Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources- St. Petersburg

on 01/13/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

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

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:96.00%
Percent of indicators rated Limited:4.00%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

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

Carolyn Kehr, Program Director, YFA New Beginnings

Tracy Bryant, Systems Coordinator, Hillsborough County

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

1 Case Managers
1 Clinical Staff
0 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
2 Program Supervisors
0 Other

Documents Reviewed

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

5 Health Records
5 MH/SA Records
21 Personnel Records
5 Training Records/CORE
4 Youth Records (Closed)
5 Youth Records (Open)
0 Other

Surveys

3 Youth | 4 Direct Care Staff | 0 Other

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

In April 2015, the agency hired a new Program Director who is a Licensed Clinical Social Worker (LCSW).

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

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

In July 2015, a new Residential Supervisor was hired.

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

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

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

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

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

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

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

In November 2015, a new camera system was installed in the shelter.

The shelter has secured money to install all new flooring throughout the shelter.

Since the last on-site review the shelter has been painted and received new furniture.

Standard 1: Management Accountability

Overview

Narrative

The Family Resources, Inc. SafePlace2B program provides shelter and non-residential services for youth and their families in Pinellas County and Manatee County. Residential shelter staff includes a Residential Supervisor, ten Youth Development Specialists, two Residential Counselors, one case manager, and one cook. All residential shelter staff and non-residential staff are overseen by an on-site Program Director. The Department of Children and Families has licensed Safe Place 2B as an emergency runaway shelter.

The agency operates a total of three 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 inter-agency training delivered by the agency, as well as, 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 procedures in place that addresses background screenings. There were nineteen employee files reviewed for background screenings. All background screenings (with the exception of one) were completed prior to the employee being hired. One screening was completed two days after the employees hire date.

There were two employees due for a five year re-screening during this review period. Both five year re-screenings were completed prior to the employees initial hire date. The Annual Affidavit was submitted on January 7th, 2016.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Family Resources has a policy and procedures in place that address the indicator. The grievance binder was reviewed. There were a total of seven grievances filed in the last six months and all were addressed. Documentation in the grievance logbook indicated that there were meetings with the youth and staff to address any issues. The agency has the abuse hotline number posted throughout the shelter. Any reports of abuse is reported to management staff and they follow through with CCC reports.

All three youth surveyed reported they knew the number to the abuse hotline and have never been denied access to call. All three youth also reported staff are respectful when speaking to the youth and they have never heard a staff use inappropriate language. All three youth feel safe in the shelter.

All four staff surveyed reported they have never heard another staff member deny a youth access to the abuse hotline. All four staff also reported they have never heard another staff member use inappropriate language when speaking with the youth or use threats, intimidation, or humiliation.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place that addresses the incident reporting process. There is also a grievance and incident reporting binder. There were a total of twelve incident reports reviewed. Of the twelve, seven were CCC reports. All reports were reported within the two hour time frame and supporting documents were attached to the reports. All reports were successfully closed with the CCC.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were three employee files reviewed for first year training requirements. Two of the three staff have completed their first year training period and documented 79 and 77.5 hours. There was documentation that all required trainings were covered. The third staff documented 35.25 hours so far for first year training; however, still has nine months left in the training cycle to receive the additional hours.

There were two staff training files reviewed for annual training requirements following their first year of employment. The staff documented 57.5 and 36.5 hours for the last full training cycle. All required trainings, as well as, additional trainings were covered.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Family Resources has a policy and procedures in place that addresses this indicator. The agency has put into place a variety of processes to ensure quality of services and focus on performance. The process consist of risk management, safety team committee, and quarterly improvement monthly meetings with the management staff.

The benchmark report received from Florida Network is reviewed and sent out via email to staff by senior management. The incident analysis is sent to management to address with their staff during staff meetings. Staff meetings are held monthly. The safety committee meets monthly and reviews any safety concerns. The risk management committee meets quarterly and incident reports are discussed. All reports are available on the agency intranet. At this time, no analysis report for the Pyxis station is available. The agency has only been using the MedCart for about thirty days.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place that addresses the Client Transportation indicator. There is an approved agency drivers list. The list consists of approved staff names that are given consent to transport a single client. In the event that a 3rd party cannot be obtained for a transport, the Residential Supervisor will give the prior approval with a notation on the client board, as well as, in the staff logbook. The clients' history, evaluation, and recent behavior is considered prior to the transport. Staff must complete a trip plan/van mileage log for each use of the vehicle. The transportation logbook was reviewed. Each staff completed the mileage log with the number of youth and the destination. This log is reviewed by the Residential Supervisor on a monthly basis.

