FLORIDA NETWORK
*of youth and family services*

**QUALITY IMPROVEMENT PROGRAM REPORT FOR**

***Family Resources, Inc.***

## Safe Place 2B – St. Petersburg

**3821 5th Avenue North**
**St. Petersburg, Fl 3755**
**(Local Service Provider)**

***Review Date(s):***
***May 1-2, 2012***

# CINS/FINS Rating Profile

| | | | |
|---|---|---|---|
| Program Name: | **Safe Place 2B St. Petersburg** | QA Program Code: | **N/A** |
| Provider Name: | **Family Resources, Inc.** | Contract Number: | **V2021** |
| Location: | **Pinellas / Circuit 6** | Number of Beds: | **10** |
| Review Date(s): | **May 1-2, 2012** | Lead Reviewer : | **K. Carr** |

## Indicator Ratings

| 1. Management Accountability | | |
|---|---|---|
| 1.01 | Background Screening of Employees/Vol. | Satisfactory |
| 1.02 | Provision of an Abuse Free Environment | Satisfactory |
| 1.03 | Incident Reporting | Satisfactory |
| 1.04 | Training Requirements | Satisfactory |
| 1.05 | Interagency Agreements and Outreach | Satisfactory |
| 1.06 | Disaster Planning | Satisfactory |
| **% Indicators Rated Satisfactory Compliance:** | | **100%** |
| **% Indicators Rated Limited Compliance:** | | **0%** |
| **% Indicators Rated Failed Compliance:** | | **0%** |

| 2. Intervention and Case Management | | |
|---|---|---|
| 2.01 | Screening and Intake | Satisfactory |
| 2.02 | Psychosocial Assessment | Satisfactory |
| 2.03 | Case/Service Plan | Limited |
| 2.04 | Case Management and Service Delivery | Satisfactory |
| 2.05 | Counseling Services | Satisfactory |
| 2.06 | Adjudication/Petition Process | Satisfactory |
| **% Indicators Rated Satisfactory Compliance:** | | **83%** |
| **% Indicators Rated Limited Compliance:** | | **17%** |
| **% Indicators Rated Failed Compliance:** | | **0%** |

| 3. Shelter Care/Health Services | | |
|---|---|---|
| 3.01 | Shelter Care Requirements | Satisfactory |
| 3.02 | Healthcare Admission Screening | Satisfactory |
| 3.03 | Suicide Prevention | Satisfactory |
| 3.04 | Medications | Limited |
| 3.05 | Medical/Mental Health Alert Process | Satisfactory |
| 3.06 | Episodic/Emergency Care | Satisfactory |
| **% Indicators Rated Satisfactory Compliance:** | | **83%** |
| **% Indicators Rated Limited Compliance:** | | **17%** |
| **% Indicators Rated Failed Compliance:** | | **0%** |

## Overall Rating Summary

| | |
|---|---|
| **Satisfactory Compliance:** | **89%** |
| **Limited Compliance:** | **11%** |
| **Failed Compliance:** | **0%** |

# Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2011).

## Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☐ DHA or designee
- ☐ DMHA or designee
- 2 # Case Managers
- 1 # Clinical Staff
- 1 # Food Service Personnel
- ____ # Healthcare Staff
- ____ # Maintenance Personnel
- 1 # Program Supervisors
- ____ # Other (listed by title): ____

## Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☐ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☐ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☐ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☐ Sick Call Logs
- ☐ Supplemental Contracts
- ☒ Table of Organization
- ☐ Telephone Logs
- ☐ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- 3 # Health Records
- 3 # MH/SA Records
- 8 # Personnel Records
- 5 # Training Records/CORE
- 11 # Youth Records (Closed)
- 14 # Youth Records (Open)
- 20 # Other: **Interagency Agreements, Licensing Credentials**

## Surveys

- **3** # Youth
- **3** # Direct Care Staff
- **0** # Other: ____

## Observations During Review

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

## Comments

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

## 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

The Florida Network of Youth and Family Services and the Florida Department of Juvenile Justiceôs Bureau of Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Keith D. Carr, Lead Reviewer, Principal Consultant, Forefront LLC
Latrice Covington, Contract Manager, Office of Prevention and Victim Services
Michelle N. Miles, Senior Management Review Specialist, DJJ Bureau of Quality Improvement
Andy Coble, LMHC, Vice President of Prevention Services, Youth and Family Alternatives, Inc.

