Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources Inc. – St. Petersburg, FL
Residential Program

October 24-25, 2018

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender 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 & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 96.43%
Percent of indicators rated Limited: 3.57%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

Marcia Tavares, Lead Reviewer, Consultant-Forefront LLC
Karen Boulding, Statewide Training Coordinator, Florida Network of Youth and Family Services
Donna Conners, Regional Monitor, Department of Juvenile Justice
Patrick Minzie, Operations Manager, Hillsborough County Children's Services
Mark Shearon, CCM/Shelter Program Manager, Arnette House

Quality Improvement Review
Family Resources Inc. – St. Petersburg
Lead Reviewer: Marcia Tavares

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

Persons Interviewed

- ☒ Chief Executive Officer
- ☐ Chief Financial Officer
- ☒ Program Coordinator
- ☐ Direct – Part time
- ☐ Volunteer
- ☒ Clinical Director
- ☒ Counselor Non-Licensed
- ☐ Advocate
- ☐ Nurse – Full time
- ☐ Executive Director
- ☒ Program Director
- ☒ Direct – Care Full time
- ☐ Direct – Care On-Call
- ☐ Intern
- ☐ Counselor Licensed
- ☐ Case Manager
- ☒ Human Resources
- ☐ Nurse – Part time
- ☐ Chief Operating Officer
- ☒ Program Manager
- _____ # Case Managers
- _____ # Program Supervisors
- _____ # Food Service Personnel
- _____ # Healthcare Staff
- _____ # Maintenance Personnel
- **1** # Other (listed by title): _____

Documents Reviewed

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

Surveys

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

Observations During Review

- ☐ Intake
- ☐ Program Activities
- ☐ Recreation
- ☐ Searches
- ☒ Security Video Tapes
- ☐ Social Skill Modeling by Staff
- ☐ Medication Administration
- ☐ Census Board
- ☒ Posting of Abuse Hotline
- ☐ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Discharge
- ☐ Treatment Team Meetings
- ☐ Youth Movement and Counts
- ☒ Staff Interactions with Youth
- ☐ Staff Supervision of Youth
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☐ Group
- ☒ Meals
- ☐ Signage that all youth welcome

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

Rating Narrative

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and shelters located in Clearwater, St. Petersburg and Bradenton, Florida. Family Resources serve both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also contracted to provider services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking, and family and youth respite aftercare services. The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth.

The agency's mission is to inspire well-being and success in the lives of vulnerable children, youth and families through responsive quality programs and safe places. To fulfill their mission, services offered include short-term residential care, transitional living programs, counseling, community education, street outreach, and after-school programs. The following is a list of programmatic achievement since the last quality improvement visit:

- The program implemented the Berke Assessment tool during the last FY to recruit suitable employees during the hiring process. Berke is a pre-employment test that measures personality and matched skill sets for specific job requirements. The tool provides an evaluation and rating that assists in determining ideal candidates for a position.
- The Department of Health and Human Services awarded the agency funding for Street Outreach services, allowing the program to offer these services again after losing the funding 5-6 years ago.
- The agency closed its LGBTQ TLP program September 30, 2018 but is focusing on implementing a Safe Connections Resource Center. As part of a 2 year strategic plan for LGBTQ with Pinellas County, the provider is allowing other local agencies to utilize 2 beds in the former TLP residential facility for DCF youth with no immediate placements.
- A 2-bedroom home was purchased by the agency through agency reserve funds for the purpose of transitioning youth from transitioning living to independent living. The program will support youth as they maintain employment and pay rent, while learning independent living skills.

- A CDBG fund of $550,000 was awarded to the agency for building renovations.
- Improvements made to the shelter during the last year includes:
  - Backyard renovation complete with a new basketball surface using agency color schemes
  - Large, colorful vinyl posters created from pictures of staff travels adorn the walls throughout the facility and are rotated through the shelter
  - All of the youth bedrooms were repainted with beautiful murals by a local artist Loy Khambray-Correa

Standard 1: Management Accountability

Overview

Narrative

Family Resources Inc. is under the leadership of a management team that consists of a Chief Executive Officer, 3 Senior Directors, a Chief Grants Officer, a Chief Human Resources Officer, and a Chief Financial Officer (interim). All residential shelter staff and non-residential staff are overseen by a Senior Director and the shelter component is staffed by a residential supervisor, case manager, counselor, Youth Development Specialists (YDS), cook, and part time nurse.

