Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Clearwater

on 02/05/2019

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/Expression	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
3.08 Video Surveillance System	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%

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

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer/Consultant, Forefront LLC

Donna Connors, Regional Monitor, Department of Juvenile Justice

Jasmine Crayton, Residential Supervisor, Youth and Family Alternatives

Diane Lindsay, CINS FINS Program Manager, Tampa Housing Authority

Felicia Wells, Program Director, YAP

Persons Interviewed

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

0 Case Managers
1 Program Supervisors
1 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

2 Clinical Staff
0 Other

Documents Reviewed

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

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

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

The shelter has hired six new Youth Development Staff (YDS) since the last review.

The non-residential program has had a busy year. They have been out in the community more and referrals have been coming in non-stop.

The non-residential program did a girls group over last summer that turned out to be very successful.

The program has hired an evening secretary to help with later screening appointments.

A new Intensive Case Manager has recently been hired to help relieve some of the workload from the other counselors.

Standard 1: Management Accountability

Overview

Narrative

Family Resources, Inc. – North youth shelter named Safe Place 2B and non-residential programs are located in Clearwater, Florida. Family Resources, Inc. provides services through a direct local service provider contract with the Florida Network of Youth and Family Services. The Family Resources agency primarily provides CINS/FINS services in Pinellas County and nearby surrounding counties. Family Resources also operates sister youth shelters, also called Safe Place 2B, that are located in St. Petersburg and in Bradenton, Florida. These agencies service youth and families in Pinellas, Manatee and other surrounding counties. Each location has a licensed clinician, Shelter Director, Residential and Non-Residential counselors, Residential staff members, and Outreach staff. A centralized Human Resources and Fiscal department handles all personnel and financial matters. Each sites' clinician reviews and oversees all counseling and mental health services provided to youth and families delivered at their respective location. The agency assigns the daily operation and direct responsibility of each shelter to the Residential Supervisor at each youth shelter. All Family Resources residential shelters have implemented uniform operating protocols for all three service locations in the areas of operations and programming for both residential and non-residential services. Other uniform protocols for all three locations include training and professional development. The agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. This report focuses on the services associated with the North Shelter.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place to address the completion of background screens for staff prior to hire. The policy includes the requirement for the program to complete a background screening on all staff and volunteers every five years. The policy was reviewed by the chief executive officer in July 2018.

The policy is implemented by requiring the human resources department to complete a background screening packet on all staff and volunteers; this includes paperwork for the prospective employee to have their fingerprints screened. The program will complete the background screening process on all staff and volunteers every five years. The program will complete an Annual Affidavit of Compliance with Good Moral Character Standards each January for all staff who were working at the program during the calendar year. This affidavit is to be sent to the Department of Juvenile Justice Background Screening Unit by January 31 of each year.

There were seven staff hired since the last annual review. There was a background screening conducted through the Agency for Healthcare Administration (AHCA) website for all seven staff; each staff received an eligible rating. Beginning in July 2018, the program was required to complete a pre-employment assessment on all direct care staff prior to employment. Of the seven newly hired staff, an assessment was completed prior to hire. One staff was hired in April 2018; the pre-employment was completed in September. The program is currently utilizing the services of two interns; there was an eligible background screening for both prior to each starting at the program. Three staff were applicable for the completion of a five year rescreen; this was completed as required for all three staff.

The Annual Affidavit of Compliance with Good Moral Character was submitted to the Department of Juvenile Justice Background Screening Unit on February 6, 2019, which is after the due date.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy in place to address the provision of an abuse free environment, in which youth, staff, and others feel safe, secure and not threatened by any form of abuse or harassment. The policy was reviewed by the chief executive officer in March 2017.

The policy is implemented by requiring any person who has reasonable cause to suspect a child is abused, abandoned or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, to report such knowledge or suspicion to the Florida Abuse Hotline. The program shall maintain information on each allegation reported to the Florida Abuse Hotline, including the names and addresses of the youth, parent and any person responsible for the youth, the age, race, gender and siblings of the youth, the nature and extent of the allegation, the identity of the abuser, reporter's name, address and telephone number, and other information which would be helpful in establishing the cause of injury or neglect. The program shall also report any allegations of abuse to the Department of Juvenile Justice Central Communications Center (CCC). The calls to the Florida Abuse Registry shall be documented in the applicable youth's file. The program shall facilitate temporary residential care in appropriate cases. The program shall document the filing of all reports, including the operator identification.

The program has a code of conduct, which is signed by all staff. The program expects staff to adhere to these expectations for the protection and fair treatment of clients and employees. Furthermore, each employee shall maintain high standards of personal conduct in the capacity of their position and act in accordance with the highest standards of professional integrity and ethics while providing respect and courtesy to co-workers, clients and the general public. There was documentation to support staff signed the code of conduct. There are signs with the telephone number of the Florida Abuse Hotline posted in the shelter area and in the non-residential area of the building. For the youth receiving residential services, youth are provided an orientation of the program's services during the intake process, which is documented on an orientation checklist. The orientation includes the number of the Florida Abuse Hotline. this checklist was noted in the reviewed files. For youth receiving non-residential services, a list of community service providers is given to the youth; the list includes the telephone number for the Florida Abuse Hotline. This list was noted in the reviewed files. There were a total of ten calls placed to the Florida Abuse Hotline alleging abuse or neglect of a youth; eight calls were placed by staff for youth receiving non-residential services and two calls were placed by staff for youth receiving residential services. The program reported there were no instances requiring management's response to staff being abusive to youth, or for using verbal intimidation, profanity or excessive use of force. This was further confirmed through a review of incident reports and calls to the CCC.

The program has a grievance process, which allows the youth to file a grievance in the event they feel their rights have been violated. The orientation provided to the youth receiving residential services includes information on the program's grievance process. There are blank grievance forms in the shelter area; located near the forms is a locked box in which the completed grievance forms are placed. The box is checked daily by the residential supervisor. There has been one grievance filed by a youth since the last annual review. The grievance was filed by a youth, to report a staff had been screaming at him for using a tissue. The grievance was filed on December 20; the residential supervisor responded to the grievance on December 26. The youth signed the grievance form to indicate his agreement with the response.

There were three youth surveyed. All three youth report they know the number to the abuse hotline, however, had never had a reason to call it. All three youth reported staff treat them professionally and with respect and they have never heard a staff use inappropriate language. All youth felt safe in the shelter.

There were three staff surveyed. All three staff knew the procedures to allow the youth to call the abuse hotline. All three staff also reported they have never heard another staff member use inappropriate language, threats, intimidation, or humiliation when speaking with the youth.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy to address the reporting of incidents, which requires a call to the Department of Juvenile Justice Central Communications Center (CCC) within two hours of the caller gaining knowledge of the incident. The policy was reviewed by the program's chief executive officer in July 2017.

The program's policy is implemented by requiring all incidents to be reported to the CCC within two hours of the caller gaining knowledge of the incident. The policy includes a list of incidents which require reporting to the CCC; this list includes but is not limited to program disruptions, escape/abscond incidents, medical incidents, mental health/substance abuse incidents, complaints against staff and youth behavior incidents. In the event a critical incident occurs, staff are required to provide immediate notification to senior management; critical incidents are defined as sexual abuse or battery, client arrest on felony charge, client death, staff arrest or misconduct, suicide attempt or significant injury to staff or client. The employees with direct knowledge of the incident must complete an incident report. The incident report is to be completed and submitted to the employee's supervisor before the end of the current shift. The supervisor reviews the report and takes any needed corrective action. The report is emailed to senior directors for their review and corrective action. The incident report is then forwarded to the Senior Director of Quality Assurance for their review and possible corrective action. Finally, the report is forwarded to the Risk Management Team for discussion and trending at the next quarterly risk management meeting.