***Please note that this report refers to each indicator by number and title only. Please see the applicable standards for the full text of each indicator. The standards are available on the Bureau of Quality Improvement website, at http://www.dji.state.fl.us.***

## Strengths and Innovative Approaches

Family Resources, Inc. (Family Resources), a private not-for-profit organization, provides a vital continuum of services to children, youth and families. The goal of the agency is to support the family as a whole and keep the family together. When keeping the family together is not a safe option, Family Resources offers community-based programs that teach young people effective coping skills as they transition into adulthood and other safe living arrangements.

The agency is working to train all staff members on Trauma Informed Care. The aims to have all staff members trained by the end of this year or sooner.

The agency has one (1) Licensed Clinical Social Worker and 1 Registered Intern. One staff member is the Residential Supervisor and the other is a Residential Counselor. Both of these staff members are accessible to the agency's residential and non-residential CINS/FINS programs. The agency also employs an additional employee in the process of testing for her State Mental Clinical license.

The agency has also implemented a web-based training program that offers an array of training options for staff members to complete through an online learning system (OLS). Additionally, the program has several other funding sources for program services that it provides to the community.

The agency also maintains an Automated External Defibrillator (AED) in the youth shelter. The AED is a portable electronic device that automatically diagnoses potentially life threatening cardiac arrhythmias in a patient, and is able to treat them through defibrillation, the application of electrical therapy which stops the arrhythmia, allowing the heart to reestablish an effective rhythm.

Family Resources is certified by the Council of Accreditation (COA). The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

The agency was recently visited by David Wilkins, Secretary of the Florida Department of Children and Families. Secretary Wilkins was accompanied the other agency officials.

# Standard 1: Management Accountability

## Overview

The Family Resources, Inc. Safe Place 2B program provides shelter and non-residential services for youth and their families in Pinellas County and Manatee County. The program, which is located at 3821 5th Avenue North, St. Petersburg, Florida, is under the day to day management of Nicole Macknew, Residential Supervisor. Ms. Macknew reports directly to Stacey Welton, Vice President Residential. Other positions include separate staff members are in place for the shelter and non-residential components of the program. Residential shelter staff includes nine (9) Youth Care Workers, two (2) Residential Counselors, one (1) Secretary, two (2) Interns and a cook. In addition to the residential program, the non-residential component has a

Director and Counselor. At the time of the quality improvement review, the shelter had one (1) vacant fulltime Youth Care staff vacant position at this location. The Department of Children and Families has licensed Safe Place 2B as an emergency runaway shelter, with the current license in effect until December 15, 2012.

The agency operates a total of three (3) youth shelters and the company handles all personnel functions through its Human Resources division located at its central office in Pinellas Park Florida. This office processes all state and local background screenings. The provider agency conducts orientation training to all shelter personnel through its Residential Supervisor. The majority of core training is also provided by a combination of training provided by the Florida Network trainer, inter-agency training delivered by the agency and outside and on-line training resources. Each employee has a separate training file containing a training plan and copies of documentation for training received. Annual training is tracked according to the employeeøs date of hire. The program provides training through a combination of web-based and in person instructor-led courses.

The Florida Network approved the programøs emergency response plan and hurricane plan for FY 2011-2012. The residential supervisor directs youth care worker staff members to conduct weekly safety and physical plant checks. The agency maintains weekly checklist documentation that is stored in a 3-ring binder.

| 1.01: Background Screening of Employees/Volunteers | Satisfactory Compliance |
|---|---|

The agency has a comprehensive background screening policy that meets and addresses all major requirements of DJJ Background Policy 1800. The agency has a separate human resources department that conducts all background and 5 year screenings for prospective and current staff members.

A total of eight (8) staff members files were selected to determine the agencyøs adherence to this indicator. Of the 8 staff member files reviewed, two (2) were 5 year rescreens and six (6) were new or transfers into the program. All files were organized in a standardized format with no exceptions found at the time of this program review. All had the required information and meet all requirements for this indicator.