The Department of Children and Families has licensed SafePlace2B as an emergency runaway shelter. The agency operates a total of three youth shelters and the company handles all personnel functions through its Human Resources division located at its central office in Pinellas Park, Florida. This office processes all state and local background screenings.

The provider agency conducts orientation training to all shelter personnel through its Residential Supervisor. The majority of core training is also provided by inter-agency training delivered by the agency, as well as, outside and on-line training resources. Each employee has a separate training file containing a training plan and copies of documentation for training received. Annual training is tracked according to the employee's date of hire. The program provides training through a combination of web-based and in-person instructor-led courses.

1.01 Background Screening of Employees/Volunteers

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The provider has a policy and procedures #1.01, for Background Screening of Employees and Volunteers, which was last reviewed July 2018 and signed by the Chief Executive Officer. However, the current policy and procedure is not updated with the agency's use of the Berke pre-assessment tool. In addition, the policy and procedure states that the 5 year re-screening will be completed every 5 years after the initial screening date rather than every 5 years from the date of hire, as required.

Procedure
Policy #1.01 requires all staff and volunteers to complete a Level 2 Background Screening as required by Chapter 985.407 of the Florida Statutes and consistent with

the Department of Juvenile Justice policies. The screening, which includes fingerprinting, must be completed and receipt of an eligible for hire rating obtained before any offer of employment is made. Additionally, a re-screening of each staff member, intern, mentor, and volunteer is to be completed every five years after the date of initial screening. Staff undergoes additional background screenings prior to any position change or transfer from one program to another. The policy further asserts the provider's Human Resources Department will complete and submit an Annual Affidavit of Compliance with Good Moral Character to the Department of Juvenile Justice Background Screening Unit by January 31, of each year on all staff who were actively employed at a program site during the calendar year.

Practice
A total of seven background screening files were reviewed for 5 new staff, 1 volunteer, and 1 staff eligible for a 5-year re-screening. All five new employees were background screened and had evidence of a DJJ Clearinghouse/BSU approval prior to hire date. All applicable new employees were e-verified and proof of employment authorization is on file for each employee. A 5-year re-screening was completed prior to the 5 year anniversary for one eligible staff.

The program had one intern providing volunteer service during the review period. The HR coordinator provided evidence of background screening that was completed prior to the intern's start date.

The program completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit via email on January 10, 2018 prior to the January 31st deadline.

The agency uses Berke, a pre-employment assessment that uses data-driven insights to predict hiring success. The program has been using the tool since January 2017. The tool measures personality traits and problem-solving skills and compare candidates to job benchmarks that are customized by the agency for direct-care positions. The tool was administered prior to the hiring of the five new staff reviewed. All of the Berke reports for the employees indicated a rating of suitability based on a score of high fit for the job of Youth Development Specialist I. As of the date of the onsite visit, the provider did not have a written policy in place for its use of the Berke pre-assessment tool with regards to suitability criteria and agency protocol.

Exception
No exceptions noted for Indicator 1.01

1.02 Provision of an Abuse Free Environment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy

The program has a current policy and procedure #1.02 in place for the Provision of an Abuse Free Environment, signed and dated March 2017, and #3.08, Grievance Process, signed and dated August 2018 by the Chief Executive Officer.

Procedure

The stated policy strives “to provide an environment in which youth, staff and others feel safe, secure, and not threatened by any form of abuse or harassment. Staff are required adhere to a code of conduct that forbids staff from using physical abuse, profanity, threats or intimidation. Youth shall not be deprived of basic needs such as food, clothing, shelter, medical care, sleep and security.” Further, the policy states any client has the right to initiate and bring to the attention of staff any complaints, grievances or actions of program staff or the youth's peers, conditions or circumstances of care that are a violation of their rights. Program procedure documents the specific information to be reported via the Florida Abuse Hotline to include the names and address of the youth, parent(s)/guardian(s) or other persons responsible for the youth’s welfare, the youth’s age, gender, race and any sibling name(s), the nature and extent of the alleged abuse, neglect or exploitation, as well as, the identity of the abuser (if known) are to be provided. The program staff then report alleged abuse to the Department of Juvenile Justice Central Communications Center and document all reports in the youth’s file. Additional procedures are required once the abuse registry determines whether the report will be investigated and if the youth will require shelter or residential services during the investigation.