There were twelve calls made to the CCC in the past six months; the calls were made for incidents such as missed medication, youth behavior, contraband and suicide risk. Ten of the calls were made to the CCC within two hours of the caller gaining knowledge of the situation. In one incident, the youth did not receive medication from November 21-23; the call was made to the CCC on November 24, 2018. In another incident, the youth missed her medication, which was noted at 7:00 AM on November 23; the CCC was called at 9:26 AM.

The program maintains a binder with incident reports; all of the reports were completed on the program's incident reporting form and had been signed by the residential supervisor. The incidents were documented in the program's logbook, with one exception. On September 18, 2018, there was an incident in which a youth had razor blades and was self harming; this incident was not documented in the logbook. The incident with the razor blades resulted in a written reprimand for the staff who completed the search on the youth. As a result of a youth being found with vaping equipment, the staff were provided training on the trends of substance abuse during their next quarterly risk management meeting; this was documented through meeting minutes and sign-in sheet.

There were no exceptions to this indicator.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy to address the provision of training to staff; the policy includes requirements to be completed within in the employee's first 120 days of hire, requirements to be completed within the first year of hire, and the requirements for annual in-service training. The policy was reviewed by the program's chief executive officer in March 2017.

The program implements their training through an anticipated annual training plan. The training outline specifies training to be completed within the first ten days of hire, within 120 days of hire and within the first year of hire. The program requires the receipt of eighty hours in the first year, and forty hours per year thereafter; the training is calculated from the anniversary of the staff's hire date. In addition, the staff receive training through participation in quarterly Florida Network Quality Improvement Committee meetings and the annual Runaway and Homeless Youth National Conference.

The training records of six staff were reviewed; three were applicable for first year training and three were applicable for annual training. The records for the three first year staff documented between 99.5-100 hours of training within the first year of training. All certifications, including cardiopulmonary resuscitation (CPR) and first aid, had been received by all three staff. The staff received training in program orientation, managing aggressive behavior, suicide prevention, CINS/FINS core training, signs and symptoms of mental health and substance abuse, behavior management, understanding youth/adolescent development, child abuse reporting, confidentiality, medication distribution, in-service component, fire safety, Title IV-E procedures, serving LBGTQ youth, cultural humility, information security awareness, equal employment opportunity, Prison Rape Elimination Act, sexual harassment, suicide prevention, trauma informed care and human trafficking. Two staff completed universal precautions training within the first 120 days of hire as required; one staff, who was hired April 30, 2018, had not completed this training as of the date of the annual quality improvement review. The training was completed in a combination of instructor-led and web-based courses. The remaining three training records documented in excess of forty hours of training in the year following their hire date anniversary. All three staff had current CPR and first aid certification. All required tropics had been received by the staff.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy to address the collection and delivery of data to the Florida Network, the Florida Legislature and the Department of Juvenile Justice. The policy was reviewed by the program's chief executive officer in July 2018.

The policy is implemented through the collection of data within the Florida Network Management Information System (NETMIS); the information is client related and local provider related. The program collects various data on a monthly, quarterly and annual basis, and shares this information with the staff.

The program receives information on a monthly basis from the Florida Network , which is reviewed by the program's management staff, and provided to the staff. This information includes quality checks, and includes information which needs to be completed, such as the next scheduled service for a youth, a screening which was missing and an exit date which needed to be verified. The program's management staff meets at least quarterly to review risk management. The meetings, which were documented with agendas and sign-in sheets, included a review of incidents, grievances and workman's compensation claims. The incidents are broken down into categories such as safety, staff misconduct, physical aggression, mental health, medication errors, client injury, client illness, contraband and inappropriate behavior/conduct. The quarterly review documents an increase or decrease in each category. The program provides satisfaction surveys; these are reviewed and are used to improve quality service delivery and to respond to the client's needs.

There were no exceptions to this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The current policy reflects that it was reviewed and approved March 2017 by the CEO. The policy outlines that the staff should avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. Their "best practice" is to have a 3rd party presence in the vehicle which could include a volunteer, interns, clinical or administrative staff, or other youth.

If a 3rd party is not available, the youth's evaluations, history, personality, etc., and the employee's work performance and history, length of employment is considered to indicate if no inappropriate behavior is likely to occur.

The Residential Supervisor or designee will communicate to staff by the end of the day via logbook entry or on a white board which youth (or all

youth) are appropriate for single transport. A Trip Plan/Van Mileage Log is completed for use in each vehicle to include:

- Date
- Driver Initials
- Destination/Purpose of travel
- Approximate mileage
- Number of occupants
- Time leaving
- Starting miles
- Anticipated time of arrival
- Actual time of arrival
- Ending miles
- Supervisory approval received from (including date/time)

All drivers transporting youth have a valid Florida driver's license and are covered under the agency's insurance policy.

The Trip Plan/Van Mileage Log was reviewed from July 2018 to present. The log was filled out in its entirety for each transport including driver's name, date, time, mileage, number of passengers, purpose of travel and location. If it was a single client transport, there was also a supervisor signature indicating the supervisor was aware of the transport.

There were no exceptions to this indicator.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that meets the Florida Network policy and procedure for outreach services that was reviewed March 2017 and approved by the CEO. Their policy outlines that they will participate in local DJJ Board and Council meetings to ensure CINS/FINS services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services. The assigned staff person (Residential Supervisor/Program Director or designee) advocate for the effective use of CINS/FINS services and update agency leadership on meeting activities. In addition, a lead staff member (COO, Program Director, Residential Supervisor or designee) will represent the agency at local and circuit level meetings convened by DJJ.

The agency staff who attend the meeting to obtain copies of the minutes to the meetings and supply to agency leadership. Verification of attendance at DJJ Board and Council meetings will be kept by the agency. Support and accommodation will be provided to staff participating in assigned meetings.

The agency provided verification of attendance to several interdisciplinary meetings including Pinellas Juvenile Assessment Center Partner's Meeting, Homeless Leadership Board Providers Council Meeting, and the Department of Juvenile Justice Advisory Board Meeting. Supporting documentation was provided (i.e. minutes, handouts) to reflect the collection of data and information from the meetings. In addition, a report was provided that reflected outreach initiatives by the agency from August 2018 – current. Some of the event names included: Manatee County Agency Fair, Adult Services SIL Meeting, Mobile Food Pantry, and Community Resource Fair, and SNAP in schools.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Family Resources agency provides non-residential counseling services through its North Family Counseling Center located in Clearwater, Florida. The non-residential services include Truancy, Marriage and Family Counseling, and Family Counseling. Family Resources non-residential program has one program director who also provides direction to other family help programs. There are two other non-residential counselors who hold master's degrees and a bachelor's level non-residential case manager. Safe Place 2B Residential Shelter has one counselor who is a Licensed Mental Health Counselor (LMHC) and one on-call master's level counselor. Centralized Intake Services are evidenced throughout all charts reviewed. The Family Resources non-residential program distributes a "Reference Guide for Clients" handbook to each parent/guardian or family. It clearly states the Rights and Responsibilities, Grievance Policy, Consent to Treatment, and Discharge Policy. The language used is appropriate for many levels of education parents might possess. The non-residential program also provides each family with the FLN "A Guide to CINS/FINS Services for Parents". This provides the options and process through which parents can find the help needed for truant, runaway and/or ungovernable youth.

Screenings are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. A case plan is developed for each client. In addition, home visits are conducted on a case-by-case basis to offer support the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by Family Resources with shelter or residential care as a viable option for youth that need additional support services. The non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist resolve issues faced by the youth and their family.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Family Resources agency has a written policy and procedure that addresses the main elements of Indicator 2.01. The policy was reviewed March 2017 and approved by CEO.