The agency has also demonstrated and provided evidence that the Annual Affidavit of good moral character has been sent to the DJJ Background Unit prior to the January 31 deadline. The completed this task on January 4, 2012.

| 1.02: Provision of an Abuse Free Environment | Satisfactory Compliance |
|---|---|

The agency has a comprehensive policy to address this indicator. The current policy was last reviewed in July 2011. The reviewer assessed all agency internal incidents (20), DJJ CCC Incidents (5) and program grievances (12). A review of the CINS/FINS residential program grievances indicates 2 grievance reports that center around staff member demeanor, attitude and negative temperance toward program residents. A review of five (5) DJJ CCC incidents indicates no evidence or presence of abuse, threatening or negative demeanor towards residents. The program posts the Florida Abuse Hotline number at various locations throughout the facility and informs youth of these procedures during program orientation and in the Resident Handbook. In addition, all staff members receive a copy of the Agencyøs Code of Conduct upon hire.

At the time of this program review, the reviewer of this indicator conducted a discussion with the Residential Supervisor staff behavior and client/youth actions that may have impacted the safety and security of the shelter environment. The supervisor provided all inter-agency written reports that occurred within the last six (6) months including work performance and disciplinary reports.

The agency utilizes a supervisory intervention approach that includes counseling and disciplinary procedures and actions policy. This policy uses a multi-step process that consists of verbal coaching, issues memorandums of understanding and counseling memorandums.

The agency also uses a graduated progression of disciplinary steps that include written reprimand, disciplinary probation, decision making leave and suspension. A review of inter-agency or program Reviews of Behavior and staff member performance was conducted. These documents included three (3) Memorandums of Understanding, 3 Supervision documents, and one (1) Notice of Disciplinary Action. The Notice of Disciplinary Action resulted in a written reprimand because one male staff member interrupted a group session activity that resulted in embarrassing a program resident client in front of other program residents and a guest speaker. The agency formally addressed that this issue with a written report within 48 hours of the incident.

During this onsite program review, the shelter housed a total of six (6) residents. Two (2) of the 6 were CINS/FINS eligible. The remaining four (4) were DCF client and not eligible to be surveyed. Both youth survey results stated that they were familiar with the abuse reporting and grievance reporting processes. In addition, youth reported that they feel safe in the program and have never heard staff threaten them or other youth; no youth stated that they have heard staff use profanity/inappropriate language; and none said they have been stopped from reporting abuse.

Four (4) staff members were surveyed during this onsite program review. Two (2) stated that they staff observed a co-worker using threats, intimidation, or humiliation when interacting with the youth and one (1) staff members stated that they observed a co-worker using profanity when speaking to youth. All staff agreed the working conditions have been adequate at the program.

| **1.03: Incident Reporting** | Satisfactory Compliance |
|---|---|

The agency has a comprehensive incident reporting policy that addresses Incident Reporting. The current policy was last reviewed on July 2011. The agencyôs policy program specifies that the agency notifies the Departmentôs Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident. The agency has a protocol that reviews the practice and execution of each documented incident.

An inquiry into the DJJ CCC database by the DJJ QI program review team member confirmed a total of five (5) official incidents documented in the system. Of these reports two (2) were Program Disruptions and Medical Incidents. Two (2) out of three (3) were called into the DJJ CCC outside of the 2 hour reporting requirement.

The agency submitted all Internal Incidents. A total of twenty (20) inter-agency incidents were reviewed during this onsite program review. The type of internal incidents documented by the agency range from client disagreements, absconds/running, contraband discovery, medication errors, minor physical injuries (no hospitalization), destruction of property and physical altercations. The agency submitted twelve (12) incidents documented by CINS/FINS program residents over the last six (6) months. The agency responded to a total of ten (10) out of 12 grievances within 24 hours or less. Five (5) grievances make reference to the problems that they have regarding staff membersôability to place them on the correct level on the BMS system. Three (3) grievances

address issues that youth state regarding agency staff members that display negative attitudes when addressing them. None of the grievances reviewed indicate serious negative or threatening staff member behavior toward CINS/FINS program residents.

It is recommended that the agency continue to ensure that all staff members are trained on all issues/events that can be determined to be reportable as DJJ-CCC incidents.

| 1.04: Training Requirements | Satisfactory Compliance |
|---|---|

The agency possesses a training policy that addresses annual training requirements for first year and on-going staff members. All first year staff members are required to complete a total of eighty (80) hours in the first year of employment and on-going staff members maintain at least 40 hours of training annually. The reviewer assessed a total of eleven (11) staff member training files. Of these files, seven (7) were first year staff member files and four (4) on-going staff member files. Six (6) out of 7 staff members have evidence that demonstrate that they are working towards or have complete year 1 requirements. Of the four (4) on-going staff members, 3 out of 4 met all of the minimum annual total training hour requirements. At the time of the this review, 2 on-going staff members training files were missing evidence of CPR and 1 was missing evidence of first aid training.