Additionally, Management is required to take immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, profanity and excessive use of force. The policy also identifies the mandatory requirements for reporting allegations and suspicions of abuse, neglect or exploitation as mandated by law (F.S. Chapter 415, and F.S. 39.201).

The policy and accompanying procedure is reinforced by the staff code of conduct which specifically prohibits any kind of maltreatment of youth. The code of conduct outlines specific rules regarding interactions with youth such as the provision of contraband to youth, social contact with youth for non-work-related purposes, the use of profanity or other abusive language in the presence of youth, and the exploitation of the relationship with the youth for personal gain. The program requires all staff to sign an Affidavit of compliance with the Code of Conduct documenting their awareness of the Code and the expectations of them soon after employment. The Code of Conduct acknowledged by staff also reinforces the mandatory reporting of suspected or known abuse neglect, or abandonment of a youth to the Florida Abuse Hotline and, in the case of institutionalized abuse or the age of the youth, to the Central Communications Center.

Staff are trained regarding the reporting of child abuse. The program also ensures youth are aware of their right to unimpeded access to program telephones to contact the Florida Abuse Hotline to report abuse and overtly posts the Florida Abuse Hotline

telephone number in the facility to ensure the youth have access to the telephone number.

The program has implemented a grievance procedure to ensure youth in the program are able to grieve actions of staff and any perceived adverse conditions or circumstances related to the violation or denial of basic rights. This procedure involves the youth's completion of a grievance form, the submission of the completed form into a locked box and a review by the program or residential supervisor within seventy-two non-weekend hours. There is an appeal process if the youth is not satisfied with the supervisor's response to the grievance. All grievances and findings are maintained in a central file for the period of one year. Staff also cooperates with staff from the Department of Children and Families and the Department of Juvenile Justice investigators and serve as advocates for the best interest of the youth in their care.

Practice

Reviewed documentation indicated the staff educate youth regarding their right to report any kind of abuse they experience and the procedures to report abuse during the intake process. Additionally, this information is also documented in the Youth Handbook provided to each youth for their reference while accessing services in the program. During the tour of the program site it was observed the program conspicuously posts the Florida Abuse Hotline number in each of the two main lobbies as well as, in the main living area of the shelter. Training files for three new staff reviewed supported the three staff received training in child abuse reporting during program orientation.

The program has a written grievance policy and procedure in place to ensure any client can exercise their right to initiate and share their concerns with staff. During the facility tour, a locked grievance box was observed in the youth living area (for the shelter) and forms readily accessible to youth to submit their grievance/feedback regarding any perception their rights have been violated. Program practice then requires the program supervisor to check both boxes daily, with the exception of weekends/holidays, (only he has key). The supervisor then reviews, and addresses the youth grievances in a timely manner. A review of the grievance binder contained a total of two grievances filed in the six month period of May through October 2018. Both reviewed grievance forms originated from youth admitted to the shelter program. Both grievances were addressed in a timely manner. The program director stated that no staff has been involved in any incidents of physical and/or psychological abuse, verbal intimidation, profanity and excessive use of force requiring management intervention during the review period.

Exception

There were no exceptions noted for this indicator.

1.03 Incident Reporting

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a policy and procedure #1.03 Incident Reporting that was signed and dated July 2017 by the Chief Executive Officer.

Procedure
There are written policies in place which describe the reporting processes for incidents that may pose a risk or liability to the organization or its clients. These processes will assist in the identification of problems and document trends and corrective actions that can be taken to minimize future risk. The procedure lists numerous types of activities which would require incident reporting to include program disruption, escape/abscond incidents, medical incidents, mental health and substance abuse incidents, complaints against staff incidents and youth behavior incidents.

Per policy 1.03 Incident Reporting, immediate notification to senior management is to occur when a critical incident occurs. The policy lists critical incidents as a significant injury to a youth or staff, death of a youth, youth on youth sexual abuse, youth arrest for a felony charge, a missing youth, a suicide attempt by a youth, as well as, employee misconduct or arrest and any incident which would have a high likelihood of media attention or agency liability. Additionally, there is a formal, written risk management system in place for identifying and addressing significant change in the number or severity of incidents.

Practice
The program complies with the DJJ policy 8000 “Central Communications Center” (CCC) on incident reporting. There were four reportable CCC incidents within the last six months: 1 abscond; 2 medication related; and 1 medical. The CCC was notified as soon as possible, but no longer than two hours after the reportable incident occurred, or within two hours of the program learning of the incident. All four incidents were documented on incident reporting forms and were noted in the log book. Follow-up was provided to the CCC assigned staff by the program until they indicated the case was closed.