1.07 Outreach Services

☐ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place that addresses the indicator.

Street outreach coordinators conduct outreach activities with youth on the streets, community, etc. to talk about the services available. The street outreach coordinators refer to all the programs including the two transitional living programs. The agency also has a SafePlace Coordinator that goes out into the community.

Family Resources is involved with several Community Outreach Meetings including: PJAC monthly meetings, PJAC Advisory Board quarterly meetings, DJJ Advisory Board quarterly meetings, Human Services Coalition quarterly meetings, PATH (People Assisting the Homeless) monthly meetings, Tampa Bay Rescue Restore Coalition bi-monthly meetings, Human Trafficking Task Force quarterly meetings, and Truancy meetings.

The agency participated in a number of community outreach events during this review period including: Health and Wellness Expo/Fair, Jr. League of St. Pete -Back To School Fair, Annual Christmas Parade/Expo - Pinellas Park Chamber, Turning Point of Manatee County - "Stand Down Expo", and Village of the Arts: 5th Annual Old Fashion Village Christmas.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Family Resources, Inc.'s SafePlace2B 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 include individual, family, and group counseling services. 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 Development Specialists are responsible for completing all applicable admission paperwork, orienting 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 two Counselors and one Truancy Case Manager. 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.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedures in place for Screening and Intake. The Referral/Screening procedure is that at first contact, an eligibility screening will be conducted to determine whether or not the shelter program or non-residential program can best meet the needs of the youth. If the youth is not eligible for services from Family Resources, at least three local referrals are provided.

There were four non-residential files reviewed consisting of three open and one closed. In three of the files, the Eligibility Screenings were completed on the same day as the referral. The remaining file was completed 43 working days after the referral.

There were four residential files reviewed consisting of three open and one closed. At the time of intake, 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 Florida Network publication describing the Case Staffing, CINS petition, and CINS adjudication process. A copy of the grievance policy and forms were posted where all families have access.

Residential youth and parents are also provided with a Youth Handbook indicating the expectations of services and behaviors.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Psychosocial Assessments.

There were four non-residential files reviewed. All four files documented the Psychosocial Assessment was completed within 72 hours of admission. All staff members completing the Psychosocial Assessments were identified as either Bachelor's or Master's level staff. All Assessments were signed within two days of completion by a supervisor. None of the youth were identified as a suicide risk through the Psychosocial Assessment.

There were four residential files reviewed—three open and one closed. All Psychosocial Assessments were initiated and completed within 72 hours of admission. Three of the assessments reviewed did not document the credentials of the staff member completing it, however; this person's credentials was found elsewhere in the files. The shelter supervisor signed the assessments within a timely manner, usually within two days. One youth was identified as an elevated risk of suicide. An Assessment of Suicide Risk was conducted and the youth was placed on Sight and Sound supervision.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Case/Service Plans. The policy indicates the Case/Service Plans will be completed within seven working days of the completion of the Psychosocial Assessment.

There were four non-residential files reviewed. All but one Case/Service Plan were completed within the seven day time-frame. All four plans had goals set and needs identified, with strong correlation to the Psychosocial Assessment. All four plans documented persons responsible for goals, target dates for completion, required signatures, and date the plan was initiated.

There were four residential files reviewed—three open and one closed. All four files documented the Case/Service Plans were developed and completed within seven working days of completion of the Psychosocial Assessment. In the three open files the Case/Service Plans documented service indicators, persons responsible, target dates for completion, required signatures, and dates. The remaining file did not document who was responsible for goals, completion targets, or youth or parent signatures.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Case Management and Service Delivery.

There were four non-residential files reviewed—three open and one closed. Counseling and Case Management services were provided for all four youth in individual sessions, as well as, family sessions as indicated in the Psychosocial Assessment and Case Plan. The Case Manager/Counselor coordinated all services required, in all cases, with the youth and family in the school and home settings. All progress and/or needs were noted in the Progress Notes of each file indicating a strong support for the youth and family.

There were four residential files reviewed—three open and one closed. In all four files, counselors were assigned at admission. All three open files had identified referral needs and coordination of the Service Plan throughout services. The Progress Notes in all three files showed evidence of monitoring family and youth progress. The one closed file did not have referral needs documented or a coordination of service plan implementation.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Counseling Services.

