



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources- St. Petersburg

on 01/07/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Tom Popadak, Training Specialist, Diversified Consultants

Pat Mcghee, Contract Manager, DJJ

Carolyn Kehr, Program Director, New Beginings Youth Shelter

Baldwin Davis, Chief Compliance Officer, Miami Bridge

Tracy Smith, Business Analyst II, Hillsborough County Department of Children's Services

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 4 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 11 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 14 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 3 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 3 Youth | 6 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Standard 1: Management Accountability

Overview

Narrative

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. Residential shelter staff includes a Residential Supervisor, eight (8) Youth Care Workers, one (1) Residential Counselor, one (1) case manager, and one (1) Secretary. In addition to the residential program, the non-residential component has a contracted Counselor. All residential shelter staff and non-residential staff are overseen by an on-site Program Director. At the time of the quality improvement review, the shelter had one (1) vacant full-time Youth Care Worker position and one (1) vacant part-time cook position. The Department of Children and Families has licensed Safe Place 2B as an emergency runaway shelter.

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 employee's date of hire. The program provides training through a combination of web-based and in person instructor-led courses.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy and procedure in place that addresses background screenings. Reviewed a total of six (6) employee files for background screenings, four (4) new hires and two (2) five-year rescreenings. All background screenings were completed prior to the employee being hired. The five year re-screenings were completed within the required time frame. The Annual Affidavit was submitted on January 3rd, 2014.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

Program has the necessary policies and procedures in place, which are in line with the requirements of the Department of Juvenile Justice and Florida Statue, to provide a safe and secure environment. The programs grievance binder was reviewed. A total of three grievances were reviewed and completed by staff with the necessary signatures. The disaster preparedness and emergency manual was accessible for review and posted throughout the program office. The evacuation route is posted for staff , youth and visitors to view. The program has a total of nine video cameras for surveillance all are functional and in good condition. Safety/Risk inspection checklist list was provided and conducted twice for non-residential and once a year for residential. The program provides a client handbook to youth in the program, as well as, visitors which detail the responsibility, and exceptions of the shelter. All youth surveyed reported they are able to self report abuse to the abuse hotline and they feel safe in the shelter. All staff surveyed reported they have never heard a staff member deny youth access to the abuse hotline.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The following documents were reviewed during the onsite QI and Compliance monitoring review: the administrative standard operating manual, grievance binder and the listing of proposed training schedule fy 13/14. A total of eight incident reports were reviewed. Of the eight reports reviewed only two required notification to the Central Communications Center (CCC) and was completed within the two hour period of reporting. The other six reports were non reportable for CCC notification and received immediate assistance by staff. The following incident types unreported were cases such as physical aggression, and destruction of property. The program complies with the requirement and procedures outline in the department policy and administrative codes.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has policy and procedures in place that addresses the required training's for first year and on-going. Reviewed eight staff training files. Of the eight staff files reviewed, four were new employees. Seven out of eight were current in First Aid/CPR, leaving one new staff needing to complete, which is scheduled for training on Friday, 1/10/14. This staff is still in compliance and on track for getting the required training hours by 10/21/14.

One out of the four annual training files did not have twenty-four hours of on-going training. This staff only had four and a half hours of training.

The agency provides a six hour diversity training day that consist of different topics and speakers. Training is offered during staff meetings which is held on the third Thursday of each month, online or using the binder to take additional training's by reading the provided material and taking the quiz. The quiz is graded by the supervisor and a certificate will be given after completed.

There is a new hire orientation training that covers eight hours of the required training's. At times, it was inconsistent to track if the staff had the orientation, however you had to look at the training certificates located in the file to verify if they had the training.

The agency has a training calendar for 2014. Each month it has listed topics that will be covered and how it will be covered. They are now offering some training's on the weekend that will address the part-time and on-call staff to get training hours.

