the program's shelter are entitled to treatment and care that does not violate their rights as children in the State of Florida. The policy gives visitation and telephone call allowance to shelter youth based on those visitors agreed to be permitted upon admission; however, the policy indicates the program will pay for at least one call a week and that additional calls may occur as part of behavior management, but calls to family members will be encouraged. The program's policy states there is no limit on visits to

shelter youth by attorneys or legal representatives. The policy further indicates that materials for at least two letters will be provided to youth in the shelter to facilitate the sending and receiving of correspondence.

Finally, the program has established a Parental Notification policy that parents will be immediately notified if their child is in shelter or if their child leaves the shelter in an unplanned way and that no child will be released from the shelter to anyone other than the parent without written consent from the parent.

The reviewer notes that some of the language in the program's policies might more appropriately be viewed as 'procedures' with regard to screenings and the time lines for performance of tasks; the grievance process details; as well as who is allowed to visit shelter youth and the frequency and manner of those visits.

Overall, the program's written procedures conform to the Standard and Florida Network requirements. The written procedures stipulate that the extent of issues or crisis will be determined, stress and risk factors will be identified and eligibility information will be gathered. These written procedures also provide for the scheduling of family counseling within seven days for youth admitted into non-residential services and, for youth placed in shelter, the program is to offer an immediate family counseling session. There is provision made in the program's written procedures for referral of youth found to be ineligible for CINS/FINS services to at least three appropriate alternative services.

The program's Admission and Intake procedure indicates that the youth and the parent or guardian receives a copy of "Rights and Responsibilities" including the grievance policy, available service options, and the Florida Network's publication on the CINS/FINS process.

The program's Intake procedure notes that grievance policy and forms are posted in each facility; a fact which is reiterated within the program's grievance procedure. The grievance process is explained to youth during intake orientation according to these written procedures. There is an informal grievance resolution process outlined in the program's written procedures for youth to resolve issues with staff. The more formal grievance written procedures provide for written submission and written acknowledgement of resolution or escalation through the program's hierarchy with a 72 hour response and the program's Board of Directors' recommendations and actions being considered final. According to the program's written grievance procedures, all documentation relating to grievances are maintained for a year.

Similarly, the program's written procedures regarding visitation and telephone calls indicate that it is part of the intake orientation for youth. These procedures require staff to complete a visitation form with the youth's parent or legal guardian listing those people who are allowed and prohibited contact with the youth during his or her shelter stay. Hours of visitation and mandates for sign-in, access prohibitions, and welfare early-termination-of-visit procedures are all clearly outlined, as well.

Review of a total of ten (10) client files was performed: four (4) open residential and two (2) closed residential, as well as two (2) open non-residential and two (2) closed non-residential case files.

The program is meeting the goals of this Standard and its own written policies and procedures. Every case file is using the required NetMIS form for intake screenings and the intakes were timely completed – usually same day (e.g. immediate) as preferred by the program's policy.

The "Consent to Treatment, Youth Rights, and Youth Responsibilities" form, on which the client and parent acknowledge receipt of the documents outlined in the program's written policy, contains a slight discrepancy. The program's written policy states that the client and parent/legal guardian receive a copy of certain documents: specifically "the grievance policy". However, number 11 on the "Consent to Treatment, Youth Rights, and Youth Responsibilities" form indicates merely that one "may ask for and receive" the program's grievance policy. Therefore, although the grievance policy is posted in the shelter and grievance forms are readily available in the program, it was not verifiable to this reviewer that a copy of the grievance policy was actually provided to the youth and parents/legal guardian at intake based on the language of the form.

There were no exceptions noted for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Needs Assessment policy (2.02) in place which closely tracks the language of this Standard requiring completion of a psychosocial/needs assessment within 72 hours of shelter admission or the first 2-3 face-to-face contacts for non-residential clients. The program's policy requires needs assessments to be completed by qualified staff (Bachelor's or Master's level) and signed by a supervisor. The program's policy does not spell out that these signatures should be dated as the Florida Network of Youth and Family Service's policy 3.03 (revised 07/01/14) specifies. However, the program's policy does require the dated signature of the reviewing licensed clinical supervisor or that of the licensed clinical staff who wrote the assessment on youth receiving a suicide risk component as indicated by the suicide risk screening.