The policy requires twenty-four hour, seven days a week availability and access to CINS services for eligible youth. An initial screening for eligibility is completed within seven calendar days of the referral, preferably immediately.

The agency's policy and procedures require that the staff conduct the screening for eligibility upon first contact to determine Client-Family needs and appropriateness for either non-residential or shelter services, or referral to other community agencies if not eligible for CINS services.

Eligibility criteria include:

- Between the age of 10-17
- Delinquency Status
- Not in danger to self or others
- Not in need of detoxification
- Mental Health Issues under control
- Not in need of immediate medical care
- No history of arson, sexual or violent offences.

All ten files documented an eligibility screening was completed within seven calendar days of referral. All ten files documented the youth and parent received, in writing, available service options, rights and responsibilities, and a parent/guardian brochure. All ten files also documented the parents and youth received information on possible actions occurring through involvement with CINS/FINS services and grievance procedures.

There were no exceptions for this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures that addresses the elements required by the Florida Network's Policy and Procedure Manual for CINS/FINS of 2.02. The Needs Assessment is completed to gather and analyze information for all youth receiving services. The policy was reviewed March 2017 and approved by CEO.

The policy requires that the Need Assessment be initiated or attempted within 72 hours of admission to shelter and for non-residential youth, completed within two to three face-to-face contacts following the initial intake.

Needs Assessments are completed by Bachelor's or Master's level staff and signed by a supervisor. If the suicide risk is required as a part of the screening it must be reviewed and signed/dated by a licensed clinical supervisor or by a licensed Clinical staff.

All five residential files reviewed documented the Needs Assessment was initiated within seventy-two hours of admission. All five non-residential files reviewed documented the Needs Assessment was completed within two to three face to face contacts.

All ten Needs Assessments were completed by a bachelor's or master's level staff and all ten included a supervisor's review upon completion.

Three out of the ten files documented an elevated risk of suicide as a result of the Needs Assessment. All three youth documented an Assessment of Suicide Risk was completed by or conducted under the direct supervision of a licensed professional.

There were no exceptions to this indicator

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses the indicator components. The policy was reviewed March 2017 and approved by CEO. The policy requires an Individualized Service Plan (ISP) plan to be developed for both residential and nonresidential youth based on information gathered during initial screening/intake and needs assessment.

The agency's policy states that the case plan is to be written within seven working days of the Needs Assessment. The case plan includes:

- Identified needs of the youth and family
- Realistic time frames (target dates) for completion
- Goals and completion dates
- Designated responsibility of the youth and family to complete the goals
- Persons responsible to assist the youth/family in goal completion
- Measurable objectives that address the identified problems or needs
- Services and counseling to be provided, to include: type; frequency; and location
- Signature of youth, parent/guardian, counselor, and supervisor
- Date the plan is initiated

All ten files reviewed documented a Service Plan was developed within seven working days of the Needs Assessment. All ten Service Plans included: individualized and prioritized goals, service type, frequency, and location, persons responsible, target dates for completion, actual completion dates, signature of the youth, parent, counselor, and supervisor, and date the plan was initiated.

Four of the ten files were applicable for thirty-day reviews. Three of the four applicable files documented all required thirty-day reviews were

completed. The remaining file should have had two thirty-day reviews; however, neither were completed.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of indicator 2.04. The policy was reviewed March 2017 and approved by CEO.

The agency procedure requires that each youth be assigned to a counselor/case manager who will follow the youth's case and ensure delivery of services through direct provision or referral. The process of case management includes:

· Establishing referral needs and coordinating referrals to services based upon the ongoing assessment of the youth's/family's problem and needs

· Coordinating service plan implementation

· Monitoring youth's family's progress in services

· Providing support for families

· Monitoring out-of-home placements, if necessary

· Referral to the case staffing committee, as needed to address the problems and needs of the youth and family

· Recommending and pursuing judicial intervention in selected cases

· Accompanying youth and parent/guardian to court hearings and related appointments, if applicable

· Referral to additional services, if needed

· Continued case monitoring and review of court orders

· Case termination with follow-up

All ten files documented a counselor was assigned to the case. All five applicable files documented the counselor established referral needs, coordinated referrals to services, and monitored out-of-home placement. All ten files documented the counselor coordinated service plan implementation, monitored the youth's/family's progress in services, and provided support for families. None of the files were applicable for referrals to the case staffing committee or to be accompanied to court hearings and related appointments. All eight applicable files documented referrals for additional services as needed. All ten files documented case monitoring. All six applicable files documented case termination notes.

There were six files applicable for a thirty day follow up and it was completed as required in all six cases. One file was applicable for a ninety day follow up and that was also completed as required.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses the key elements of Indicator 2.05. The policy was reviewed March 2017 and approved by CEO.

The agency offers counseling, both to their shelter youth and non-residential youth and their families.

Counseling services are in accordance with the youth's case/service plan and addresses the needs identified during the assessment process.

Residential programs offer individual, family and group counseling sessions held a minimum of five days per week with the goal of family reunification. Nonresidential programs offer therapeutic community-based services that provide the intervention necessary to stabilize the family in the event of crisis and minimize out-of-home placement.

Counseling services are based upon the family/youth's needs and goals set in the agreed upon case plan.

All ten files reviewed documented the youth's presenting problems were addressed in the Needs Assessment, Initial Service Plan, and Service Plan reviews. All ten files documented case notes were maintained for all counseling services provided and documented the youth's progress. All ten files documented the youth and families received counseling services in accordance with the Service Plan. Individual and family counseling was provided by the program. All ten files documented on-going clinical reviews of the case and staff performance.

The five applicable residential files documented group counseling was provided at least five days a week. All groups reviewed were at least thirty minutes in length, documented a clear leader, documented a clear and relevant topic, and provided an opportunity for youth engagement.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that was reviewed March 2017 and approved by the CEO. The policy states that they will provide case staffing to review the case of any youth or family that the program determines is in need of services or treatment if:

- The youth/family is not in agreement with services or treatment
- The youth/family will not participate in the services selected; or
- The program receives a written request from the parent/guardian or any other member of the committee.

The committee will convene within (7) days, excluding weekends and holidays, after the receipt of a written request from a parent/guardian for a case staffing.

The committee will schedule the staffing according to the availability of the family and the staffing committee is contacted within (5) working days to confirm scheduling times of the meeting. The parent/guardian is provided a written report immediately following the case staffing or within (7) days of the case staffing committee meeting, if the parent/guardian was not present. The report will outline the recommendations of the committee for or against a petition being filed, additional services and/or referrals recommended.

The agency has been designated as the Centralized Intake agency, as the agent for the Department of Juvenile Justice as it serves the CINS/FINS population in District Five, Pinellas County. The Case Staffing Committee will have a representative from the Department of Juvenile Justice, a CINS/FINS provider, and a representative from the youth's school district. The committee meeting may include: a State Attorney's office representative, the alternative sanctions coordinator, representative from the areas of health, mental health, educational and social services, a supervisor of the department's contract provider, a law enforcement representative, and any person recommended by the client, family, or Family Resources.

The case staffing committee with meet on a monthly basis at a time designated by the Chairperson. However, the Chairperson may call additional meetings for emergency cases. The Chairperson or designee will mail confirmation of time, date, and location of the case staffing to the youth, family, and the staffing committee within (5) working days. The case staffing will convene within (7) days.