Several new/recent hires have outstanding training, but still have time to complete this prior to the close of their respective training year. There are noticeable differences in training file formatting across all files assessed during this program review. Some staff member training files have hand written training logs versus other training files that do not have updated hours. Additionally, some new/recent hires are using a slightly different training file format. The Residential Supervisor reports that they have not had or scheduled a CINS/FINS training at this site since her date of hire in October 2011.

The agency has begun training on Trauma Informed Care (TIC) for the entire agency. This new training component will better prepare the staff members for various youth and family issues.

| 1.05: Interagency Agreements and Outreach | Satisfactory Compliance |
|---|---|

The agency has several interagency agreements with various agencies that provide the services listed in the indicator. The program also has interagency agreement specific to its CINS/FINS residential services program. The agreements include several interagency agreements, including schools in all service area counties served by the agency, law enforcement, local schools, health, mental health, and substance abuse providers. These program offerings also include information on other program services offered by the agency including services for families needing assistance with food and housing and services for pregnant teens.

There is a staff person assigned to conduct outreach activities and enters information in to NetMIS for tracking and documentation of all formal outreach activities. The agency interagency agreement manual was reviewed for current agreements and outreach effects, basic behavior, abuse parenting, family and various services. The reviewer of this standard reviewed more than twenty (20) agreements. Of these agreements, all except five (5) agreements have information that indicates that the original agreement period have expired dates with no indication of renewal. During this onsite program review, it was recommended that the agency establish a

reasonable effective period (1 year, 2 years, 3 years, etc.) for all of its agreements and to establish a renewal process for all expiring or expired interagency agreements.

| 1.06: Disaster Planning | Satisfactory Compliance |
|---|---|

A review of the agency's current disaster and emergency manual and the organization revealed that it is in line with the all requirements for Indicator 1.06 Disaster Planning. The agency's current disaster plan includes various types of emergency situations especially those included in this standard.

The agency has a comprehensive Emergency Response Plan that was approved by the local Fire Department. The Emergency Response Plan includes: 1) all of the required types of emergency situations; 2) evacuation sites for the shelter; 3) meeting sites on the outside of the building in the event of evacuation; 4) evacuation routes to ensure safe and secure transportation; 5) checklist of all appropriate and necessary equipment; 6) staff contact list; and 7) notification procedures to the Florida Network and other funding sources/agencies. The disaster plan designates evacuation facilities and when to evacuate.

The plan states supplies must be taken and the facility has a detailed list of everything needed. All supplies are kept in one location and are checked weekly during hurricane season. Information is sent to the shelters in May each year including any new forms. All call-down lists and evacuation routes are also updated each May. The program participates in the Universal Agreement for Emergency Disaster Shelter with the Florida Network Member Agencies. All new hires receive personal disaster training.

## Standard 2: Intervention and Case Management

### Overview

Family Resources, Inc.'s Safe Place 2B St. Petersburg program is contracted to provide CINS/FINS non-residential services for youth and their families in Pinellas and surrounding counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week. Trained staff members are available to determine the needs of the family and youth. Residential services, including individual, family, and group services, are provided. Case management and substance abuse prevention education are also offered. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on- going counseling, and educational assistance. The shelter staff includes a program supervisor, a secretary, a residential supervisor, a group living manager and youth care workers. The youth care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision.

The non-residential component is under the day to day management of Carol Albrecht, Non-Residential program director and two (2) counselors. Ms. Albrecht reports directly to Pat Gerard, Vice President of Residential. The counselors are responsible for providing case management services and linking youth and families to community services. A CINS Case Manager coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for

habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court as needed. This position is supervised by Stacey Welton.

| 2.01: Screening and Intake | Satisfactory Compliance |
|---|---|

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 2.01. A total of ten (10) client files were reviewed for this standard. Of these files five (5) are residential and five are non-residential. There were two (2) open residential files, three (3) closed residential files, 3 open on-residential files and 2 closed non-residential files. All eligibility screenings were completed within seven (7) of being referred.