Exception
There were no exceptions noted for this indicator

1.04 Training Requirements

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a policy and procedure #1.04, Training Requirements, which was signed and dated March 2017 by the Chief Executive Officer.

Procedure

The program's written policy and procedures ensures staff are appropriately trained to conduct all job position duties and trained in all required areas to meet the standards of the Department of Juvenile Justice for CINS/FINS providers. Current standards require specific trainings (i.e. orientation, managing aggressive behavior, suicide prevention, child abuse reporting and universal precautions among others), to be completed in the first 120 days of hire and a total of eighty hours completed during the first calendar year of employment. After the first year of employment, each staff is required to complete a minimum of forty hours of training each year. Training is to be completed annually in suicide prevention and human trafficking, and every two years regarding Prison Rape Elimination Act course number 110 (PREA) and fire safety. Staff are to remain certified in cardiopulmonary resuscitation and first aid throughout their employment.

Specialized suicide-risk assessment training (twenty hours) and supervised experience is required for non-licensed clinical staff who work in shelter/residential programs under the supervision of a licensed mental health clinician. There must be written confirmation by the licensed clinician, indicating the non-licensed staff has completed the required supervised assessments and training in the non-licensed clinician's training file on a specific form before the non-licensed staff can be authorized to solely conduct suicide risk assessments.

The program will maintain a training file, individualized for each staff specific to their position and training requirements. Training is available to staff throughout the year and is delivered via instructor led courses, webinars, computer based courses and various training events provided by multiple outlets including but not limited to the Florida Network, local community resources and various local provider personnel approved to deliver training. Staff is also enrolled in the Department of Juvenile Justice's SkillPro Learning Management System, which is a computer-based network of training courses.

Practice

The program maintains an individual training file for each staff person. A total of six staff training files were reviewed. Three files belonged to staff whose first year of employment was recently completed or ongoing during the audit review period; the remaining three files were for staff who were beyond their first year of hire.

The training files of the first year employees were for two direct care shelter staff and one shelter counselor. The two direct care shelter staff files showed they had completed the 120 days training requirements (with a couple of instances of missing the 120 day requirement by a few days only). The remaining training hours for the first year were met by both of these employees so far with just a few courses left to complete by the end of their first year. Employee 1, hire date 2/14/18, has three remaining SkillPro courses to complete by 2/14/19; Employee 2, hire date 5/9/18, has one SkillPro course left to complete by 5/19/18. The Shelter counselor has one remaining course to complete before 3/20/19 and her training hours far surpass the 80 hours requirement.

The training files of the in-service employment staff included a clerical/administrative position and two direct care positions. All three of these employees completed the

training requirements applicable to their positions. Additionally all the staff files reviewed showed each of these employees had surpassed the 24 hours of training required (and the additional 16 hours of training for a 40 hour total for DCF by the two direct care shelter staff).

Note, it was difficult to determine which courses were covered for the onsite job-specific training, which accounts for approximately 20 hours of training, as they lack specificity such as the course content or training topic.

Exception
No exceptions noted.

1.05 Analyzing and Reporting Information

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a written policy and procedures #1.05, for Analyzing and Reporting Information which was last reviewed March 2017 and signed by the Chief Executive Officer. In addition, the agency has a comprehensive PQI Plan dated 2016 to ensure programs adhere to the highest quality standards with quality and integrity and that agency resources are effectively utilized. The PQI plan and policy #1.05 address the protocol for collection and analysis of data related to case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data and Netmis data reports.

Procedure
Family Resources has a comprehensive team model that allows every employee to be a member of at least one PQI team. The teams report basic data, goals, areas of concerns, and activities toward meeting goals, corrective action activities, and needs through reports on a monthly or quarterly basis. These are presented to a QI Council, comprised of senior and program management members, and representatives of all agency-wide teams. The QI Council, in turn, relates through the Strategic Planning Team to the Board of Directors. Feedback is provided at all stages.
Peer record reviews are conducted quarterly in all programs in the first month following the end of a quarter. On the last Thursday of every month the listing for clients served for all programs will be pulled. This list will then be emailed to the respective Senior Directors to send out to their respective Supervisors. A minimum of five records for each program is randomly chosen and include both open and closed cases for all programs. Each program will then complete the peer review process by the 15th of the month by completing the respective peer review form. Reviews are conducted by peers utilizing a standard form and data is aggregated into a summary report which is sent to the COO. The COO provides an aggregate report on peer review activities for the Directors and Supervisors meeting on a quarterly basis.