All files had training certificates to support the staff training tracking form hours. The supervisor uses this method to assist when completing the staff evaluation.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a process in place for collecting and tracking data on patterns and trends. The report has the capability of capturing data which has been very effective in improvement to creating and developing services. The process has four interesting parts, the peer review, risk management, the safety committee, and the quarterly improvement meeting, which is with directors and supervisors. The safety/risk inspection checklist was explained on how it works and the time frame in which the process takes. The safety/risk is conducted every two years and the administrative every year as another tool to track trends and patterns for improvement. The program provided two binders, one the peer review safety team and the other the risk management team. Each binder consist of tabs to separate the directors and supervisors team meeting agendas/minutes, Safety committee meeting agenda/minutes, follow up emails, and risk management team incident report. Annual reports are reviewed quarterly which included a number of reports, medication related incidents, serious incidents and types of incidents, injuries, safety and facility issues and concerns, peer review summaries, shelter and non-residential performance tracking tool and the Florida Network Agency Contract Benchmarks all have a role in improving the system of the agency. Staff reported the agency is looking to expand its research in implementing new graphs and reports.

A peer review safety binder was reviewed for the necessary documentation for auditing. From review of the binder a total of three summary reports were reviewed and compared with the quarter reports from July-September 2013-14 and the period of October - December 2013-14, all information was accurate and easy to follow. Each summary had an attached performance tracking sheet and a network agency contract log/benchmark for tracking purposes which detailed all incidents, accidents, beds, etc. It was recommended to staff for consistency that the

program either include the individual peer review sheets or remove for consistency. The period of July - September did not have the individual peer sheets therefore it was questioned.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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 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 the Program Director, and includes one (1) contracted counselor, who works on an as needed basis. The counselor is 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.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Family Resources-St Petersburg has a policy for Screening and Intake that meets the FLN indicators for Standard 2.01. It states a Screening is completed to determine whether Family Resources can best meet the needs of the youth or not. All Screenings will result in an appointment being made w/ family counseling services, shelter programs or referral to other appropriate services. The policy states each youth and parent/guardian receives a copy of the "Rights and Responsibilities", including the grievance policy, and available service options, as well as the FLN publication describing the case staffing, CINS petition, and CINS adjudication process.

There were nine charts reviewed which included: four closed shelter, two open shelter, one closed non-residential and two open non-residential. All indicators were met, without exception, for residential files. All Screenings were completed at time of first call/referral received. Parents are provided a FLN brochure as stated above in agency policy. Parents are also provided with a Parent Packet providing services available, program goals, youth/shelter security, shelter guidelines and privacy practices.

All indicators were met, without exception, for non-residential files. Parents in the Family Counseling program receive the FLN brochure as well as a FR Consumer Information Packet. All indicators are addressed in Packet and brochure.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

Family Resources provided policy for Standard 2.02. The FR policy met all indicators of Standard 2.02 as provided through FLN.

There were nine charts reviewed: four closed shelter charts, two open shelter charts, one closed non-residential chart, and two open non-residential charts.

Family Resource's policy indicates that either a Bachelor or Master's level staff may complete the Psychosocial Assessment. All nine Psych Assessments were completed by Masters level and/or MSW Intern staff. Supervisors with Masters and/or licensure sign all documentation providing "best practice" clinical skill. Licensed Clinical Supervisors consistently signed any suicide risk assessments completed. This Standard is met in all aspects consistently throughout each indicator. The Psychosocials were often completed the same date the youth was admitted to either the shelter and/or non-residential programs which is a "best practice" policy.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The policies of Family Resources for Standard 2.03 requires a Service Plan to be completed within 7 working days of the Psychosocial Assessment. The policy also indicates this Plan will be developed with the youth and family to meet the specific identified needs of the both.