All youth files reviewed have documentation of available services options, rights and responsibilities, possible actions through involvement with CINS/FINS, and grievance procedures. Nine (9) of the 10 contain evidence that the Parent/Guardian brochure was received. Parents are given a consumer handbook, available in both English and Spanish, which explains rights and responsibilities, how to receive services, release of confidential information, grievance procedures, and other relevant program information. Screening and intake areas meet each standard required.

All parents receive brochures on the agencyôs other programs and a brochure on parent options for ungovernable children and possible actions occurring through involvement with CINS/FINS services. The brochure also includes information about the Case Staffing Committee, CINS Petition, and CINS Adjudication. Youth also receive a Safe Place 2B Resident Handbook that explains program procedures, services, expectations, as well as similar information that was provided to the parents.

| 2.02: Psychosocial Assessment | Satisfactory Compliance |
|---|---|

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by indicator 2.02. A total of ten (10) files were reviewed, five (5) residential and 5 non-residential all psychological assessments were initiated within 72 hours for residential and completed within 2 to 3 face-to-face contacts for non-residential clients. All psychological assessments were completed by Bachelorôs or Masterôs level staff. Nine of the ten (10) psychological assessments were signed by a supervisor. There were no elevated risks of suicide noted on any of the psycho-social assessments. One assessment of suicide risk was competed because the client stated there were numerous Baker Acts in the clientôs record.

All Psychosocial Assessments were completed by a Bachelorôs or Masterôs level staff member and included a supervisorôs review signature upon completion.

| 2.03: Case/Service Plan | Limited Compliance |
|---|---|

A total of five (5) files were reviewed to assess this indicator from non-residential service delivery for compliance with standard 2.03. Of the cases reviewed, two (2) were closed files and three (3) were open files. Overall, all files complied with case plan development time

frames and were done on the same day the psychosocial assessments were completed. The goals in each of the service plans were individualized and aligned well with the issues noted in the psychosocial assessment. All plans indicated the initiation date and all but one (1) had all required signatures

The reviewer noted that the review dates on the log were pre-signed by the counselor on 3 of the files when no review had either been done or the time frame has not occurred as of this date. No client or parent initials on log even when reviews had occurred. One file did not have evidence of any entries on the log even though it was beyond 30 days. In addition, there were some inconsistencies in the plans in regards to target dates and location.

In one youthõs file, the psycho-social assessment does not have a substantial amount of information and only covers the basics. The goals match treatment plan, but seem a bit vague and lack measurability. Consistent client and parent signatures on review dates are lacking. Review dates appear to be pre-populated by counselor, no mention in progress notes of review. There is evidence of a significant gap (3 months) in time between sessions with no explanation. In another youth file, the service review log is not complete. In addition, there is no frequency or location in the treatment plan and the time frame is also blank. Another file indicates that there are no client or parent signatures on the review log. Documentation dates appear to have been pre-populated by counselor. No location is noted in the youthõs treatment plan. Another youth file does not include the location in the treatment plan. There are no reviews for the treatment plan as family did not return to services. The designation of location is missing and no plan reviews are due as the case is under 30 days. Further, there is no evidence of signatures on plan other than counselor.

| **2.04: Case Management and Service Delivery** | Satisfactory Compliance |
|---|---|

A review of the agencyõs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 2.04. A total of five (5) client case files were reviewed for compliance with indicator 2.04. All 5 client files were observed to show satisfactory compliance with all indicators within the standard. None of the files reviewed were involved in the case staffing or court process. All of the client files had evidence of active case management and facilitation by the counselors with good documentation of family involvement. Progress notes clearly stated and follow the prescribed goals noted in the treatment plan and appropriate referrals are made when indicated. No exceptions were noted in this standard.