The program's written procedures for this Standard provide a list of items required to be included in a 'psychosocial assessment'; which is what the Florida Network of Youth and Family Service's policy 3.03 (revised 07/01/14) requires to be included in a 'needs assessment'. The program's procedures require assessments to be signed by a case manager or counselor and a supervisor and, for those with a suicide risk assessment, the signature of the reviewing licensed clinical supervisor (or written and signed by licensed clinical staff). The program's written procedure does not emphasize that these signatures should be dated as required by the Florida Network of Youth and Family Service's policy 3.03 (revised 07/01/14).

Review of a total of nine (9) client files was performed: three (3) residential open three days or more and two (2) closed residential, as well as two (2) open non-residential and two (2) closed non-residential case files.

The program is meeting the requirements of this indicator. Each of the nine files reviewed reflects timely completion of the Needs Assessment by appropriately credentialed staff both for residential and non-residential clients. The reviewer particularly notes that the program's licensed clinical staff and supervisor(s) are consistently dating their required signatures on the Needs Assessments and applicable suicide risk assessments in the case files reviewed; thus, no exception is noted for the omission of this requirement in the program's written procedure.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy for Case/Service Plans (2.03) requiring development of an individualized service plan (known as an ISP) for every youth in the program's CINS/FINS program based on the information gathered from the youth's initial screening, intake and assessment. The policy conforms to the indicators for this Standard, but the program's policy does not emphasize that the ISP should be completed within seven (7) working days following completion of the assessment. The policy does state that the ISP should be developed with the family and the youth and requires each ISP to include the components generally described in the Florida Network of Youth and Family Service's policy 4.04 (revised 07/01/12). The program's policy also states that the signature of the youth and parent/legal guardian on "the treatment plan" (ISP) indicates their agreement to participate.

The program's policy establishes that clients will be served their full range of services in the least restrictive environment and, if a necessary service is not provided by the program, the program's staff will facilitate referral to another agency.

The program has written procedures to implement its policy on case/service plan and conforms to the requirements of this Indicator. These written procedures require that the Needs Assessment be completed as soon as possible upon first face-to-face contact according to the program's written procedures for residential services clients so that a service plan can be developed based on the needs identified within seven (7) working days of completion of the assessment.

This program differentiates its written procedures on case/service plans for its non-residential clientele to clarify, in conformance with this Indicator, that a needs assessment should be completed within the first 2-3 face-to-face counseling sessions. However, the program's written procedure for non-residential service plans does not include the requirement that it be developed within 7 working days from the completion of the Needs Assessment. Instead, the program's written procedure generally requires the individualized service plan to "be initiated with the family and/or youth as soon as possible".

For both residential and non-residential clients, the program's written procedures require parental involvement. For residential case plans, the programs' written procedure states that the "plan development will include the involvement of the parent/legal guardian" and documented by the "youth and family signing the service plan." For non-residential clients, the program's written procedures states the "service plan shall be signed by the youth and parents".

The program's written procedures indicate that all case/service plans should be reviewed with the family every 30 days. Special emphasis is noted in the program's written procedures that residential case plans' reviews occur at a minimum of 30, 60 and 90 days.

Review of a total of nine (9) client files was performed: three (3) residential open three days or more and two (2) closed residential, as well as two (2) open non-residential and two (2) closed non-residential case files.

The program is meeting the requirements for this indicator. Of the five residential case files reviewed, all had a case/service plan developed within seven days of completion of the Needs Assessment. All but one of the four non-residential case files reviewed had a case/service plan dated the same date as intake, and the other had a case plan in place within 7 days of intake.

All of the case/service plans reviewed contained a date that the plan was initiated and identified persons responsible; target completion dates for the identifiable goals; signature of a counselor and supervisor; and the service type, location and frequency of services. However, none of the five (5) residential case files reviewed had a parental signature on the case plan. Only one (1) of the four non-residential case plans reviewed lacked a parental signature. This was a distinct requirement in the program's written policy and procedures for this Indicator.

Of the three (3) case files open more than 30 days, this reviewer observed that the program timely and consistently performed the reviews.

Exceptions:

None of the five (5) residential case files reviewed had a parental signature on the case plan.

One (1) of the four non-residential case plans reviewed lacked a parental signature.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has an established written policy for Case Management and Service Delivery (2.04) in accordance with this Indicator to provide service coordination on behalf of clients as substantially set for in the Florida Network of Youth and Family Services Policy 4.05 (revised 7/1/2012), which includes: information gathering, supportive linking, advocating coordination and monitoring of services case review and termination with appropriate referral when direct services from the program is no longer needed.