There were three active case staffing files reviewed. All were referred differently: one was referred by a judge, another by a truancy program, and the third by Adoption Related Services. The family was notified no less than five working days prior to the staffing (copies of mailed letters are included in each file) and the committee was notified no less than five working days prior to the staffing (proof of emails sent to the committee were reviewed in the "Case Staffing" binder). All of the meetings included a local school district representative, a DJJ representative, a CINS/FINS provider (Family Resources), a mental health representative, the youth, and parent/guardian. For two of the three cases, a representative with the State Attorney's office was in attendance. For one of the cases, another representative was at the meeting who was significant in the youth's referral to the case staffing committee. As a result of the case staffing committee, a new plan for services was initiated. A copy of the written report that was provided to the families was included in each case file inclusive of recommendations and reasons for the recommendations. Two of the written reports included a parent/guardian signature and the chairperson confirmed that the family received it immediately after the meeting. For the one case in which the parent was absent, the case staffing was held on 8/15/18 and a copy of the letter sent along with the written report was mailed to the family on 8/20/18. The program has established a case staffing committee and has regular communication with committee members (proof of email communications was reviewed in "Case Staffing" binder). The program has an internal procedure for the case staffing process (as outlined in their policy and procedures), which includes scheduled committee meetings.

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Indicator 2.07 Youth Records. The policy was reviewed March 2017 and approved by CEO.

All youth records are kept in a secure area with locking cabinets, Youth records are maintained and in neat and orderly manner so that staff can quickly and easily access information. When in transport, all records are locked in a container that is marked confidential.

All ten youth files reviewed were marked confidential and maintained in a secure room, inside locked file cabinets that were also marked confidential. The agency uses an opaque, locked container, marked confidential, to transport files. All files reviewed were maintained in a neat and orderly manner.

There were no exceptions to this indicator.

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of the indicator. The policy was last reviewed in August 2018 by the Chief Executive Officer/President.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have intentional contact with youth will have knowledge of this policy. Areas in which youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

The shelter has copies of the Zine located in the main lobby for staff and visitors to take and read. There was also documentation that all staff had received training on the SOGIE policy. This was documented in the staff training files. This is training is provided for all staff and interns.

The shelter has signage located throughout the shelter including in the hallways, dining area, staff offices, lobby area, the leadership room, and dayroom indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. The youth sleeping rooms are being remodeled but when they are finished, they will also have postings in them. Signage includes signs of rainbows and statements in rainbow colors. The program’s screening form used at intake has been updated to ask the youth which gender they identify with.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

Family Resources, Inc. provides residential CINS/FINS services through a contract with the Florida Network of Youth and Family Services. The north Safe Place 2B shelter is located in Clearwater, Florida. At the time of this Quality Improvement review, the program was staffed with a Residential Supervisor, Shelter Counselor, a Case Manager, fifteen Youth Development staff, a Secretary, and a Registered Nurse (RN). The cook position was vacant.

The Residential Supervisor oversees the day-to-day operations of the youth shelter. The shelter provides a “Client Handbook” to each youth upon admittance. Beyond that, each parent sits with the youth while staff goes through the handbook so both youth and parent will know what the expectations are while the youth is in the shelter. All forms are signed by parent/guardians and youth showing an understanding of these. This identifies and explains the many family services offered by Family Resources.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of Family Resources, Inc. to provide continuous maintenance to its properties and used furnishings to ensure that all areas are kept safe, clean, landscaped and well maintained. The facilities are conductive to providing programming that fosters healthy, social, intellectual and physical development.

It is the policy of Family Resources, Inc. to develop a daily master schedule that offers a variety of structured daily programming to engage youth in activities that foster healthy social, emotional, intellectual, and physical development.

A housekeeping and maintenance plan ensures the facility remains clean, safe and in good repair. Weekly preventive maintenance inspections shall include checking fire safety equipment, communication equipment (cell phones, weather radio) and any other safety related equipment or supplies needed in an emergency or to prevent injury to staff and youth. If the agency should ever acquire an emergency generator, this will also be included in the weekly preventive maintenance inspection. Weekly inspections shall also be conducted for housekeeping of internal and external areas. Regular procedures shall be in place for pest control and garbage removal.

Family Resources, Inc. shall provide youth access to bathrooms that are clean, functional and include at least:

- Two operable toilets for every eight youth
- Two operable wash basin with hot and cold running water for every eight youth
- Bathroom stalls with partitions and doors

Family Resources, Inc. provides sleeping quarters for each youth that have adequate lighting for the tasks performed there, bed coverings and pillows, an individual bed for each youth, and no extraneous cover, wire mesh, paper, cardboard, or any other masking material installed over glass, windows, vents, or sprinkler heads in sleeping areas. Each youth has a safe, lockable place to keep personal belongings, if requested.

This policy was last reviewed March 2017 by the CEO.

The following procedures shall be maintained by staff:

- The residential supervisor will conduct weekly inspections of the physical plant utilizing the physical plant checklist and daily room checklist and attend to those areas needing attention. Weekly inspection shall also include fire safety equipment, and emergency communication equipment such as cellular phones and the weather radio and any other safety related equipment in the shelter to determine that such equipment is in its appropriate place and is in working order.

- The residential supervisor or their supervised designee maintains a log to note areas needing attention and facilities needed maintenance and/or repairs as needed. Maintenance needs are entered into the Helpdesk for follow-up facilities maintenance staff.

- The residential supervisor coordinates and manages a schedule of regularly scheduled maintenance activities and inspections, such as fire, health department, pest control, garbage management, and grounds maintenance.

- Clean linens and bath towels ae provided as needed.

- Each youth has a safe lockable place to store personal belongings, if requested.

- Staff shall inspect the sleeping rooms on a weekly basis to determine whether the area continues to have adequate lighting, proper bed coverings and pillow, and no coverings over the window other than blinds or curtains installed by the program. A bulletin board may be provided in each room so that youth can personalize their room during their stay, increasing the home-like feeling of the facility. Individual room decorations shall not include lewd, profane, or offensive dress or language. Such as determination shall be made by program staff and offensive materials removed and stored immediately upon delivery.

- Staff will prepare a schedule that will include education, recreation, specialized treatment services, life and social skills training, reading and leisure activities which may include use of television, but only as part of the behavior management system or for educational purposes. At least one hour of physical activity is provided daily. These activities are designed to provide each youth with opportunities to mature physically, mentally and socially through exposure to competition, peer influence and leadership.

- The schedule will be posted in areas accessible to youth and substantially followed. Idle time for youth will be minimal. At least one hour of physical activity is provided daily. Youth will have the opportunity to complete homework as part of the daily programming. A variety of books will be kept in the “library” and youth will have the opportunity to read in the general areas or in their rooms.

- Youth are provided the opportunity to participate in a variety of faith-based activities. It is the policy of Family Resources, Inc. to acknowledge and accommodate religious preferences whenever possible. All youth will be given the opportunity to participate in religious services on voluntary basis. Non-punitive activities shall be provided for youth who do not participate in religious activities. Throughout the provision of services, spiritual, and religious preferences will be acknowledged and accommodated whenever possible by the following means: special diets, access to religious services and any other practice that does not conflict with the milieu of the facility. In accordance with client’s rights, equal treatment regardless of race, sex, sexual orientation, gender identification, ethnic group, religion, age or handicap shall be provided.