One (1) case has been open for an extended period since 12/20/2011. As of the date of this review, the case has a total of four (4) sessions. Documentation of referrals are present and family involvement is noted. Another case has been open since 12/08/2011. There is evidence of numerous sessions, extensive work done with family, good family involvement and referrals are

noted. One (1)closed file was open for a short period from 11/28/2011 and closed 12/6/2011. A total of 3 sessions are noted and referrals were made during that time with evidence of family involvement. Another closed file was opened on 01/17/12 and closed on 04/17/2012. Only 2 documented sessions noted that referrals were made. An additional case was opened on 04/04/2012. A total of 5 sessions are documented with detailed notes and no referrals were required. This case also documents good family involvement.

| 2.05: Counseling Services | Satisfactory Compliance |
|---|---|

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 2.05. Counseling services are provided on a consistent and regular schedule for the youth in both CINS/FINS Non-residential and Residential programs. Of these cases six (6) CINS/FINS cases, two (2) were Non-residential that had been transferred in from recent residential stays and four (4) were Non-residential cases. A total of 6 out of 6 cases demonstrated evidence of individual and family counseling services in accordance the Case Service Plan. All 6 cases document the events that occur in each counseling session provided through the review of Service Plans (excluding 1 non-residential chart) with all having extensive, clear and informative case notes.

The 4 residential charts not only have case notes indicating group counseling sessions, but also contain evidence in each chart of the individualôs participation (including worksheets, writing, art, etc). Further, there is a consistent chart protocol and documentation evidencing clinical review of case records, youth management and staff performance for CINS/FINS service in all charts. (One non-residential chart did not have a supervisorôs signature on one Service Plan. All other paperwork in that chart had supervisorôs signature where required.) The agency consistently displays compliance with major requirements and procedures outlined in the Florida Networkôs Policy and Procedure manual for CINS/FINS for this indicator.

The program has a process in place where all youth files, both residential and non-residential, are reviewed at least monthly by a supervisor to ensure accuracy and completion of major documents regarding the service provided.

| 2.06: Adjudication/Petition Process | Satisfactory Compliance |
|---|---|

A review of the agencyôs policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by indicator 2.06. Counseling services are provided on a consistent and regular schedule for the youth in both CINS/FINS Non-residential and Residential programs. Of these cases, six (6) CINS were Non-residential with two (2) being Case Staffing charts and four (4) Residential with one (1) being a Case Staffing chart.

The agencyôs case staffing committee meets to review cases of youth/families not in agreement with services and/or not participating in services. In the 3 charts reviewed none of the parents requested in writing a case staffing. Further, 3 of the 10 charts are adjudicated youth with 2 charts from Non-residential and 1 from Residential (due to a court order for shelter at the adjudication).

The current adjudication/petition process encompasses a designated staff member who initiates the case staffing process for all youth/families non-compliant with service plans and did so for all 3 cases. An organized binder provides copies of letters of family notification of over five (5) working days prior to the case staffing. Documentation of e-mails for the notification of the case staffing committee members were provided as required. In addition, committee members were notified by e-mail more than 5 working days prior to the case staffing. Local school district representatives and DJJ and/or CINS/FINS providers were present for all three meetings. Other members included for all 3 were non-residential community counselors, local law enforcement representative, school resource officers. There was no indication the youth/family asked for anyone else to be invited nor did anyone else attend.

All 3 youth/families were provided with new service plans after adjudication as a CINS youth.

Recommendations were provided for all 3 families as new and/or revised service goals. Copies of letters sent to all 3 families were in the Case Staffing binder dated within 7 days of the meeting outlining recommendations and reasons behind the recommendations. The Case Staffing case manager has all legal documents filed in each of the 3 charts for the adjudication of the youth and court orders presenting the judicial intervention for the youth/families. The Case Staffing binder had copies of the summary reviews for all 3 cases to case staffing committee members and youth/family prior to the court hearing. The agencyøs adherence to Indicator 2.06 was well documented and organized in accordance to the Florida Networkøs Policy and Procedure Manual for CINS/FINS.

## Standard 3: Shelter Care/Health Services

| Overview |
|---|

The Safe Place 2B St. Petersburg youth shelter is located is a modern structure that is licensed by the Department of Children and Families (DCF) for twelve (12) beds and it primarily serves youth from Pinellas County, as well as youth from surrounding counties. The shelter also admits youth from the Department of Children and Families (DCF) and as part of the Basic Center and Street Outreach Programs. At the time of the quality assurance review, the shelter was providing services to six (6) DJJ youth. The shelter is not designated by the Florida Network to provide staff secure services. The agency has two (2) staff members onsite that are licensed counselors.