All nine charts provided dates in the documentation showing the Service Plans were developed most often within two - three working days; thus, providing "best practice". The case manager meets with the youth after the Psychosocial Assessment has been completed and develops the Service Plan with the youth. All Service Plans provide information of the individualized and prioritized goals for the youth's needs. This is created with a type of service, the frequency of service to be provided and the location where the service will be provided. The goals consistently show what the youth, family/parent, and case manager/counselor will be responsible. Youth help develop target dates in the conversation so as to have a time frame for their progress. The youth each signed their own Service Plan in all nine charts. The case manager/counselor signature, along with a supervisor signature was also on all nine Service Plans. One closed shelter chart had no "frequency" for service type. One open shelter chart had no parent signature as neither parent showed for session. One closed shelter chart did not have a Case Plan parent signature as the chart was not available when the parent was present; however, documentation shows the parent was present for the review of the Plan.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

Family Resources policy for 2.04 is in conjunction with the FLN standard and indicators. Case management is at "best practice" level by the shelter. The case manager works with the youth to provide group education. This staff member also provides the "action" of advocating for youth through making contact with parents, schools, and other professionals that might be involved in the child's life. This is evidenced by clear documentation.

A Master's level counselor provides the clinical work with the youth and family in both the shelter and the Family Counseling program. Documentation in all nine charts reviewed show meeting dates, times and issues addressed. A "best practice" coordination of case management and service delivery is found in the on-going assessment of youth and family needs by the Team Case Consultation system. This team consists of the case manager, counselor and other staff. This is documented with a specific form and signed by all who attend. The referral form is clear and used consistently in all charts. It is a list of local resources for major needs of families, including but not limited to local financial services, medical, mental health, substance abuse, etc. This list not only includes the kinds of services but the names of agencies providing services and contact information.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

Family Resources policy aligns with the FLN Standard 2.05. This policy in practice is indicated by the documentation from the nine charts reviewed.

The counseling services are provided by Master's level counselors in the shelter and non-residential programs. The counselors in the non-residential program Progress Notes and Session Log show the dates and times families comply with appointments, reschedule appointments and do not show for appointments. The Progress Notes provide the information the family is working on in conjunction with the Service Plan, the progress and/or lack thereof. The Progress Notes provide a snapshot of the family, the needs and the potential for success. Residential counseling is provided to the shelter youth and parents/guardians concerning the issues that led the child to be placed in the shelter. The Progress Notes provide the players involved in the issues, who is willing to work toward success and who might be an obstacle in the process. Counseling sessions are consistent and well documented. Information from the Psychosocial and goals from the Service Plan are consistently woven through the counseling sessions to provide ongoing recognition and potential for change.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy that addresses all of the key elements of this CQI indicator. The agency CINS Policy Manual provided to us during this CQI site review consists of internal agency policies, the Florida Network Policy Manual and the CINS/FINS CQI standards. The agency's internal policies were last reviewed, updated and approved by the agency's COO Pat Gerard in September of 2013. The agency also maintains separate policy manuals for Administrative Operations and Human Resources.

During this CQI site review three client case files were evaluated in terms of the service delivery process for youth who had been through the case staffing committee and/or CINS Petition process. The Case Staffing Committee (CSC) meets every third Tuesday at the Pinellas County Juvenile Assessment Center (JAC). The CSC consists of representatives from Family Resources, The Pinellas County School Board, State Attorney, Clearwater Police, St. Pete Police, Pinellas Sheriff's Department, Operation PAR (substance abuse) and a school board social worker/mental health representative (licensed). Notification of the CSC meeting location, date and time is provided in writing to youth and families who will be participating in the CSC meeting at least 10-14 days prior to the meeting. Documentation of the notification letter is maintained in each client case file. There were no parental requests for a CSC meeting at the time of this site review. CSC members are notified via email about the date and time of the meeting and are provided an agenda of the youth and families scheduled to be present and those cases to be reviewed at the 30, 60 and 90 day periods. The outcome of the CSC meeting may include up to twenty different recommendations. The recommendations are checked off on the CSC Recommendation Form and a copy is provided to the family on site if they attend the meeting. If the youth/family are not present a copy is mailed to them within seven days. Approximately 25 to 30 new cases are heard every six months by the CSC. An interview with the assigned CINS Case Manager indicated that the CSC is very active and effective. Approximately 70% of the youth going through the CSC process are successful at completing the recommendations and those who do not comply go to the CINS Petition process. Youth may also be court ordered into the shelter in St. Pete or into Staff Secure Shelter in Clearwater.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Each youth file reviewed was marked confidential and maintained in a neat and orderly manner. Each file had a check list at the beginning of the file indicating the layout of the file, which allows staff to be able to quickly and easily access information. According to staff interviews, files are kept in a locked file cabinet. This reviewer was shown the file cabinet where the shelter files are kept. The cabinet was locked and was only accessible by the program staff.