There were four non-residential files reviewed—three open and one closed. The documentation in these four files indicated counseling was provided according to the needs identified in the Psychosocial Assessment and Care/Service Plan. It was easy to follow the development of the identified needs through the Psychosocial Assessment, Case Plan, reviews, and Progress Notes provided. There were signatures of supervisors to show the review of this process.

There were four residential files reviewed—three open and one closed. In all four of these files Counseling Services were in accordance with the Case/Service Plan. The youth's presenting problems were in accordance with the Psychosocial Assessment and Case/Service Plans and were reviewed. All files had individualized counseling notes documenting progress or further needs. All files were reviewed and signed.

There were posted schedules of groups in the living room.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for the Adjudication/Petition Process.

There were two files reviewed—one open and one closed. All steps in the process were completed (including the notification of the family no less than five days before the staffing). This was documented by a letter in the file. Notification to the committee members was documented through e-mails. In both case staffings, committee members included local school district representation; a DJJ representative or CINS/FINS provider, State Attorney's Office, and SEDNET staff. In one file, a substance abuse representative was present. There was a revised plan for services present in each file with signatures from all who were present. If the parent/youth was present a copy of the summary was made and provided at that time. If the family/youth did not attend, a copy was mailed within seven working days per the Case Staffing Chair.

A schedule of meetings was provided. The list of committee members is on each case staffing review form. An agenda for case staffings was provided in the Case Staffing binder.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There were four non-residential and four residential youth files reviewed.

All four non-residential files were organized, easy to follow, marked with “Confidential” on the outside, and in good shape. Files were transported in a locked, confidential container.

All four residential files were marked “Confidential”, kept in a secure room, organized well, clean, and in good condition.

Standard 3: Shelter Care

Overview

Rating Narrative

The SafePlace2B St. Petersburg youth shelter is located in a modern structure that is licensed by the Department of Children and Families (DCF) for twelve beds. 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 Improvement review, the shelter was providing services to five CINS/FINS youth.

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 Youth Development Specialists 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 of the bedrooms house three 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 Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy for Shelter Environment that was last reviewed in October 2015.

All Fire and Health Safety inspections were current. The shelter has twelve beds with two bedrooms on each side of a larger living area. One side is for girls and the other side is for boys. There is a common dining area for meals for youth in the shelter and transitional living youth program next door. The dining area was clean and the menu was posted in the kitchen. The kitchen was also clean and the food was stored properly. There was a daily activities schedule posted in the common area.

The shelter recently had the inside painted, purchased new furniture for the common sitting area, and upgraded the security cameras. Each bedroom is equipped with two or three beds and one bathroom. Evacuation routes were posted throughout the shelter. There was a lockable space behind the staff desk for the youth's personal belongings. There was a defibrillator located in the lobby area. Fire inspections and extinguishers were updated as of January 12, 2016. Mock emergency and fire drills were conducted. Health Inspection was completed on 11/2015. The grounds were very well maintained. There was a basketball court in the back of the building. This area is shared with the transitional living youth program. The program's DCF license expires December 15, 2016.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy, procedure, and practice in place regarding Program Orientation. A review of five files (three open and two closed) revealed that the shelter is meeting the necessary requirements for this indicator. Upon entering the shelter each youth is given an orientation and overview of the program. A review of program expectations, rules, and behavior management strategies were discussed with each youth. In all five of the files reviewed, there was documentation that the youth and staff signed the orientation form indicating the process had been completed.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Youth Room Assignment. According to the policy, several factors are considered when assigning a youth to a room such as but not limited to: the youth's history, gender, age, propensity to violence or aggression, mental health, substance use, etc.

Of the five files reviewed, three were open and two were closed. All contained the necessary documentation indicating that all youth were assigned rooms upon entering the shelter and completing their Intake Process.

In three of the open files reviewed there were alerts on the Youth Alert Board in the Dayroom. However, there were no alerts on the files that indicated that the youth had any issues but within the file there was clear documentation that all three youth warranted alert dots on their individual files. Medical, Mental Health, and Substance issues were all identified within these files.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place regarding Log Books. A review of the shelter revealed that it has a log book in place that is only handled by shelter staff, which is used to disseminate vital information regarding the youth in their care. The majority of the entries were legible, brief, and with the names of the youth and staff involved.