The program has an established written procedure in accordance with this Indicator to assign a counselor/case manager to each youth entering shelter or non-residential CINS/FINS who will follow the youth's case and insure delivery of services (both through the program or referral) and provide services as substantially set for in the Florida Network of Youth and Family Services Policy 4.05 (revised 7/1/2012), as well as documenting case notes of each contact taken on behalf of the youth, actions taken and discussions with other service providers under properly documented and executed release of information forms.

Review of a total of nine (9) client files was performed: three (3) residential open three days or more and two (2) closed residential, as well as two (2) open non-residential and two (2) closed non-residential case files. However, three (3) case staffing files were also referenced for review on a portion of this Indicator.

The program is meeting the requirements of this indicator. Each of the nine (9) residential and non-residential files indicated that the program timely assigned a counselor/case manager to each youth. Documentation in each file showed that the counselor/case manager coordinates the youth's service plan based on the youth's needs assessment and establishes any referrals to outside community-based service providers were necessary. The counselor/case manager tracks the youth's progress, provides family support, and monitors any out-of-home placement.

Three files for case staffing (all the program had) were reviewed to verify that the program's counselor/case managers do refers matters to case staffing. However, there were no court actions during the period for this reviewer to assess further involvement.

There were no exceptions noted for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has an established written policy for Counseling Services (2.05) in accordance with this Indicator to provide counseling services to youth and families to address needs identified during the assessment. The program's policy requires its shelter to provide individual and family counseling as well as group counseling five (5) days a week. In addition, the program's policy for non-residential youth and families counseling services are provided at the program and aim to provide (among other things) necessary crisis intervention and delinquency/dependency prevention services. The program's policy further establishes that family involvement will be incorporated to address the issues of the youth served and the program will extensively endeavor to engage families, guardians and significant others in its planning and services activities.

The program has an established procedure in accordance with this Indicator to ensure that individual case files are maintained for all youth and families serviced in a manner ensuring compliance with client confidentiality as set forth by the Florida Network of Youth and Family Services. Furthermore, the program's procedure requires all case files to reflect coordination between the presenting problem, psychosocial assessment, service plan, service plan reviews (as needed), counseling and case management notes and follow-ups with case notes kept in chronological manner to track the youth's progress. The written procedures for counseling in the program are differentiated between shelter counseling and non-residential counseling, where full-time non-residential counselors are expected to carry a minimum of 69 cases annually and an annual average of twelve (12) sessions per family. The program's written procedures provide for an internal peer review process as well as regular reviews by the clinical supervisor to ensure compliance with this Standard.

Review of a total of nine (9) client files was performed: three (3) residential open three days or more and two (2) closed residential, as well as two (2) open non-residential and two (2) closed non-residential case files.

The program is meeting the requirements of the indicator. Each file reviewed contained documentation evidencing that youth and families are receiving counseling services in accordance with their case/service plan. The files show that the program is maintaining individual case files on all youth and case notes are kept for all counseling services provided. The program has written policies and procedures in place to ensure that there is an on-going internal clinical review of case records and staff performance.

The program is providing both individual and group counseling to both residential and non-residential clients and sheltered youth are offered group counseling five (5) or more days per week as indicated by the activities schedule in the shelter.

There were no exceptions noted for this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy for Adjudication/Petition Process (2.06) which reflects the substance of this Indicator requiring a case staffing be held upon certain specified conditions. The policy also mandates convening a case staffing within seven (7) days after receipt of a written request for a staffing from a parent/legal guardian as required by the Indicator. In addition, the program's policy specifies that the scheduling, time and place of a case staffing should be convenient and accommodating to the parent/legal guardian. Furthermore, the program requires by policy that a written report be provided to the parent/guardian within seven (7) days after a case staffing outlining the reasons for the committee's recommendations, additional services, referrals and the basis for whether or not a petition will be filed.

The program's procedure for this Indicator establishes that the program is the designated agency for the Florida Department of Juvenile Justice in the 5th Judicial District for Pinellas County. These written procedures describe the circumstances for referral of a youth to case staffing and specifically incorporate by reference that the guidelines established by the CINS/FINS Operations Manual Section 4: Program Services.

The program's procedure provides that the case staffing committee recommendations for needed services and/or treatment be directed to the case manager to implement with the child and family and that the case manager provide reports to the case staffing committee on a youth's progress or issues with implementing the recommendations. The policy also notes that the case staffing committee has final decision-making authority on whether or not a CINS/FINS petition is filed when recommended by the case manager.