Standard 3: Shelter Care

Overview

Rating Narrative

The Safe Place 2B St. Petersburg youth shelter is located in 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 three (3) DJJ youth. The shelter is not designated by the Florida Network to provide staff secure services.

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 Environment

Satisfactory

Limited

Failed

Rating Narrative

The shelter environment is clean, tidy and neatly arranged with adequate furniture and lighting throughout. There is no evidence of infestation or any other environmental hazards or nuisances. Bathrooms are clean and hazard free as well as the kitchen is well kept with a few noted points that are referred to as exceptions.

Externally, there is ample recreation area for youth to use and the landscaping and grounds maintenance are very well managed. There are no noticeable hazards in place around the facility.

All the relevant licenses and certificates are posted throughout the building as well as the mandatory helpline telephone numbers for client. Youth have individual beds in shared bedroom space, occupied beds were made up appropriately and empty ones displayed the required mattress covers. Clients have ample individual and shared storage areas in their rooms as well as a controlled area where other items can be secured by staff.

Recreational and activity schedules are posted as well as the house rules and expectations. Clients have access to a confidential grievance box and grievance forms are readily available for them to complete as these are displayed under the box.

Health and safety inspections are generally current with the exceptions of: Emergency lighting in main entrance lobby is not working.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy that addresses all of the key elements of this CQI indicator. The agency CINS Policy Manual provided to us during this CQI site review consists of internal agency policies, the Florida Network Policy Manual and the CINS/FINS CQI standards. The agency's internal policies were last reviewed, updated and approved by the agency's COO Pat Gerard in September of 2013.

During this CQI site visit we reviewed five client case files (three open, two closed) to evaluate the documentation related to program orientation during the intake process for youth being admitted to the shelter program. All five client case files reviewed contain a "Client Orientation Checklist" that met the requirements of this CQI indicator. All five forms were signed and dated by the client and staff conducting the intake. Interviews with three youth at the shelter confirmed that a comprehensive orientation was completed at time of intake, that they had received a client handbook and that they each had signed the form that was in their respective client case files. Interviews with two youth care staff members also supported the agency policy and practice related to new client orientation at the shelter in a consistent manner.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy that addresses all of the key elements of this CQI indicator. The agency CINS Policy Manual provided to us during this CQI site review consists of internal agency policies, the Florida Network Policy Manual and the CINS/FINS CQI standards. The agency's internal policies were last reviewed, updated and approved by the agency's COO Pat Gerard in September of 2013. The agency also maintains separate policy manuals for Administrative Operations and Human Resources.

The facility has four bedrooms with three beds each for a total of twelve beds, six being designated for females and 6 for males that are on opposite sides of the central living area of the facility. Each room is numbered (1-4) and each bed is designated as being near the door, the window or in the middle of the room.

The agency assigns each youth to a room and a bed at intake utilizing information collected on the CINS Intake form. The youth's room/bed assignment is also designated on the dry erase board located in the living room area of the facility. The agency takes into consideration the following factors to determine the appropriate room/bed assignment: gender, age, physical size, history of aggression and potential for conflict. During this site visit there were four CINS/FINS youth at the facility. All four were documented on the dry erase board. Interviews with youth also confirmed the room/bed assignment process was consistently followed. A review of five client case files (three open, two closed) also confirmed that the CINS Intake Form was completed in each case and the room assignment section was completed consistently in all five cases. An interview with the Shelter Manager also confirmed how the room/bed assignment process works and how it is documented in the client case file and on the dry erase board.