The shelters environment appeared to be safe, clean, neat, and well maintained. There is a practice in place where the program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual, and physical development. Furnishings are in good repair. The program appears to be free of insect infestation and grounds are landscaped and well maintained. Bathrooms and shower areas are clean and functional. There was no graffiti on walls, doors, or windows. Lighting is adequate and exterior was free of debris. The dumpsters were covered except for the kitchen garbage can not having a lid. All doors were secure, and the agency vehicle was equipped with major safety equipment. The in and out access is limited to staff members and key control is in compliance. There were detailed egress maps, general rules, grievance forms, abuse hotline information, DJJ incident reporting number, and other related notices. The DCF child care agency license was posted. Interior areas are free from hazardous objects. All chemicals are listed and approved for use, stored securely, and inventoried weekly on Sundays. Washers and dryers were in operational and in use during tour and lint collectors were clean. Each youth has their own individual bed with clean covered mattress, pillow and sufficient linens, and a blanket. Each youth is assigned a safe to keep personal belongings. The facility fire inspection was completed in January and the agency passed inspection. There were multiple fire drills done within the month. A few were over the two-minute requirement. Tornado mock drills are conducted more than quarterly. Annual fire safety and inspections were completed in January and are up to date. The agency has a satisfactory grade report from DOH and has menus signed by a licensed dietitian. All cold food is properly stored, marked, and labeled. The dry storage areas were clean and all food properly stored, labeled, and gone through often to check for expired items. The refrigerator and freezer were clean, as well as, appliances. Youth are engaged in structured activities and daily schedule shows minimal idle time. Recreational time is available for more than an hour daily. Youth are provided the opportunity to participate in a variety of faith-based activities and the daily activity is posted and accessible to staff and youth. Homework is also a part of the daily programming, tutors are available and there are many appropriate books for reading.

There were no exceptions in this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of Family Resources, Inc. to orient all new clients on program procedures within twenty-four hours of admission to the program. This orientation will serve to introduce the clients to the program’s philosophy, goals, services, and expectations. Orientation will include:

- Identification of key staff and their rolls
- A review of emergency building evacuation procedures
- A tour of program
- Room assignment
- Disaster preparedness instructions

- Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts
- A review of policies of contraband and those items and materials considered contraband
- A review of daily program schedule
- A review of the programs dress code and expectations relative to youth's hygiene practices
- A review of the youth's rights, including how to contact the Florida Abuse Hotline
- A review of program services and the grievance procedure
- A review of the procedure to request medical care, 24 hours a day
- A review of the procedure to access mental health care
- A review of the visitation schedule
- A review of telephone and mail procedures
- A review of program rules governing youth conduct
- A review of the consequences which may result when youth violate rules of the program

This policy was last review March 2017 by the CEO.

Staff shall maintain the following procedures during the intake process, which shall take place within twenty-four hours of admission:

- Staff will explain the previously listed topic areas during the intake process.
- Staff will take a picture of the youth and explain rationale for the picture to the youth.
- A youth orientation checklist will be completed, signed by client and staff at the end of the client intake process and copy filed in clients file.
- Staff will give youth a copy of the Safeplace2B youth handbook which details the program.
- Staff will designate a resident (when available) to provide the client a tour of the shelter. During the tour the client will be introduced to available staff and during the introductions a description of staff function will be explained.
- All program postings will be pointed out and explained. Procedures for the postings will also be outlined and reviewed in youth hand book.
- In the event a client is requesting admission during late hours of the night, orientation items with an asterisk on check list prior to bed time.
- Staff will inform clients of the need to alert staff of suicidal feelings or awareness of others having suicidal thoughts.

There is a practice in place where the agency begins their orientation processes during the first twenty-four hours. There were seven files reviewed and all youth received an orientation and youth handbook on the day of admission. The youth and family were informed of disciplinary actions, grievance procedures, emergency disaster plan, and contraband rules. The youth were given a tour and assigned a room or the couch if on sight and sound. Suicide prevention alert notifications were in the files as needed, which was only one out of the seven files. Signatures were obtained by both the parent/guardian and youth. The checklist shows that daily activities were reviewed with the youth and they have the abuse hotline number available to them.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of Family Resources, Inc. to interview youth upon admission to determine the most appropriate room/sleeping arrangements.

Room assignments in multi-occupancy rooms will be based on a classification process with consideration given to potential safety and security concerns. This includes, but is not limited to:

- Review of available information regarding youth's history & status, and exposure to trauma
- Initial collateral contacts and initial interactions with and observations of the youth
- Separation of younger youth from older youth
- Separation of violent youth from non-violent youth
- Identification of youth susceptible to victimization
- Presence of medical, mental, or physical disabilities
- Suicide risk
- Sexual aggression and predatory behavior
- Gender identity when possible

It is the policy of Family Resources. Inc., to make information that is discovered as a result of the findings in the health intake screening available to staff regarding medical or mental health conditions of clients that could become a medical or mental health emergency and respond to these emergencies should one occur. In addition, information concerning a special need or risk of suicide, security, youth's allergies, common side effects of prescribed medications, foods and medications that are contraindicated or other treatment is communicated to staff. Staff shall be provided sufficient information and instructions that will allow them to recognize and respond to the need for emergency care and treatment as a result of these medical, mental health or substance abuse problems.

This policy was last reviewed in March 2017 by the CEO.

During the intake process staff will observe clients and interview them to make the most appropriate room assignment. Staff will examine clients age, sex, height, weight, level of maturity, gang affiliation, current alleged offense, prior delinquency background, level of aggression, ability to act responsibly, attitude upon admission to the program, past involvement in assaultive or aggressive behavior and the current emotional state of the client. Clients who are determined to need special accommodations for their own protection or for the protection of the other youth will be assigned appropriately. The reason for special accommodations should be documented in the clients file or milieu and approved by the residential supervisor as soon as possible after admission. Supervisor approval by phone is permitted but must be documented.

Staff shall maintain the following procedures in the event that youth is admitted into shelter with a medical or mental health condition that may result in the need for emergency care and treatment. Such medical conditions may include diabetes, asthma, seizure disorders, severe allergies, pregnancy, tuberculosis, hemophilia, and cardiac disorders.

The following actions will be taken if such condition is revealed in the process of the client intake and health screening:

- The condition and action to be taken will be noted in the milieu log book
- The condition and action to be taken will be recorded in the form of the progress note
- This progress note will be highlighted for improved awareness
- The condition and action to be taken will be recorded in the shift exchange log and shall be carried forth from one shift to another until the youth is discharged from the shelter
- The client file will be coded with system alert sticker on the outside indication that there is a potentially serious medical condition
- All staff will review the last two shifts of log book and shift notes at the beginning of each shift
- All youth who are deemed to be on sight and sound observation for safety reasons shall sleep on the couch or a cot in the main area until removed from precautions by a licensed staff. Their room number will be noted in log book upon assignment
- Should an emergency occur, see policy and procedure for emergency care for complete instructions
- Information regarding HIV/AIDS will only be disclosed on an as needed basis and remain consistent with the Florida Law and Policy and Procedures of Family Resources Inc.

There is a practice in place that includes an initial classification of youth to include, youth's history, status, and exposure to trauma. There is

documentation of the youth's description such as age, gender, disabilities, physical strength, gang affiliation, suicide risk, and if they are sexually aggressive or display reactive behavior. The youths room assignment is completed at intake and states a clear rationale for the room assignment. There were seven files reviewed and staff made appropriate room assignments for each youth.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of Family Resources to maintain a permanent log to record routine daily activities, events and incidents, emergency situations and unusual incidents. This log should not contain opinions or unnecessary commentary unrelated to reporting elements described below. The house log is a bound journal with sequential pages that is a continuous record of all significant events occurring throughout any 24-hour period.

This policy was last reviewed in March 2017 by the CEO.

The log shall be reviewed and signed by all staff upon arriving or leaving assigned shifts. The direct care staff should review at least the previous two shifts in order to be away of any unusual occurrences, problems etc. an entry with signature and date is made to document the review.

All entries should be written in ink, should be brief and concise as possible and shall have a staff members signature and date and time of entry noted in the left-hand column.

All recording errors should be struck through with a single line. The staff person must initial the correction. The use of white-out is prohibited. The word "error" may be written by the recording if space permits. There should not be any bank lines between entries.