The procedure also establishes the composition of the case staffing committee as set forth in the Indicator and provides that a written report be provided to the parent within seven (7) days (as mentioned in the program's policy).

The program's written procedures also address the case staffing procedures such as who sets the agenda, which clients are to be reviewed, location and time of the monthly case staffing (with allowance for additional meetings as necessary), the manner in which the case staffing is managed, votes taken and ties are broken. The written procedures indicate that the chair of the case staffing may defer decision on a matter to allow for additional assessment, interim goals or investigation of external options. However, the procedure reiterates that the case staffing results in providing the youth and family with a new or revised plan for services that specifically contains: a statement of the problem, needs of the youth and parent, measurable objectives that address the identified problems and needs, what services and treatment will be provided (including frequency, type, location, staff responsible and time frames for achievement).

Review of three (3) client files that were subject to case staffing in the program in the last six months was performed, as well as review of the program's case staffing notebook; which, contains the case staffing sign-in sheets, letters to the youth and family, supporting documentation and reports or letters

summarizing the recommendations of the case staffing.

The program is meeting the requirements of the Indicator and the program's policy and written procedures. Only one of three files reviewed involved a parental request for a case staffing and it was held within seven days of that request. In one instance, a case staffing appears to have been held without the attendance of a school representative, but no recommendations were issued from that case staffing.

The reviewer found that the case staffing committee's recommendations and reports on individual clients were not maintained within the client files, but instead were in the program's case staffing binder. Although not required by the Standard, the reviewer notes that program's policies and written procedures for this Standard indicate that a new or revised plan will be instituted as a result of the case staffing committee's recommendations and that the case manager will monitor and report back on the client's progress.

There were no exceptions noted for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure in place that address to maintain client records in a manner that protects the confidentiality of those records. All files will be marked "confidential" on the outside of the front cover of the file. The files will include chronological sheets and youth demographic data, program information, correspondence, service plans, psychosocial information, case management information and miscellaneous information.

All client records will be stored in a secure area or within a locking cabinets. Client records will be available and accessible at all times. When photocopies or other reproductions of the client records are provided to authorized external users, these copies will be marked with a red stamp stating the "This information has been disclosed to you from records whose confidentiality is protected by Federal law."

Original files shall not be removed from the premises, except to transfer to another program site or on order of the court. Records will be transported in a locked, opaque container that is marked confidential. Agency procedures shall be followed before releasing records in these instances.

The agency has a policy and procedure in place for youth records. All youth files were marked confidential and kept in a secure room at all times. Files that were transported were handled according to the agency procedure. The files are maintained in a neat and orderly manner.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

During the Quality Improvement review, the Manatee SafePlace2B shelter was found to be in good condition-- the furnishings were new and the rooms and common areas were clean and were newly painted. The sleeping rooms are equipped with beds and each youth has an individual bed, bed coverings and pillows.

Staff members in the Residential Program include: a Shelter Supervisor, one Case Manager, Youth Development Specialists, one Intake Specialist, and a Food Specialist/Cook. The Shelter Supervisor oversees the day-to-day operations of the youth shelter. The Youth Development Specialists are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. The program provides group sessions to clients a minimum of five days a week on various topics that address issues including substance abuse prevention, anger management, effective communication, leadership skill building and many others. The agency utilizes a behavior management system that is also used in its other residential programs. Health and medication related activities are also provided, maintaining inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administers first aid when needed, and coordinates all off-site appointments to medical providers.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in which continuous maintenance is provided to its properties and furnishings to ensure that all areas are kept safe, clean landscaped and well-maintained. The facilities are conducive to providing programming and fosters healthy, social intellectual and physical development.

The residential supervisor or designee conducts weekly inspections of the physical plant utilizing the physical plant checklist and daily room check list and attends to areas needing attention. The residential supervisor or designee maintains a log to note areas needing attention and facilitates needed repairs and maintenance as needed.

The shelter's environment is safe clean and extremely well maintained. The youth rooms are uniquely painted with different themes, each offering an inspirational message. The rooms have client rights, shelter rules evacuation and disaster plans posted. The lighting in each room is adequate and each youth has a personal light above their bed. The bathroom and shower areas were clean and functional. There is a bathroom in each youth room which supports the agency's policy of offering two operable toilets for every eight youth. No slip mats in the showers was offered as a suggestion to prevent potential slip and fall incidents.