See Tom's report

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Log books were reviewed for the past year and the reviewer noted that they are being completed consistently each day and includes all intakes and incidents that occur. Entries are in ink and are brief, concise and as legible as possible. A system is in place where noted documentation are color coded by highlighting that specific entry. The shelter manager reviews the log book weekly and shows that review with a

highlighted entry. This entry is done as required by the standard and agency policy. However staff and supervisors do not state that they have read the log book for the past two shifts as the standards and agency policy requires. Corrections are usually not made following the required protocol of using a single line and initialing and dating along with the words error or void. Log books, going back a year were reviewed and when there is a correction it is struck out and "error" annotated per agency policy. However CINS/FINS standards requires correction to be initialed and dated. There is a tendency to overwrite instead of making the appropriate correction to single used words. Highlight markers seep through the pages making the document page difficult to read and messy in instances. In one instance between December 22nd and 26th 2013, there appears no differentiation with documentation dates, due to the use of the highlighter obscuring relevant date change information. Signatures and Names are inconsistently readable and so a name print and signature sheet could be attached to front of log book, updated for new staff.

Rating Narrative

The agency's BMS is structured on a level system that is dictated by resident behavior over a twenty-four hour period. It begins from the orientation stage until it gets to the highest level that is gold. Between these levels, there are bronze and silver. At all levels youth will have attainable goals for the day and behavior expectations, all of which are posted and explained at orientation and displayed in the handbook. BMS is well defined in the policy manual as well as in the client handbook and are reflective of these guidelines. Staff interviewed seemed to have clear knowledge and a grasp of how this worked. Youth also thought it was a fair and practical system that worked for them. For staffing, five training files were reviewed and all staff had training conducted for BMS and that appears to be ongoing. Behavior Interventions, as part of the overall BMS, is clearly defined as a policy statement, however there is no written administrative guideline or process for staff to follow in such an instance where such intervention is necessary. Agency has a strong and structured BMS Policy that covers incentives and consequences for behaviors. Review of six staff files revealed that BMS is not part of performance evaluation goals which, if conducted, will meet the standards in providing feedback and evaluation.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The program has a written policy and procedure that addresses all of the key areas of this QI indicator.

The program consistently maintains minimum staffing ratios and generally maintains having one staff on shift for each gender as the youth served. The agency consistently is in line with the standards requirements of having two staff on overnight, that is also the agency's policy. The staffing schedule is made in advance and is posted for all staff to review. There is a list of holdover roster for on call staff as well as staff telephone numbers are available to all relevant staff. Youth are accounted in the daily log book at intervals and overnight checks are kept in a separate binder where youth are documented as being checked every fifteen minutes as the standards and policy requires. A period of staff shortage in December resulted in female staff only covering, instead of male/female to meet the gender requirements of the program and specific to CINS/FINS standards 3.06. Program staff provided orientation training documentation that explains protocol in such instances, however recommend that this be written in policy. In the meantime, still no evidence was provided to show how the decision was reached for those shift covered that did not meet policy and standards requirement. The agency has video surveillance monitoring on site and CINS/FINS standards recommends that if facility has a video cameras, backup is for eight days

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy that addresses all of the key elements of this CQI indicator. The agency CINS Policy Manual provided to us during this CQI site review consists of internal agency policies, the Florida Network Policy Manual and the CINS/FINS CQI standards. The

agency's internal policies were last reviewed, updated and approved by the agency's COO Pat Gerard in September of 2013. The agency also maintains separate policy manuals for Administrative Operations and Human Resources.

During this CQI site visit a total of three Domestic Violence Respite client case files were reviewed. One youth stayed a total of seven days in shelter before being discharged in compliance with the DVR program policy. Two of the youth began their placements as DVR referrals and later transitioned into CINS/FINS services following their fourteen day placement approved by the Florida Network in accordance with DVR program policies.

Each of the youth admitted under the DVR program had documented domestic violence charges making them eligible for admission under the DVR program requirements. Documentation of Florida Network approval of the DVR placement was provided in each of the three cases reviewed. The service plans in each of the three files also contained service plans that addressed the DVR placement issues such as anger management, conflict resolution, coping skills and decision making. An interview with the Program Director, the Shelter Manager and the VP for Youth and Family Services confirmed that Florida Network policies and procedures related to the DVR program are being followed on a consistent basis. The agency does not provide Staff Secure Shelter services at the St. Petersburg location (SSS is provided at the Clearwater shelter site).