Log book entries which could impact the security and safety of the program may be highlighted.

Client information regarding referral and intake events of the shift should be noted.

Any visitors on premises during shift and any arrangements made for client or program visitation should be noted.

House census and room assignments will be noted at the beginning of each shift or when house count changes. Additionally, all incident when youth were removed and returned to general population.

Emergencies will be recorded.

Logbooks are maintained for 5 years before destruction.

The residential supervisor shall review and sign the permanent log weekly. Upon review the residential supervisor makes a note chronologically in the log book as to any corrections, recommendations and follow-up required. The entry is signed and dated.

There is a practice in place to document daily activities, events, and other major occurrences. Safety and security issues, incidents, and all important events are clearly documented. All staff come in on shift and review the log book. The supervisory review is done weekly and stamped and a written review providing feedback and comments etc, is done when necessary. All entries were brief and in legible ink however there were several abbreviations without a code. There were very few errors and they were properly corrected with a clear line and signature.

There were no exceptions with this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

It is the policy of Family Resources, Inc. to incorporate a behavior management system designed to foster accountability and compliance with

the programs rules and expectations. The system shall consist of rewards, privileges and consequences to empower youth in their personal growth while encouraging clients to fulfill programmatic expectations. The behavior management system is designed to promote a positive peer based feedback process aimed at personal growth and fostering a model for effective community living. The system ensures the protection of individual rights, assures the safety and security of the youth, the staff, the public, the state of individual property. This system is critical to the effectiveness in reducing recidivism.

Consequences are connected to the behavior and serve as incentives to improve youth choices. The system provides on-going feedback to youth concerning their program behavior. The consequences for violation of program rules are generally the loss of program privileges, up to and including termination from the program.
Consequences may not be punitive in nature and may not involve seclusion, restraint or restrictive intervention. At no time shall a staff member utilize consequences or sanctions that are humiliating or degrading to the youth in any way. Corporal punishment is strictly forbidden under any circumstances. Family Resources does not permit the use of isolation, manual or mechanical restraint or locked seclusion with clients. The only circumstances under which a client may be restraint is to protect another client from an imminent attack.
The framework is to provide award/incentive, motivation, and a positive e behavioral model for clients in the shelter and transitional living programs. Each client works to meet specific objectives that include completing house chores, developing positive and supportive attitudes among residents and between residents and staff during their stay at the shelter. Demonstrating progress in addressing individual issues and in the ability to work as a team is the last component in meeting goals.

The agency has a procedure in place where the residents discuss levels achieved as a group each day. This approach allows for:

- A feeling of belonging among clients
- Team support and positive peer pressure to assist clients in meeting personal objectives
- Developing meaningful and obtainable goals it he spirits of friendly competition
- Providing staff with client based and client driven methods of motivation and behavior and management
- Developing consequences that are relevant to the shelter experience and the offense
- An element of fun and expectation of reward in the shelter environment
- Ensure a win-win outcome to all participants

Staff in discussion with the group, determine the level of performance of each item and designates a resident as being on orientation, citizenship, leadership ownership. Rewards are commensurate with the level of performance. On ownership level, consequences are given as well as information on how to regain citizenship level.

Staff verbally recognizes the residential clients on an on-going basis for task successfully accomplished and improvement for strength the client may possess. Consequences of rule violation are also discussed. Staff are to use the step by step approach for processing violations of programmatic values.

There is a practice in place that shows behavior management strategies. The intent of the system is to promote safety, fairness, and protection of rights within the shelter. The system provides constructive discipline and a system of positive and negative consequences to encourage youth to meet the expected behavior. The behavior management system states the values, program rules, and grading system clearly. Youth sign stating they understand the expectations of them while they are in the program. There are a wide range of incentives such as the store, more privileges, outings, and use of game systems. Consequences for behavior are fair and enough to get the clients motivated. Clients are able to process behaviors with a case manager or counselor when they are on ownership level. Staff are trained in practicing the behavior management system which shows in the four staff commitments and by verbally recognizing successes and improvement for all clients on a daily basis.

There were no exceptions for this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided a policy for Staffing and Youth Supervision that was reviewed on March 2017 and approved by the CEO. The policy outlines that if there are staff shortages in which the staff members may be the same gender, the supervisor can demonstrate continued effort to hire the right combination of staff for shifts. Staff schedules are to be posted in a visible place and prepared one week in advance. An on-call

staff roster is maintained containing their contact information in the event they are needed for coverage.

The shelter will have on duty one male and one female, at all times, during waking and community activities times as well as sleep time. If a staff member is unable to work due to extenuating circumstances, a replacement will be contacted and asked to report to work. In the event a direct care staff does not relieve the previous shift, the supervisor is contacted and the staff will remain until a replacement is found.

Staff will observe youth every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction. This is observed through a “scan machine” or a daily log which is maintained for each room of the shelter.

The program has a policy in place that meets the general staffing ratio requirements. Staff schedules from August 2018 to present were reviewed and reflect at least two staff members per shift, including overnight work shifts. In some instances, there have been three staff on duty to ensure adequate supervision and coverage for the youth. From August to December 2018 there were four shifts observed in which there were two female staff scheduled and no male staff. There was documentation the agency's human resources department was posting job advertisements for direct care staff positions. In December 2018 the shelter hired another male staff and from December until the date of the review there was a male and female staff scheduled on each shift reviewed. The staff schedules are posted in the shelter area behind the reception desk in a visible space. An overtime rotation roster in a binder located at the staff desk with their contact information.

The agency is equipped with functioning surveillance cameras that are well positioned and the supervisor showed tape coverage for the last thirty days. Staff was observed on camera completing bed checks for the youth in their sleeping rooms every fifteen minutes and documentation was outlined in a “Bed Check” binder. Although couple shifts had two females on duty, the supervisor showed current job postings seeking male Youth Development Specialists.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for Special Populations that was approved in October 2018 and approved by the CEO.

Staff Secure Youth

The policy outlines that a high level of one-to-one engagement will be provided by a combination of strategies that include, but are not limited to:

In-depth orientation to the program with youth

Assessment and service planning appropriate to specific issues and time frames

Under no circumstances will staff attempt to physically restrain youth from running.

The shelter strongly encourages parental involvement to develop collaborative service plans and aftercare. The program will only accept staff secure youth who have been adjudicated as CINS/FINS youth. The staff secure shelter services should be a last resort after other alternative, less restrictive remedies have been exhausted by the provider.

Domestic Violence Respite

The policy outlines that youth who have a domestic violence charge can be served Domestic Violence Respite. Youth as young as 8 or 9 years old can be served under this provision and considered for admission under special circumstances.

The youth must meet the following criteria inclusive of the following:

Youth must have a pending Domestic Violence (DV) charge.

Youth must be screened by the JAC/Detention or screening unit and has been deemed eligible for DV Respite Care.

Youth length of stay in DV Respite Care does not exceed 21 days.

Probation Respite

The criteria under the agency's Probation Respite policy includes the following criteria:

Referrals should come from DJJ Probation Officer.

Youth must be on Probation with or without adjudication.

The length of stay should not exceed 30 days unless a request for additional days is made to the JPO by the 25th day.

All case management and counseling needs have been considered and addressed.

Domestic Minor Sex Trafficking

The shelter will serve with youth approved by Florida Network who may exhibit behaviors which may require additional supervision for the safety of the youth or the program. All requests may be approved for a maximum of seven days. Approval for support beyond seven days may be obtained on a case-by-case basis.

Intensive Case Management Services

Under the Intensive Case Management Services, the youth served must meet the following criteria:

Youth must be ordered or referred by case staffing committee.