During the tour of the facility, the review team toured all major areas include sleeping rooms, kitchen, bathrooms, dining area, medication storage area, recreation area, wash room, as well as other areas. The structure was found to be clean and in good working order and all major furnishings were in good repair. Major areas such as the bathrooms, the common area and dining room were clean. The direct care staff members are primarily responsible for hygiene and cleaning of the shelter. The bedrooms were found to be clean. Each sleeping room is categorized by a right, middle and left sequence. Four (4) of the bedrooms house 3 beds each with an individual bed, bed coverings and pillows. The outside grounds are surrounded with a privacy fence and residents have access to green space, a gazebo and an open basketball court.

| 3.01: Shelter Care Requirements | Satisfactory Compliance |
|---|---|

A total of four (4) residential files were reviewed for compliance with standard 3.01 indicators 1-3. All 4 files contained a checklist that is utilized upon intake with the youth during orientation. The checklist contains the required program orientation components including a review of client rights and the grievance process. All 4 of these forms were initialed and signed by both the staff member and youth. A copy of the youth handbook was provided to the review team. The hand book was found to cover all the required elements. Client rights are also noted on an individual form on the Intake form that is then signed and copied for the client per the program supervisor. All 4 files contained this form with appropriate signatures. There were a total of 13 grievances reviewed for the monitoring period, all were within the specified timeframe and were signed by the appropriate parties. The client handbook that was provided to the review team also contains a

description of the grievance process. The agency policy and procedure are in place for each of these indicators. Policy 3.11 ñProgram Orientationò covers both indicators 1 and 2 in standard 3.01, addressing all the needed elements. Policy 3.03 ñGrievance Processò addresses all the

required elements of indicator 3.01 in standard 3.

The current policy requires that all youth admitted to the shelter and resident bedrooms be checked via visual observation and documentation every 10-15 minutes during sleeping hours. The agency uses an electronic scan gun to scan and track all bed checks. Each bed check is conducted by the Direct Care staff member. At the time of the onsite Quality Improvement review, agency staff members were conducting bedroom checks manually due to a malfunction in the automated system. A random selection of eight (8) overnight bed check counts were reviewed for this indicator. The monitor reviewing this indicator reviewed bed check shift logs from March 2012 through April January 2012. At the time of this onsite review, video camera footage reviewed that six (6) out of eight (8) overnight bed check counts were conducted on average of 10 minutes on the overnight shift. Overnight bed check counts on April 1 and April 29, 2012 were not consistent. Overnight bed check documentation on April 1, 2012 reviewed onsite indicates that the agency utilized Daily Bed Check Form with pre-populated 15 minute time intervals. Overnight bed check documentation on April 29, 2012 reviewed onsite indicates that the agency utilized

Daily Bed Check Forms that require the user to write in the actual bed count time in real-time. The shift schedule and video camera footage reflects compliance with at least one male and one female staff member is scheduled to work on each overnight shift. The agency was informed to not use pre-populated bed check count forms when the automated scan gun is not operational. If the automated system is not in operation, it is best practice to use daily bed check forms that require direct care staff to document bed check counts in real-time.

| 3.02: Healthcare Admission Screening | Satisfactory Compliance |
|---|---|

All youth are required to be screened upon admission for any medical concerns and conditions. The agency/local service provider has written procedures to address the admission process to include an in-depth health screening through the completion of the CINS Intake Assessment form. The health screening form addresses all elements of the indicator: current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings. The procedures indicate youth have unimpeded access to emergency medical care at all times. The procedures indicate if a major medical condition exists the youth will be immediately referred to their physician, emergency room or a public health care department. The policy lists examples of major medical conditions to include diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia; head injures which occurred during the previous two weeks, acute allergies, chronic bronchitis or other chronic disorders. The procedures indicate that staff would contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medications and general precautions in the case of an emergency.

All medical referrals were documented on a daily log. All six (6) files (two open and four closed files) reviewed contained documentation of the CINS/FINS Intake form that was completed the day of the youthôs admission. The form addressed all elements of the indicator with the exception to observation of scars, marks or tattoos. The program utilized another

form to address the requirements, i.e. ñSubject Description Sheetò All 6 files reviewed contained the required forms. The written procedures addressed the referral process and follow-up medical care.

| 3.03: Suicide Prevention | Satisfactory Compliance |
|---|---|

The shelter had a written plan that outlined the suicide prevention and response procedures. The plan indicated each youth admitted to the shelter will be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. If the youth answers ñyesò to any of the 6 questions, the youth care worker will immediately refer the youth to a qualified mental health professional to determine the specific level of suicide risk or, if a qualified mental health professional is not available the youth will be placed on Constant Sight and Sound supervision until a full suicide assessment can be completed by a qualified mental health professional. The shelter utilizes two (2) levels of supervision: one to one supervision and constant sight and sound supervision. The plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Networkõs Policy and Procedure Manual for CINS/FINS.