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Safe Place 2B St. Petersburg youth shelter provides screening, counseling and mental health assessment services. The Residential Supervisor and Program Director are Licensed Mental Health Counselors (LMHC). 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 residential youth shelter. Trained shelter staff assist in the delivery of medication to all youth admitted to the residential youth shelter. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. 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 written policy that addresses all of the key elements of this CQI indicator. The agency CINS Policy Manual provided to us during this CQI site review consists of internal agency policies, the Florida Network Policy Manual and the CINS/FINS CQI standards. The agency's internal policies were last reviewed, updated and approved by the agency's COO Pat Gerard in September of 2013. The agency also maintains separate policy manuals for Administrative Operations and Human Resources.

A total of five residential client case files (3 open, 2 closed) were reviewed for the initial health screening during the intake/admission process at the shelter. The agency utilizes the standard, State-wide CINS Intake Form that documents the assessment of a youth's general health condition and/or issues at intake. Of the five files reviewed all contained a complete CINS Intake Form with the medical information documented on the back of the form.

One youth who was admitted on 1/4/14 was on medication for ADHD and stated that he had asthma. There was no indication as to the severity or recency of the asthma condition noted in the chart. Upon interview the Shelter Manager and the Shift Leader provided additional documentation that was signed by the youth's guardian at intake that indicated there was no current medical condition that required medical follow.

After interviewing both staff members it was determined that the asthma condition reported at intake was not a medical issue or concern as it relates to this youth's current medical status, safety or well being. Additional documentation was provided in the form of daily shift notes that showed that the youth had not reported or demonstrated any signs or symptoms of asthma and was functioning well at the facility.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency Suicide Prevention policy is in place. The policy was last reviewed in September 2013. The policy states that each youth will be screened for suicide risk by the six suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to any of the six questions, the youth care worker will either immediately refer the youth to a qualified mental health professional if indicated, available, and accessible, to determine the specific level of suicide risk, or if a qualified mental health professional is not available, place the youth on constant sight and sound supervision until a full suicide assessment can be completed by a qualified mental health professional. The assessment will be done within twenty-four hours during the weekdays or within seventy-two hours if over the weekend.

Youth awaiting an assessment by a qualified mental health professional are placed on constant sight and sound supervision. If at any time the youth engages in suicidal/homicidal gestures, repeatedly states they wish to harm themselves or others, and/or states a specific plan for suicide, they will be placed on one to one supervision and referred immediately for a Baker Act.

In non-residential services, if the youth answer "yes" to any of the suicide questions, a full suicide assessment will be conducted. If the assessment indicates, one to one supervision will be initiated and the Clinical Supervisor will be notified to determine the appropriate actions. The parents/guardians will be notified as quickly as possible if the youth answers "yes" to any of the suicide questions. Parents will also be provided with additional resources in the community for further assessment services. If at any time during or after the screening process, the youth presents as an immediate risk to self or others; staff will immediately call 911 for assistance with Baker Acting the youth.

There were four files reviewed for youth placed on suicide precautions. All four youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. All four youth were immediately placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. All four files documented the assessment was completed within twenty-four hours by a masters level counselor. All the assessments contained documentation of a consultation with the LMHC either by telephone or fax. Three of the four files documented the LMHC contacted signed the Assessment of Suicide Risk the next time on site. One file documented the Assessment of Suicide Risk was signed three months later by a different LMHC from the one contacted. All four youth were placed on standard supervision after consulting with the LMHC. There were thirty minute observations maintained the entire time the youth were on sight and sound supervision. If the youth were on sight and sound supervision during the overnight hours there was documentation the youth slept on the couch in the dayroom. All supervision levels and changes were documented in the shelter logbook.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place to address medication procedures recently reviewed and updated in September 2013. The policy addresses storage, inventory and verification procedures, over-the-counter medications, disposal, and incident reporting. The policy addresses requirements outlined in the DJJ Health Services Manual. The shelter provided documentation of all staff who are trained to help youth in self-administering medication.