The agency's health and safety inspections are current and in compliance. The fire safety inspection was conducted in April and no violations were noted. The sprinkler inspections are conducted quarterly and the last inspection was done in January with no violations noted.

Fire drills were conducted monthly on at least two of the three shifts for the last six months. Emergency care drills were conducted monthly on at least one shift. The form documenting emergency care drills are in a binder includes date, time, type of emergency, staff/residents involved and guidance for what to do in real emergency situations.

The grounds on the exterior of the building were well maintained and free from debris.

There is a daily program schedule posted and it affords youth an opportunity for a variety educational

groups presented formally and informally. The groups are conducted by counselors, direct care staff as well as outside providers.

The laundry room has functional machines and it is well kept and organized.

No exceptions noted for this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in which all new clients are oriented on program procedures within 24 hours of admission to the program. At that time clients are introduced to the philosophy, goals, services and expectations of the program.

Staff will conduct program orientation within 24 hours of intake. Resident checklist will be completed to ensure all aspects of the orientation process have been fulfilled. When possible staff designates another youth to provide the client a tour as part of the orientation process.

There were four residential files reviewed for Program Orientation. Orientation was provided within 24 hours, as the agency policy calls for. In all four of the files reviewed, orientation was conducted on the same day of intake evidenced by the Orientation Checklist in each file signed by youth and staff. The orientation checklist is consistent with agency policy.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in which youth are interviewed upon admission to determine the most appropriate room/sleeping arrangements. Room assignments in multi-occupancy rooms will be based on a classification process with consideration given to potential safety and security concerns.

During the intake process, staff will observe clients and interview them to make the most appropriate room assignment. Staff will examine the client's age, sex, height, weight, level of maturity, gang affiliation, current alleged offense, prior delinquency background, level of aggression, ability to act responsibly, attitude upon admission to program, past involvement in assaultive or aggressive behavior (both sexual and physical) and the client's current emotional state.

There were four residential files reviewed for Room Assignments. Three of the four files reviewed contained documentation indicating the youth's room assignment. All other files contained information obtained during the intake process to support the appropriateness of room assignments. The room assignments in the files matched the census/alert board located in the dayroom. Alerts documented on each file were also documented on the alert board. Each youth room can be identified by the number on the door.

Exception:

One of the four files reviewed did not contain documentation indicating the youth's room assignment.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a logbook policy to maintain a permanent log to record routine daily activities, events and incidents. The house log is a bound journal with sequential pages that is a continuous record of all significant events occurring throughout any 24 hour period.

The agency has a procedure in which logs shall be signed by all staff upon arriving or leaving assigned shifts. Direct care staff should read at least the previous two shifts in order to be aware of any unusual occurrences. Logbook entries which could impact the security and safety of the program may be highlighted. House census and room assignments will be noted at the beginning of each shift or when the house count changes. Additionally, all incidents when youth were removed and returned from the general population will be noted.

The agency has a logbook policy in which safety and security issues are documented. The agency uses a highlight system which is consistent and easy to follow. The highlight system helps to distinguish and track significant activity. The occurrence of fire drills, youth movement and critical incidents was documented, highlighted and the designated color was used throughout logbook. Supervisory review is documented weekly and a red stamp is used to provide evidence of the review.

There were no exceptions noted for this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy to incorporate a behavior management system designed to foster accountability and compliance with the program's rules and expectations. The system shall consist of rewards, privileges and consequences to empower youth in their personal growth while encouraging clients to fulfill programmatic expectations. Consequences are connected to the behavior and serve as incentive to improve youth choices.

Residents discuss levels achieved as a group each day. The approach allows a feeling of belonging amongst clients. Through team support and positive peer pressure clients are assisted in meeting their personal objectives. Staff is provided with client based and client driven methods of motivation and behavior management. Meaningful and obtainable goals are implemented through friendly competition. Consequences are relevant to the offense and shelter experience.