Each youth and family must have six direct contacts per month

An approved self-report assessment is completed at intake and no less than every 90 days following intake and at discharge.

Family/Youth Respite Aftercare Services (FYRAC) – Non-Residential Only

The agency outlines that youth served under the FYRAC contract must meet the following criteria:

Youth is referred by DJJ for the following reasons: a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating. All FYRAC referrals must have documented approval from the Florida Network office.

Deliverables can be verified by one or a combination of the following and adhere to these services:

1. Intake and initial assessment session
2. Life Management Sessions
3. Individual Sessions
4. Group Sessions

At the time of the review, there were no staff secure youth case files to review.

There were two domestic violence closed case files that were reviewed and met the indicators outlined in the agency policy and procedures. Both youth were admitted to DV Respite placement pending a domestic violence charge and exhibited evidence for being screened by the JAC/Detention, but did not meet the criteria for secure detention. The youth did not exceed the 21-day length of stay in DV Respite placement and the progress notes reflect if the youth was transitioned to CINS/FINS or released to a parent/guardian. The case plan reflects goals focusing specifically on aggression management and communication to reduce re-occurrence of violence in the home. Referrals were placed in the file for aftercare services consistent with all other general CINS/FINS program requirements and youth/family needs.

There were two closed probation respite case files reviewed that followed the agency's policies and procedures. It was documented that the referral came from DJJ Probation and all youth were referred regardless of probation status. The length of stay was no more than 14 – 30 days in the shelter. There is evidence of case management and counseling needs considered and addressed reflected in progress notes, documented interventions, and referrals. All services provided by Probation Respite was consistent with all other general CINS/FINS program requirements.

At the time of the review, there were no domestic minor sex trafficking case files to review.

There was one active and one closed Intensive Case Management case file reviewed. Both youth were referred to intensive case management by the case staffing committee. The Time Log in each file documented at least six direct contacts with the youth and family each month. The progress notes and Time Logs were reviewed which outlined a minimum of six collateral contacts each month. A Child Behavior Checklist (CBCL) was completed at the intake for each youth. For the closed file, the clinician documented that the discharge CBCL was not completed due to the client moving. Each youth has a self-reporting assessment that was completed (the active case was opened 1/28/19, the 90-day

benchmark has not arrived). As for the closed file, the intake was 9/6/18 and the termination was 10/22/18. Therefore, client was discharged prior to 90-day due date to complete a follow-up self-report assessment. Both case plans demonstrate a strength-based and trauma-informed focus. The progress notes reflect areas of advocacy, parent engagement, and documenting milestones.

There were was one active and one closed FYRAC file reviewed. One file provided documentation that the youth was referred by the DJJ JPO. The second file indicated that the youth was at the Safe Place in Palm Harbor receiving DV respite and was transferred to Family Resources (Clearwater). There was no other referral or supporting documentation reflecting the original DJJ referral. A printout was included in each file documenting referral approval from the Florida Network office. The needs assessment and other paperwork reflect face-to-face interaction to gather family history and demographic information. Each file included a service plan that included the signature of the youth and his/her parent/guardian as well as orientation paperwork for the program. The active case was opened on 1/25/19 and individual sessions have commenced. The clinician was not able to pursue life management sessions with the closed case as they documented in the progress notes several attempts to schedule with the client which led to “no shows” and no response. Subsequently, the case was terminated. No group sessions were documented in the files due to the reasons listed above (active case is new and no response for the closed file).

There were no exceptions to this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place to address the Video Surveillance System indicator that was last reviewed March 2017 and approved by the CEO. The policy outlines that they will have a video surveillance system (that operates 24 hours a day, 7 days a week), to monitor and capture a recording of agency happenings to assure the safety of all youth, staff, and visitors to residential shelters.

The policy does not require monitoring 24 hours a day, 7 days a week but consistent video recording. Some of the procedures include:

· Cameras are in interior and exterior areas to cover general locations

· Never have cameras placed in bathrooms or sleeping quarters

· Supervisory review of video is conducted bi-weekly and documented to assess the activities of the facility to include a review of a random sample of overnight shifts

· Have cameras that have the availability to record date, time, and location, maintain resolution that enables facial recognition, and have back-up capabilities that enable cameras to operate during a power outrage.

The shelter has a written notice that is conspicuously posted on the premises as you enter. The orientation packet is given to both youth and parent that outlines that the purpose of the video surveillance is to ensure the safety of the youth, staff, and visitors. Cameras were visibly observed in the interior and exterior general locations including the intake office, hallways, parking lot, leadership room, kitchen space, lounge area, and veranda area. There were no cameras seen in the bathroom and sleeping quarters areas. The video system was reviewed and is able to capture and retain video photographic images including facial recognition. The system is able to record the date, time, location, and store video for a minimum of 30 days. The supervisor showed the technology room where there are two backup battery packs in the event there is a power outage. Although there is not a list of personnel who can access the video surveillance system, all supervisors are able to see the shelter remotely through a mobile app. Supervisor reviews the video a minimum of every 14 days and is noted in a logbook. The logbook documents activities of the facility including the overnight shifts. Supervisor explained that if a request could be made due to a CCC report if further managerial review is required. The video recording is saved and forwarded to the unit. If there is a request from law enforcement due to a pending investigation, a warrant is needed to access any video recordings.

There were no exceptions to this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Family Resources agency provides screening, counseling and mental health assessment services. The residential counselor is a Licensed Mental Health Counselor (LMHC). The Family Resources agency has staff members are that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The agency also uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter. The Family Resources agency assists in the delivery of medication to all youth admitted to the residential youth shelter. The agency operates a detailed medication distribution system. 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. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury. The agency has a full complement of staff of both male and female staff members across all three work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention, and medication distribution training.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Healthcare Admission Screening to address the requirements of this indicator. The policy was last reviewed in March 2017 by the Chief Executive Officer/President.

The admission process will include an in-depth health screening through the completion of the CINS Intake Assessment Form. If there is any concern that a physical condition merits screening or it is apparent that there is a major health care issue, the youth will be immediately referred to their physician, emergency room, or the public health care department. In the event a youth is admitted with a chronic medical condition, staff will contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medication, general precautions, and how to proceed in the case of an emergency.

The policy does not address the agency nurse conducting the health screening if present during the intake, and if not then reviewing the intake within five business days.

There were five open and four closed residential files reviewed. All nine files documented the CINS Intake Assessment Form was completed at admission. There was one youth who had Asthma but only used an inhaler in emergency situations. The youth did not require any type of follow-up medical care; however, there are procedures in place to contact the parent if it is needed. There were five youth taking medications and the medications were documented. There were three youth who had different types of allergies and those were documented as well. The CINS Intake Assessment Form was signed by a supervisor, in all nine files, either on the day it was completed or the following day. The form was also reviewed and signed by the Registered Nurse, in six of the nine files, within two days of admission. The remaining three youth were recently admitted within the past two days so still had time to be reviewed by the RN.

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place titled Comprehensive Master Plan for Suicide Prevention and Response to address the requirements of this indicator. The policy was last reviewed in March 2017 by the Chief Executive Officer/President.

The plan states that each youth will be screened for suicide risk by the six suicide risk questions on the CINS/FINS Intake form. If the youth answers "yes" to questions two and three, the youth is considered to be at high risk of suicide and must be placed on One-to-One supervision and referred for Baker Act. If the youth answers "yes" to questions 1, 4, 5, or 6 on the Intake Form then the youth is determined to be at moderate risk for suicide. The youth will be placed on sight and sound supervision until a full suicide risk assessment is completed. The assessment will be done within twenty-four hours during the weekdays or within seventy-two hours if over the weekend.