The Risk Management Committee is responsible for implementing and overseeing the Risk Management policy and plan. Quarterly reports are presented to the Senior Leadership Team of Family Resources, Inc., who reports to the board at least annually. Incident reports are reviewed by the Safety Committee of the Risk Management team on a quarterly basis. The COO receives copies of all incident reports and completes a compilation report of incidents, accidents, and grievances quarterly. The report is also reviewed at the bimonthly Directors and Supervisors team meetings.

All programs at Family Resources utilize satisfaction surveys, which contain participant self-reports regarding improvement in the presenting problem, service delivery, staff effectiveness, and ideas for improvements. Surveys completed monthly are compiled by each program and aggregated into an annual report. The Program Team reviews the results of the surveys on a quarterly basis. The agency surveys community providers and funding entities on a bi-annual basis to determine their perception of the quality of the programs and to assist in identifying other relevant needs. This information is utilized in the quality improvement process as well as in the development of the Strategic Plan.

Family Resources collects data utilizing a form created by the Florida Network Children in Need of Services (CINS) programs. The form collects basic demographics, history of abuse, delinquency, substance abuse and other items and that information is entered into the statewide database along with service data, and follow-up data. The measurable outcomes dictated by the FN are tracked monthly for the shelters and family counseling offices and aggregated into an annual report.

Netmis data is emailed from the Florida Network to the agency CEO who shares this information with the directors and supervisors at their bi-monthly meetings.

Practice

A review of peer record reviews for FY 17-18 was conducted. The record reviews were conducted quarterly for all programs. The program documents compliance for each record as well as deficiencies. Detailed reports of the case record reviews include: significant findings, data analysis, and report summary/recommendations.

The Risk Management Committee completed a Risk Management Analysis for the 1st quarter 2018-2019. Incident reports are reviewed and analyzed by the committee in terms of incident total by program; agency-wide incident totals by type; and incident type by program. The report also aggregates data for grievances and workers compensation.

A copy of the most recent Consumer Satisfaction Survey Result for period April-October 2018 was reviewed. Survey results are tracked monthly for the shelter and non-residential clients separately and compiled into an annual report.

Program outcomes data are documented monthly by each program, incorporating the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. A copy of the report was reviewed. The reports of the outcomes data demonstrate the

provider is capturing and monitoring outcome indicators for both the residential and non-residential program.

The program conducts QI Mock Reviews with a team of directors, supervisors, and case managers. A sample of 5 files for each program is selected for the review. The review covers each indicator of the QI Standards and a final report is written that provides feedback on exceptions/concerns, methodology for improvement, person(s) responsible, time frame for implementation, whether or not a tracking form is required, and date of staff training. The most recent Mock Review was conducted on 7/3/2018.

Senior leadership meets every Wednesday to discuss and review policies and procedures, data presentations, and fiscal information. Monthly team/staff minutes were reviewed for the review period and were found to have documentation of discussion by of information discussed regarding FN Netmis data, QI activities, reports, and areas identified as needing improvements or changes needed from analysis.

Exception:
No exceptions noted for Indicator 1.05.

1.06 Client Transportation

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a clear and precise policy on this standard that is 1.08, for Agency Vehicles and 1.10- Transportation Policy. The policies and procedures were last reviewed by the CEO in March 2017.

Procedure
The agency's procedures state that the program director will be notified of any single youth transports and director will evaluate the youth's history, personality, recent behaviors and length of stay within the program to determine if the single transport can be approved. Upon approval the trip will be documented clearly and an open phone line will be had during the entire trip with several check-in during the trip. The agency has a very clear transportation log that captures all contractual requirements.

Practice
The program transportation log for the past six months was reviewed and they were all filled out appropriately. A total of 4 single transports were noticed and it was verified that the residential supervisor approved the trips and trips were documented correctly in the digital log book and the transportation log. Single transports were 8/13/18, 9/3/18, 10/2/18, and 10/4/18 and all were documented and approved per policy and procedure. There is a current list of approved drivers which is maintained by the program.

Exception
None

1.07 Outreach Services

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
Family Resources has a written policy and procedure that addresses the elements of indicator 1.07 for Outreach Services. The policies and procedures were last reviewed by the CEO in March 2017.