The program has a detailed written description of the Behavior Management System which is explained during program orientation. Youth and staff sign the orientation check list at intake indicating the BMS has been explained. Additionally, youth receive a copy of the system during orientation which outlines all aspects of the behavior management system. The BMS utilizes a level system for rewards and consequences. There are four different levels which make up the Behavior Management System. All residents begin at the "Orientation Level" for their first 24 hours at the shelter. During that time residents review the youth handbook, learn shelter policies, expectations and safety information. Youth then transition to the "Citizenship Level" for 48 hours. While on the citizenship level youth have basic privileges and are expected to follow shelter rules. The highest level is the "Leadership Level" which affords youth the most rewards. The leadership level also comes with elevated expectations for those youth. They are expected to serve as youth leaders for their peers as well as new clients. Negative or inappropriate behavior will result in youth being placed on the "Ownership Level". Youth placed on the ownership level lose privileges without having their rights compromised.

Staff is trained in the practice of administering the behavior management system which promotes skill-building for the youth. Training occurs during their job shadowing period in the first week of employment. Staff training is documented in training files.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy to have two staff members on duty in residential program at all hours of the day, one male and one female. During times of critical staff shortages, direct care staff may be of the same gender if supervisor can demonstrate a continued effort to hire the right combination of staff gender for shifts. The staff schedule is posted and visible for staff. An on-call staff roster is maintained containing home and work telephone numbers of staff who may be called to provide coverage when needed. Staff shall observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction.

Staffing patterns at residential shelters include two staff, one male and one female at all times, during waking, community activities and sleeping hours. If staff is unable to report to work for any reason, a replacement will be contacted and asked to report to work. Staff must remain on site until a replacement reports to provide relief. Staff will observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction.

The agency has a policy in place for Staffing and Youth Supervision. The staff schedule is posted on a cork board near the front lobby and is easily visible. There is also a Shift Coverage Form that staff must fill out if they are having another staff member cover their shift. This form must be signed off by the individual who is covering the shift. A staff list with phone numbers is located at the staff work desk in case additional coverage is needed.

The site has a surveillance system that is located at the staff desk and also in the Residential Supervisor's office. Both stations monitor the daily activity in and around the facility. Random samples of the overnight shift revealed bed checks were being conducted while youth were in their rooms during the hours of sleep in 15 minute increments.

Exceptions:

Staff schedules reviewed for the last six months reconciled with the program's logbook revealed 18 times during the months of January and February only one staff on the 11-7 overnight shift. The agency has a policy to have two staff members on duty in residential programs at all hours of the day, one male and one female. On several occasions during the same time period, there were 8-10 youth present on the 11-7 shift with only one staff.

The practice of conducting room checks is satisfactory and maintains compliance. However, the documentation of the room checks are not being indicated in real time.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Special Populations youth. It addresses Staff secure youth, Domestic Minor Sex Trafficking, Domestic Violence Respite and Probation Respite.

Policy: Domestic Violence Respite policy states that youth served in this program meets all the required criteria. Case plans will reflect goals for aggression management, family coping skills, or other interventions designed to reduce propensity for violence in the home.

Probation Respite youth will have the referrals come from DJJ Probation Officer and with or without adjudication. All case management and counseling needs have been considered and addressed. Services

will be consistent with all other CINS/FINS program requirements.

During the review, the agency had two DV cases and all had the required documentation for placement in this program. The youth stay did not exceed 21 days.

There were two youth in probation respite. One youth initially came into the program as CINS youth and was transferred to Probation. Documentation from JPO to transfer to the appropriate placement was noted in the file.

Case plan notes for both special population youth were detailed. All case management and counseling needs were considered and addressed.

There were no Staff Secure Youth that had been admitted to the program.

There were no exceptions noted for this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that all CINS/FINS shelters will have a video surveillance system that operates 24 hours a day, 7 days a week to monitor and capture a recording of agency happenings to assure the safety of all youth, staff and visitors to residential shelters.

The program will have cameras in the interior and exterior to cover all general locations. Hallways where youth sleep, areas youth and staff congregate and where visitors enter and exit will be covered. Video is stored for a minimum of 30 days, and should be available within 24-72 hours for the purposes of investigating allegations of incidents and to accommodate quality improvement visits. Supervisory review is conducted bi-weekly and documented to assess the activities of the facility to include a review of a random sample of overnight shifts.

The program has cameras on the interior and exterior of the facility. The system can record footage for 30 days with date and time indicated. Program Supervisor conducts reviews of the cameras at a minimum of every 14 days. A review of the cameras on eight dates from May 21, 2017 through June 13, 2017 revealed the room checks were being conducted in 15 minute increments. The time of the checks differed from the time documented by 3-5 minutes consistently.