The Program Director or in this case the designee, the Program supervisor, reviews and signs off in the log book on a weekly basis. It was recommended the review also include any feedback or directives for staff. The log book is highlighted with different colors to reflect vital information or occurrences regarding the youth in the program. Staff members also review the log book for the previous two shifts.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place regarding the Behavior Management System. A review of youth files, youth notes, and the Behavior Management System revealed that the shelter is meeting the necessary requirements for this indicator. The shelter also has a Rewards Store in place where the youth can purchase items based on their level and behavior. The store items consist of food, personal hygiene items, and items to assist with school work.

The Behavior Management System is designed to gain compliance with the rules of the program, influence positive behavior, and increase accountability. All Staff appeared to be versed in the functioning of the System. The System is not designed to be punitive but does hold the youth accountable for their actions or lack thereof.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Program has written policy, procedure and practice in place regarding Staffing and Youth Supervision. A Staff Schedule is posted within the Multi-Purpose Room and the Program Supervisor maintains a roster which has a listing of Program Staff's contact information in the event that overtime is needed.

A review of (5) client files & contact notes, program log book, and staff schedules revealed that the program maintains the appropriate staff to client ratio at all times. There is at least one staff member of each gender present with the exception of a few weekends where they may have (2) female staff on a particular shift. A review of client accountability also revealed that the program staff do a good job monitoring youth every (15) minutes when they are in rooms. Overall, the Program does appear to provide adequate staff in order to ensure safety & security for both clients and staff alike.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Special Populations. There were only two files available for review for this particular indicator. In one of the files the youth ran away the same day he entered shelter. Based on the information reviewed, the shelter is meeting the requirements of this indicator.

The shelter appears to have a good working relationship with their JAC. The shelter has not had any Staff Secure or Probation Respite youth since the last on-site Quality Improvement review.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SafePlace2B St. Petersburg youth shelter provides screening, counseling, and mental health assessment services. The Program Director is a Licensed Clinical Social Worker (LCSW). The shelter has staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both the residential and non-residential CINS/FINS programs.

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

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

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Healthcare Admission Screening that was last reviewed and updated in October 2015.

A total of six residential youth files were reviewed for the initial health screening during the intake/admission process at the shelter. The agency utilizes the CINS/FINS Intake Form that documents the assessment of a youth's general health condition and/or issues at intake. Of the six files reviewed, all contained a completed CINS/FINS Intake Form.

The CINS/FINS Intake Form documented four of the six youth were on medications. Three of the four applicable files documented the names of the medications, as well as, the reasons on the Intake Form and one file did not.

One youth documented a seizure disorder of Epilepsy; however, there was no further information in the file about the disorder. Reviewer could not tell if the youth required any type of follow-up care or monitoring of the condition while in the shelter. Staff did provide documentation the youth was on medication for the Epilepsy. In addition, staff contacted the parent during the review and received further clarification on the youth's Epilepsy condition.

In one file reviewed, information was found on the Consent for Transportation and Emergency Medical Treatment Form that the youth had asthma and an allergy to Penicillin. None of this information was found on the CINS/FINS Intake Form. The youth's Needs Assessment indicated the youth used an inhaler at home for the asthma for wheezing. There was no further information in the file concerning the youth's asthma, if any follow-up care was needed or if the youth needed the inhaler while at the shelter. The youth's parent was contacted during the review and reported the youth no longer has the inhaler at home and has not used it in many months.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Comprehensive Master Plan for Suicide Prevention and Response. The policy was last reviewed in October 2015. 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 questions 2 and 3, the youth is considered to be at high risk of suicide and must be placed on one-to-one supervision. Staff will refer the youth for a Baker Act. If the youth answers "yes" to questions 1, 4, 5, or 6 on the CINS/FINS Intake Form then the youth is determined to be at moderate risk for suicide. The youth will be placed on sight and sound supervision until a full suicide risk assessment is completed. The assessment will be done within twenty-four hours.

There are four different levels of supervision used in the shelter. One-to-One Supervision, this is the most intense level of supervision and is used while waiting for the removal of the youth from the program for the purpose of Baker Act. Constant Sight and Sound Supervision, this is used for youth who are identified as being at moderate risk of suicide but are not expressing current suicidal thoughts or threats. Elevated Support, this is a step-down alert, the youth was previously identified as a suicide risk but is no longer considered at-risk for suicide. Standard Supervision, is for youth who's screening of suicide risk did not indicate the need for further assessment and they may be placed in general population.