Procedure
This program encourages and offers preventative and outreach services to the members of the communities they serve. Family Resources offers informational and educational CINS/FINS services to youth and families, alcohol and drug treatment, adolescent behavior, parenting classes, youth education issues and information. The provider's procedure indicates that outreach services will be designated to lead staff to coordinate and provide services to communities, audiences, individuals, and group with a particular customer focus. Family Resource staff is required to attend the DJJ circuit meetings and obtain copies of the minutes to the meetings to supply to agency leadership. Staff representing the agency will provide verification of attendance at DJJ Board and Council Meetings.

Practice
There were five events attended during our review timeframe. The first was the Circuit 6 Department of Juvenile Justice Advisory Board Meeting conducted on May 3, 2018; both minutes and staff attendance is verified. Second was the Manatee County Juvenile Justice Council meeting on June 21, 2018; minutes were provided and there is verification that shows a representative of the agency attended the meeting. Third, on July 27, 2018, the PJAC Advisory meeting was conducted; there were minutes provided and there was verification that a representative attended the meeting. Fourth, on August 21, 2018 Pinellas County Substance Abuse Advisory Board Meeting was conducted, there were minutes provided and there was verification that a representative of the agency attended the meeting. Finally the Homeless Leadership Board Providers Council Meeting was conducted on October 19, 2018 minutes were not applicable for this event, but there is verification that a representative of the agency attended the event.

The agency maintains interagency agreements that describe and specify services, fees, scope and nature of cooperation, collaboration, and responsibilities of all agencies involved in providing program services identified as needed by parent and/or youth. Copies of all interagency agreements are maintained in a binder by the program representing services and resources available to youth and family.

Exception
No exceptions.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Through a contract with the Florida Network, Family Resources, Inc. operates SafePlace2B South Campus. The program, which is in St. Petersburg, provides CINS/FINS residential and non-residential services to youth and their families in Pinellas County. The program provides intake and screening for services twenty-four hours a day, seven days a week. The program has trained staff who are available to discuss the needs of the youth and their family.

The residential services include individual, family and group counseling, as well as case management and substance abuse prevention education. Referral and after care services begin upon the youth's admission into the program. The aftercare services consist of referrals for the youth to community resources, on-going counseling services and additional educational assistance. Youth Development Specialists are responsible for completing the admission paperwork, providing orientation to the youth, and supervising the youth while in the shelter. The residential component consists of one full-time Master's level counselor and one full-time Bachelor's level counselor.

Non-residential services within the program include individual and family counseling. Non-residential services counselors provide case management services for truant and ungovernable youth while also linking youth and families to community resources. The non-residential component also encompasses the Case Staffing Committee. This is a statutorily mandated committee that develops a service treatment plan for truant youth, ungovernable youth and runaway youth when all other interventions have been exhausted or upon the request of the parent/guardian of the youth. The Case Staffing Committee can also recommend the filing of a CINS Petition with the Court as needed. The non-residential component consists of a full time licensed supervisor who supervises full time Master's level therapists and the residential counselor as well.

2.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a policy in place to address Screening and Intake (Family Resource: 2.01). The policy was reviewed and signed in July 2018 by the program's chief executive officer.

Procedure

The program's policy is implemented by the following procedures: at the initial contact with the youth, a screening will be conducted to determine whether the Residential or Non-Residential facets of the program will be deemed appropriate for the youth. The youth must meet several points of criteria, including, but not limited to: being between 10-17 years of age, may not be currently adjudicated delinquent, may not be a danger to self or to others, mental health issues must be under control, and the youth is not in need of any immediate medical care. Youth with a history of arson, sexual or violent offenses may not be eligible, and must be approved by a supervisor. The screening will also be utilized to serve as an overview of the presenting problems and any other pertinent history which will help determine what best fits the needs of the youth. If eligible for the shelter, the youth is placed in the residential program, and a family session is offered to the parent/guardian. All screenings will result in an appointment being made with family counseling services, shelter programs or a referral to other appropriate services. If the youth is not deemed eligible for services through Family Resources, the family will receive three community referrals as a follow-up for services.