There were no exceptions noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SafePlace2B Manatee youth shelter provides screening, counseling, and mental health assessment services. The shelter has staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both the residential and non-residential CINS/FINS programs.

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

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

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy called Healthcare Admission Screening. The purpose of the policy is for the agency to utilize a screening process for all health related conditions as a part of the admission process for all clients admitted to the residential and non-residential program. The current policy is documented on the policy as being last updated on March 2017. The policy has also been initialed by the agency's President and CEO. The policy addresses a screening process that includes Current medications; Allergies; Existing (acute and chronic) medical conditions; Recent injuries or illness, Presence of pain or other physical distress; Observation for evidence of illness, injury, physical distress, difficulty moving, etc.; Observation for presence of scars, tattoos, or other skin markings. The policy also addresses the agency's position on providing unimpeded access to emergency medical care at all times for youth admitted with chronic medical conditions.

The agency's Healthcare admission procedure requires staff to follow a certain process to conduct an official health screening. The process to conduct a healthcare admission screening involves using the Florida Network Intake Screening and Assessment Form. In the event that a health or medical condition is determined to be present during the screening, the client will be immediately referred to the emergency room, public health department or their physician. The procedure also requires a staff person to contact parent/legal guardian to inquire information about general precautions, current medication, appointments with medical professionals, and protocols regarding medical situations. Any real medical or health issue detected requires that staff follow a certain protocol such as notifying 911, administering first aid, contact parent/guardian, program director, accompanying client to medical appointment and writing an incident report.

A random sample of eight (8) client files serviced in the last six (6) months was conducted to determine the agency's adherence to the requirements of this indicator. The review consisted of a total of five closed and three open client files. Of these files, all contained the required healthcare screening form used during the initial screening process. All eight files contained the Florida Network of Youth and Family Services CINS/FINS intake form. This form contained several healthcare screening questions on the second page of

the document. A sample of healthcare screening questions include: are the residents currently on medications; do the residents have any existing medical conditions; do the residents have allergies; and are there any scars, tattoos, or other skin markings, as well as several other health and medical questions. Each client file included markings in accordingly, documenting either their existence or non-existence of a health or medical condition. In general, all resident files contain the overwhelming majority of documented responses to the necessary healthcare screening questions.

Exception:

Three of the eight files had no marking or had a blank space in the Physical Health Screening section that did not confirm or verify an existing health condition.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a suicide prevention policy. The name of the agency's policy is titled comprehensive master plan for suicide prevention and response. The agency's policy includes their approach to addressing residents with mental health and/or presence of suicide risk and behaviors upon admission and their mental health history. The policy was the last reviewed in March 2017 by the agency's president and chief operating officer. The agency's policy includes an initial screening and referral for assessment process.

The policy also includes a clinical assessment of the youth when placed on a supervision status level. The policy includes levels for suicide risk that include one to one supervision, constant sight and sound supervision, and elevated support. In general, the policy meets the requirements of the indicator. All staff are required to receive training that include signs and symptoms of mental health and children and adolescents. This training is required annually for each staff member.

The agency's procedure requires that all direct care staff and counselors be trained in the ability to conduct a mental health screening for existing and/or past mental health issues and suicide related risks. This requirement for screening must be conducted upon each eligible resident admission into the program. The process involves an initial screening that utilizes a standard intake information form. The process also involves the use of a mental health alert system that indicates colored-coded notification to all staff members that a certain youth has been placed on an elevated level of supervision due to their existing suicide risk and behavior. Once the youth indicates a positive response to a suicide risk question the youth is required to be placed on elevated supervision. The use of a red dot indicates that the youth is placed on sight and sound supervision. The use of a green dot indicates that the youth has a mental health issue that may include a diagnose-able condition. The staff is required to conduct observation checks of 15 minutes or less for every resident placed on sight and sound supervision.

Each Masters level counselor must complete the assessment. Once the assessment is completed it must be reviewed and/or approved by the license clinician. Each youth placed on sight and sound supervision cannot be returned to general population status unless it is approved by a licensed clinician. Documentation of placing a youth on and removing them from site and sound status must be documented in the agency program log book.

A total of five client files were reviewed to assess the agency's adherence to the requirements of the suicide prevention indicator. This review included a total of four closed cases and one open client case. All cases were screened during the initial intake process for the past and existing presence of suicide risk and/or mental health issues. All client cases included the suicide screening and all sections and each suicide screening were completed and signed by the supervisor in each client's file.