There were five files reviewed for youth placed on suicide precautions. All five youth answered "yes" to at least one of the six questions on the CINS/FINS Intake form. Three of the five youth were immediately placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. There was documentation in one of the two remaining files that the Assessment of Suicide Risk was completed immediately following intake by the Licensed Clinical Social Worker (LCSW) and the youth was placed on standard supervision. In the last file there was no documentation of an Assessment of Suicide Risk being completed even though the youth had answered "yes" to one of the 6 qualifying questions. For the three youth who were placed on sight and sound supervision, documentation and an Assessment of Suicide Risk was completed within twenty-four hours by the LCSW. The youth were placed on standard supervision and 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 for Medications. At the time of the review the policy was in the process of being updated to include the new Pyxis Med-Station 4000 Medication Cabinet.

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

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

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

Sharps are maintained in a box in a locked cabinet inaccessible to the youth and are inventoried during each shift. The shelter does not distribute over-the-counter medication unless they are permitted by the parent/guardian. In addition, no youth on prescribed medications are permitted to take OTC's unless verified and approved to be taken with these medications by a pharmacist.

There were two youth currently in the shelter on medication. The agency still maintains hard copies of all documents relating to the medication process, as well as, enters all information into the Medication Cabinet system. The youths' Medication Distribution Logs (MDL) reviewed documented the youth's name, date of birth, any allergies, side effects of the medication, dosage, reason, method of administration, prescribing physician, and full signatures of youth and all staff. Each MDL documented when a medication was given, staff and youth initials, and perpetual inventory with running balance. There was no picture of the youth either on the MDL or attached to the MDL. All MDL's reviewed for both youth documented that all medication was given at prescribed times.

The shelter has had two incidents in the last six months, reported to the CCC, relating to medication errors. The first incident was due to a youth receiving medication that had been discontinued the day before. The pharmacist was contacted and reported there should be no adverse side effects and to continue with the new medication the next day. There was documentation the staff responsible for the error was re-trained on the medication administration process. The incident was reported to the CCC and was successfully closed out. The second incident was due to a missed dose of medication. The pharmacist was contacted and reported there would be no harmful side effects and resume with normal dose at the next scheduled time. There was documentation the staff responsible for the error was re-trained. The incident was reported to the CCC and was successfully closed out.

4.04 Medical/Mental Health Alert Process

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process last reviewed and updated in October 2015. There is one alert board located in the dayroom for staff to review. The alert system consists of color-coded dots with each colored dot representing a different alert. There are eight different colors used for alerts. The color red is for constant sight and sound, yellow is elevated support, green indicates a mental health issue, blue indicates a substance abuse issue, purple is sharps restriction, black is medical issues, orange indicates the youth is on medication, and pink indicates allergies or special diet. 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 three youth currently in the shelter applicable for alerts. One youth documented one alert on the alert board for medication; however, did not document the alert for the medical condition of Epilepsy. The second youth documented only one alert on the alert board for medications; however, according to the youth's file the youth also required three additional alerts for an allergy to penicillin, a medical condition of asthma, and a mental health alert. The third youth did not document any alerts; however, according to the youth's file should have had three alerts for a medical condition of Fibromyalgia, a substance abuse alert, and a mental health alert. None of the youth files documented the applicable color coded dots on the outside of the youths file. Three additional closed files were reviewed and alerts documented in the files were appropriately documented with the corresponding colored dot on the outside of the youth's file.

One open youth file reviewed contained an older, outdated, Alert Code System Form in the file which does not correspond with the current alert system.

All staff interviewed were familiar with the alert system and the different alerts the youth currently in the shelter were on. However, there seems to be issues with alerts arising during different parts of the screening and assessment process making it into the alert system.

Any dietary alerts and restrictions are also documented on the alert form located in the kitchen.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Episodic/Emergency Care that was last reviewed in October 2015.

All staff have current training in CPR/First Aid. There is a first aid kit located in the shelter in a cabinet behind the staff work area. The contents of the first aid kit are checked monthly by staff. The knife-for-life and wire cutters are also located in the cabinet behind the staff work area in the shelter.

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

The shelter has completed nine emergency medical drills in the last six months. The drills were documented on various shifts and topics. Some drills included actual events that had occurred.