Observations of medication storage revealed medications are stored in a double-locked cabinet, in the staff workarea in the dayroom. The shelter utilizes medication storage racks, for all oral medications, with a tray designated for each bed. A separate box is used for all topical medications so they are stored separately from oral medications. At the time of the review, the shelter had no youth currently on any topical medications and only one youth receiving oral medications. There is a small refrigerator located in the laundry room for any medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration. The shelter does not provide over-the-counter medications, unless the youth comes in with it and has a doctor's order, so they did not have a stock of over-the-counter medications. The shelter keeps a supply of sharps in a double-locked cabinet, in a box. The supply includes seven pairs of scissors and eleven razors. The sharps were generally inventoried everyday on each shift, which exceeds the once per week inventory requirement. The razors are signed out and signed in when used by the youth.

At the time of the review there was one youth in the shelter on medications, this youth's file, as well as, three additional closed files were reviewed to verify the medication administration process. All four files contained a medication verification form that was completed and documented all medications the youth was taking. The shelter maintains a Client Medication Log, for all youth currently in the shelter on medication. The log is divided into sections and the youth's Medication Distribution Log (MDL) is filed under the appropriate bed. A picture of the youth is located on the front of the section and a print out of side effects is located with each MDL for each medication the youth is on. Once the youth is discharged all documents from the Client Medication Log are filed in the youth's file. All MDLs reviewed documented the youth's name, date of birth, allergies, side effects, medication the youth was taking with dosage and time to be given, staff initials, youth initials, full printed name and signature of each staff member who initialed a dosage, and the full name and signature of the youth receiving medication. All MDLs documented medications were given at the time specified or within the one hour time frame before or after the time specified. A perpetual inventory with running balances was maintained on each MDL, as well as, shift-to-shift inventories.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a policy in place for Medical and Mental Health Alert Process last reviewed and updated in September 2013. There is one alert board located in the dayroom for staff to review. The alert system consists of color-coded dots with each colored dot representing a different alert. There are six different colors used for alerts, green is a mental health or substance abuse alert, blue indicates the youth is on one-to-one supervision, red indicates the youth is on sight and sound supervision, purple indicates the youth is on sharps restriction, black is a medical issue or allergy, and orange indicates the youth is on medication. The applicable color-coded dot is placed on the front of the youth's file for each alert the youth is on. The color-coded dot is also placed next to the youth's name on the alert board.

There were two youth in the shelter applicable for alerts. Both files documented all the youth's alerts on the front cover of the file coincided with the alerts documented on the alert board in the dayroom. All staff interviewed were familiar with the alert system and different alerts the youth currently in the shelter were on. All dietary alerts and restrictions were also documented on the alert form located in the kitchen.

There is one alert board located in the dayroom for staff to review. The alert system consists of color-coded dots with each colored dot representing a different alert. There are six different colors used for alerts.

The applicable color-coded dot is placed on the front of the youth's file for each alert the youth is on. The color-coded dot is also placed next to the youth's name on the alert board.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy that addresses all of the key elements of this CQI indicator. The agency CINS Policy Manual provided to us during this CQI site review consists of internal agency policies, the Florida Network Policy Manual and the CINS/FINS CQI standards. The agency's internal policies were last reviewed, updated and approved by the agency's COO Pat Gerard in September of 2013. The agency also maintains separate policy manuals for Administrative Operations and Human Resources.

A review of the Episodic Care Log and CCC incident reports for the past six months revealed that there was one incident that qualified as a medical emergency. The incident involved a youth who came out of their bedroom at 10 PM at night complaining of chest pains. The youth's mother was notified by phone and she spoke to the youth to try to determine the extent of the problem. The mother then spoke to staff and stated that she could not respond to the shelter due to other child care issues. The shelter staff contacted the on-call supervisor who instructed them to call 911 and request EMT assistance. EMT transported the youth to the Hospital. Attempts to notify the mother were unsuccessful (would not answer phone).