The youth were properly placed on sight and sound supervision until an assessment was completed by a licensed professional or a non-licensed staff person under the direct supervision of the licensed clinician.

The agency has a total of three licensed clinicians. All assessments reviewed were completed by a Masters level staff person under the direct supervision of a clinician. All 5 assessments had evidence that the non-licensed person consulted directly with the clinician regarding the assessments.

All residents placed on sight and sound supervision had fully completed observation logs documenting checks conducted every 15 minutes or less. Each of the five files reviewed had documentation that the supervision level was not reduced until the non-licensed staff person consulted the assessment results with the licensed professional. The assessment contained documentation that both the non-licensed staff person and the clinical professional signatures were on the suicide assessment form. The program has not changed its suicide risk and prevention processes since the last on site program review.

No exceptions are noted for the indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a medication policy that is titled Medications. The policy was last viewed in March 2017 and was signed for approval by the agency's chief executive officer. The current policy includes storage, inventory and verification procedures, delivery or assisting in distribution of medication, over-the-counter medications, disposal, incident reporting, operation of the Pyxis MedStation, disposal, and medication distribution away from the shelter.

Upon admission into the agency's youth shelter, the resident and parent is required to be interviewed about the use of current medication. The agency is only required to except medications from a licensed pharmacy. The youth can only accept medication that is properly labeled according to policy. Each staff member is required to follow the verification of medication process according to policy. Staff that have been successfully trained by the registered nurse to utilize the Pyxis MedStation 4000 cart can distribute medications to clients during their shelter stay. All medications and over-the-counter medications are required to be stored in the Pyxis MedStation. The client record must be created for every resident on medication during the shelter stay. The agency is required to follow all policies regarding medication count on all shifts and schedule distributions of medication to each resident.

The agency as a registered nurse that oversees the distribution of medications for the entire facility. The registered nurse is in charge of training all staff persons to properly distribute medications to residents during the shelter stay. Registered nurse works four hours per day for a total of five days per week. The registered nurse also works on weekends as needed.

The agency maintains all medications including over-the-counter medications in the Pyxis MedStation cart. The medication cart is located in a separate room that is locked. The agency has a total of six super users. All medication including liquid oral and topicals are stored in separate tubes inside the Pyxis MedStation cart. Medications are accounted for two persons three times per day at each shift change.

The agency maintains sharps that include arts and craft scissors and shaving razors. All sharps are documented and conducted as required by policy. The agency has a total of three first aid kits. Each first aid kit is fully stocked and maintained by the registered nurse. The agency uses a paper medication distribution log to document each use of medication distribution. The distribution of medication is consistent with the Florida Network's medication management and distribution policy. All medications distribution sessions are overseen by the nurse or the nurse oversees regular staff distributing medication to clients.

Discrepancies are cleared and required to be cleared prior to the close of the work shift.

There are no exceptions documented for this Medication indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

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

A review of a total of seven client files was conducted to assess the agency adherence to the medical and mental health alert process indicator. A total of 7 client files included an indicator for a medical/mental health behavior or food allergies condition. All seven youth were properly placed on the program's alert system. All the alerts included the proper color-coding concerning either medications, mental health, or behavior issues. Staff are provided information and instructions as required to respond to the needs for a medical and/or mental health issue. Staff also received training on emergency care, first aid, CPR Universal for cautions and other related emergency circumstances.

There are no exceptions documented for this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an emergency and episodic emergency care policy. The policy was reviewed and approved by the agency's Chief Executive Officer in March 2017. The review of the policy indicates that the agency's policy meets the general requirements of this indicator.

The agency is required to assess the situation and administer the proper aid that includes first aid and/or a direct call for a 911 emergency assistance and continue to assist the youth until official EMS care arrives. The agency is required to document all emergency situations according to policy. The agency is required to maintain a log of episodic and/or emergency events. Agency staff members are also required to contact parents anytime an offsite emergency and/or first aid event occurs.

A review of the last six months of episodic/emergency care resulted in a total of three events being documented in the agency's log. One event occurred in December 2016, another event occurred in April 2017, and the last event occurred in May 2017. All emergency events indicated that the youth required off-site emergency medical care. Each event included an incident that was reported to the CCC as required. Each youth that was taken off site was returned and included receipt of medical clearance and/or discharge instructions. Each parent was notified as required. Two emergency events were documented in the logbook as required.

Exception:

One of the three emergency episodic events was not documented in the logbook.