There are four different levels of supervision used in the shelter. One-to-One Supervision, this is the most intense level of supervision and is

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

The shelter's counselor is a licensed mental health counselor (LMHC) and completes all Suicide Risk Assessments for shelter youth. In addition, the program also has access to the Vice President of Community and Clinical Services and the Vice President of Residential Services who are licensed as well.

There were four files reviewed for youth placed on suicide precautions. All four youth answered "yes" to at least one of the six screening questions on the CINS/FINS Intake form. All four youth were placed on constant sight and sound supervision until seen and assessed by the counselor. All four youth were assessed using a Suicide Risk Assessment within twenty-four hours. All Suicide Risk Assessments were completed by a LMHC. The youth were removed from suicide precautions after completion of the Suicide Risk Assessment. Thirty-minute observations were maintained the entire time the youth were on suicide precautions. The LMHC also documents a very detailed note in the youth's file detailing the results of the Suicide Risk Assessment.

Documentation was found in the logbook of youth on suicide precautions and also changes in supervision levels. Any youth on suicide precautions during the overnight hours sleep on the couch in the dayroom.

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Medication Management and Distribution to address the requirements of this indicator. The policy was last reviewed March 2017 by the Chief Executive Officer/President.

There are procedures in place for the verification of medication at admission by a staff member. Medications must be verified using one of the four methods outlined in the CINS/FINS Policy and Procedure Manual. There are procedures in place for the utilization of the Pyxis Med-Station 4000, including: storage, access, and inventory. There are processes in place for the delivery or assisting in the self-administration of medications. There were procedures in place for medication distribution for youth away from the shelter and the discharge of youth with medication. There are procedures for disposal of medications.

The agency has a Registered Nurse (RN) who is on-site seven days a week for approximately two hours in the morning and two hours in the evening. The RN will distribute all the morning and evening medications when on-site.

The agency provided a list of seventeen staff who are trained to supervise the self-administration of medications. There are six Super Users listed, including the RN. The program has a Super User designated for each shift.

The RN train's all staff on the use of the Pyxis Med-Station and the medication administration process at hire. The RN also completes on-going trainings with staff on various health related topics. The RN completes health education groups with the youth. The RN creates games to go along with the groups to make groups fun and interesting, and keep the youth engaged.

All medication is stored in the Pyxis Med-Station. Regular prescription/non-controlled medications are stored in drawer two. Controlled medications are stored in the third drawer of the Med-Station. Drawer four is used for over-sized medications. Medications are verified at admission usually by the RN; however, if the RN is not present for the admission the staff will call the pharmacy to verify the medication.

There has been one discrepancy in the last thirty days. The discrepancy was closed out by the end of the staff members shift. The RN maintains a notebook of all discrepancies. The discrepancy report from the knowledge portal is printed out each week and reviewed and signed by the RN and the Residential Supervisor. Most discrepancies reviewed were staff in -putting incorrect counts and loading errors. There were no open discrepancies at the time of the review.

Trained direct care staff complete an inventory every shift of all the controlled substances. This is completed by two staff members and is documented on the youth's Medication Distribution Log (MDL). A perpetual inventory is maintained on the youth's MDL each time a medication is given. Non-controlled medications are inventoried by maintaining a perpetual inventory each time it is given and inventoried one time each week by the RN. The shelter does not maintain any over-the-counter medications that would require a separate inventory.

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. The RN maintains a log documenting the temperature of the refrigerator twice each day. At the time of the review the temperature was 36 degrees.

The shelter has sharps located in a locked box in a cabinet in the staff work area of the dorm. The shelter maintains fifteen pairs of scissors and disposable razors that are restocked as needed. These sharps were inventoried each shift for the past six months. A perpetual inventory is also

maintained each time one of the sharps is used.

The RN currently runs a Discrepancy Report from the Knowledge Portal each week. The RN uses the Knowledge Portal to view other reports as needed.

The shelter has a process in place for refills of medications when they get low. The RN will call the youth's parent once the medication has approximately seven days remaining and request them to bring in a refill. The RN will continue to call the youth's parent if the medication is not received in a timely manner.

The shelter has two alert boards located in the dayroom and the medication room. The board located in the dayroom documents which youth are on medication, the times to be given, and if the medication is a controlled substance. The board in the medication room also documents the youth's name, the medication, and the times to be given.

There were two youth in the shelter currently on medications. The Medication Administration Log was reviewed for these two youth. All medications were verified at admission either by the RN or the pharmacy. The Consent for Self-Administration of Medication and Verification of Prescription Medication form was found for each documenting all medications the youth was taking. All the MDL's reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, times to be given, common side effects, reason, and the full printed name of each staff administering medication, as well as, the youth. A picture of the youth is located in front of the MDL in the Medication Administration Log. All MDL's reviewed on site document that perpetual inventory counts with running balances are being maintained on each medication. All MDL's reviewed for the youth also documented that all medications were given at prescribed times. All inventories of the medications were documented on the MDL's.

The shelter also maintains a binder with print-outs of side effects for every medication in the shelter. As new medications come in the RN will add the print-outs to the binder if they are not already in there.

There RN maintains a Medication Disposal Log. There have been twelve medications disposed of since the last on-site review. All medications were taken to a local pharmacy, Walgreens, to be disposed. The RN and Residential Supervisor signed all disposals.

There were two medication errors reported to the CCC in the last six months. One of the errors was a youth receiving the wrong dosage of medication for three days. The prescription was for 20mg a day or one pill. However, it was noticed on day three, by a staff member, that the pills in the bottle were only 10mg pills. So the RN stopped the medication and contacted the parent to bring in the right dosage pills before continuing the medication. The second error was a youth who did not receive a medication one day. There was documentation the Pyxis Med-station had malfunctioned and would not open so that the staff could dispense the medication. The pharmacy was contacted and informed the to continue with the next scheduled dose and there would be no side effects from missing the medication.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Medical and Mental Health Alert Process to address the requirements of this indicator. The policy was last reviewed March 2017 by the Chief Executive Officer/President.

There is one alert board located in the dayroom for staff to review and also an alert board in the nurse's station. The alert system consists of color-coded dots with each colored dot representing a different alert. There are eight different colors used for alerts, red indicates the youth is on constant sight and sound supervision, yellow is elevated support, green is a mental health alert, blue is substance abuse, purple is sharps restriction, black indicates a medical issue, orange indicates the youth is on medication, and pink indicates allergies and/or special diet. The applicable color-coded dot is placed on youth's file for each alert the youth is on. The color-coded dot is also placed next to the youth's name on the alert board.

A total of five open and two closed files were reviewed for adherence to this indicator. All files reviewed had an alert that was appropriate to their screening and assessment results. All applicable color-coded dots were found on the spine of the youth's file. All alerts documented in the youth's file corresponded with the alerts documented on the alert board. Any food allergies or dietary alerts are also documented in the kitchen. All alerts were also documented in the logbook.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy titled Episodic/Emergency Care to address the requirements of this indicator. The policy was last reviewed in March 2017 by the Chief Executive Officer/President.

All direct care staff shall be trained and certified in first aid and CPR procedures within three months of beginning work with youth, and shall be retrained on the location and use of the knife for life. Proper first aid equipment and supplies will be available at all times in all sites where youth are served. First aid kits will be located in a designated area of each site that is accessible to staff. First aid kits must be kept in an orderly manner so that needed supplies can be easily found. The kits will be examined and replenished after each use and inventoried at least once a week. There will be a “knife for life” and small wire cutters stored in the same area as the kit in a manner available to staff in the event a youth attempts suicide.

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

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

The shelter has completed three mock drills in the last six months, one was a youth hitting their head and the other two were suicide drills.

There were no exceptions to this indicator.