All 6 files reviewed (two open files and four closed files) contained documentation that indicated a suicide risk screening was completed during the initial intake and screening process. All 6 files contained documentation that indicated the suicide screening results were reviewed and signed by the supervisor who was also the licensed clinical social worker. All applicable youth were placed on sight and sound supervision until assessed by a licensed professional or non-licensed staff under the

direct supervision of the licensed professional. The supervision level was not changed or reduced until approved by a licensed professional. Three (3) of the 6 files were applicable for requirements of a suicide risk assessment. All 3 files contained the required documentation. Two (2) of the 3 files were applicable for sight and sound supervision requirements. Both youth were placed on the appropriate level of supervision based on the suicide risk assessment results. Supportive documentation was reviewed to include precautionary observation logs and thirty minute checks.

| 3.04: Medications | Limited Compliance |
|---|---|

The agency had written procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. Observations found all medication was stored in a double locked cabinet that was inaccessible to the youth. Oral medications were not stored with topical medications. The shelter had a secured refrigerator designated for medication only however at the time of the review it was empty. The agency does not provide over-the counter medication and did not have any stock over-the-counter medications. A perpetual inventory with running balances was maintained for all medications. At the time of the review, there were no youth taking narcotic or controlled medications.

The sharps maintained at the shelter consisted of scissors, razors and pill cutters. The shelter maintained a daily count of the sharps at each shift change for the last six (6) months. A review of the Central Communication Center (CCC) reports indicated on February 23, 2012 a youth did not receive

his morning psychotropic medication i.e. Focalin XR 10 mg. Both staff was required to attend a medication training to be held at the shelter by the DJJ Nursing Consultant. The training was cancelled. Administration indicated staff completed an on-line training class and will be rescheduled for another instructor led training class. Another CCC report indicated on March 24, 2012 a youth did

not receive his morning dose of anti-convulsing medication i.e. Oxcarbazapine 150mg. On March 25, 2012, the same youth did not receive his noon psychotropic medication i.e. Adderall RX 20 mg. Agency administration indicated all staff members involved received appropriate corrective action. Written corrective action was documented and reviewed.

| 3.05: Medical/Mental Health Alert Process | Satisfactory Compliance |
|---|---|

The agency has a written procedure to address medical and mental health alert process. The shelter maintained a large dry erase board with appropriate color coded dots to identify various medical/mental health conditions. The green dot indicates a mental health or substance abuse condition, blue dot indicates one-to-one supervision, red dot indicates sight and sound supervision, purple dot indicates sharps restriction, black dot indicates medical issues and allergies and orange dot indicates medical or mental health medications.

The agency utilizes a color coded guide for the various conditions to maintain the youthôs privacy and confidentiality. Both open files contained the appropriate color coded dots which were documented on the dry erase board and the individual files. One (1) of the four (4) closed files did not include an alert for the youthôs allergy to penicillin. Shift Exchange Information forms and log book entries were reviewed to indicate staff members were provided sufficient information and instructions regarding the youthôs medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment.

| 3.06: Episodic/Emergency Care | Satisfactory Compliance |
|---|---|

The shelter has a written procedure to address episodic/emergency care. The programôs written policy indicates they provide immediate on-site first aid and emergency care in case of injury, acute illness, and suicide or homicide attempts. All staff members are to be trained in first aid and Cardio Pulmonary Resuscitation (CPR) within three months of employment. A review of eleven (11) staff member training files indicated one (1) on-going staff person was missing documentation for current CPR and First Aid certification.

There were three (3) episodic events within the last six (6) months. All 3 episodic events were documented on the episodic log and in the program log book. There was documentation for the parent/guardian notification requirement and obtaining off-site emergency services i.e. EMS or the police for Baker Acts. At the time of this review, the shelter had a first aid kit, wire cutters and a knife for life. Staff members are also required to be trained on the location and use of the knife-for-life.

| Overall Rating Summary | |
|---|---|
| Satisfactory Compliance: | 89% |
| Limited Compliance: | 11% |
| Failed Compliance: | 0% |