Practice

A census roster for youth who received non-residential and residential services in the past six months was requested; six youth (three non-residential and three residential) were randomly selected for review. Of the three non-residential files selected, all were closed. For the non-residential youth, there was an eligibility screening conducted on all three youth within seven days of the referral. However, in one file, the referral for services was completed in November 2017; the youth's screening was conducted April 6, 2018. The program was able to produce an email from the referral source to document the referral had been sent via fax on November 7, 2017 but the program does not have a fax machine, therefore the referral was not provided to the program. The referral was re-sent on April 5 and the screening was completed April 6, 2018. All three non-residential files documented the youth and parent/guardian received information regarding available service options, the rights and responsibilities of the youth and the parents/guardians, possible actions through the involvement with CINS/FINS services, and the grievance procedure. The youth's parent/guardian received the parent brochure. This was documented by the signature of the youth and the youth's parent/guardian on the program's consent to treatment, youth rights and responsibilities form which was present in all three files. All three files were compliant with the indicator.

Two of the residential files were open and one was closed. For the three residential youth, there was an eligibility screening conducted on all three youth within seven days of the referral. All three residential files documented the youth and parent/guardian received information regarding available service options, the rights and responsibilities of the youth and the parents/guardians, possible actions through the involvement with CINS/FINS services, and the grievance procedure. The youth's parent/guardian received the parent brochure. This was documented by the signature of the youth and the youth's parent/guardian on the program's consent to treatment, youth rights and responsibilities form which was present in all three files. All three files were compliant with the indicator.

Exception
No exception noted for this indicator.

2.02 Needs Assessments

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a policy in place to address Needs Assessment (Family Resource: 2.02). The policy was reviewed and signed in July 2018 by the program's Chief Executive Officer.

Procedure
For residential youth, a needs assessment must be completed within seventy-two hours of admission. The non-residential assessment should be completed within two to three face-to-face contacts with the youth. As a result of the needs assessment, a suicide risk assessment may be required for the youth. The suicide assessment must be reviewed by licensed clinician. Each suicide assessment must be reviewed and signed by the clinical supervisor.

Practice
A census roster for youth who received non-residential and residential services in the past six months was requested; six youth (three non-residential and three residential) were randomly selected for review. Of the three non-residential files selected, all were closed. For the non-residential youth, all needs assessments were completed by Master's level staff. Each assessment was signed by a supervisor upon completion. None of the youth were identified with an elevated risk of suicide risk; however, one youth had a history of self-injurious behavior; the applicable youth was referred for an Assessment of Suicide Risk, which was completed by a licensed mental health clinician. For all three non-residential youth, a needs assessment was completed after two to three face-to-face meetings with the youth. All three files were compliant with the indicator.

Two of the residential files were open and one was closed. For the residential youth, a needs assessment was completed within seventy-two hours of the youth's admission to the shelter. All needs assessments were completed by Master's level staff. Each assessment was signed by a supervisor upon completion. One youth was identified with an elevated risk of suicide; the applicable youth was referred for an Assessment of Suicide Risk, which was completed by a licensed mental health clinician. All three files were compliant with the indicator.

Exception
No exception noted for this indicator.

2.03 Case/Service Plan

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a policy in place to address Case/Service Plan (Family Resource: 2.03). The policy was reviewed and signed in July 2018 by the program's Chief Executive Officer.

Procedure
For residential and non-residential youth served, the service plan will be developed within seven working days of the completion of the needs assessment. The case plan will be based on the completed needs assessment and will include measurable goals, timelines, persons responsible, location of services and the services to be provided. The case plans are to be signed by the youth and parents. The service plan will be reviewed every thirty days for progress in achieving goals, and for making any revisions to the plan that may be necessary.

Practice
A census roster for youth who received non-residential and residential services in the past six months was requested; six youth (three non-residential and three residential) were randomly selected for review. Of the three non-residential files selected, all were closed; two of the residential files were open and one was closed. For the non-residential files, a service plan was developed for each youth within seven days of the development of the needs assessment. Each service plan included all requirements, including individualized and prioritized goals identified by the youth's needs assessment, the service type, frequency and location, the person(s) responsible, target dates for completion, the actual dates of goal completion, the youth's signature, the parent/guardian's signature, the counselor's signature, the supervisor's signature and the date the plan was initiated. Two of the plans required thirty day reviews. One was completed as required. For one youth, the plan was initiated on June 30, 2018 and the thirty day review was completed on August 11, 2018. All three files were compliant with the indicator.

Two of the residential files were open and one was closed. For the residential files, a service plan was developed for each youth within seven days of the development of the needs assessment. Each service plan included all requirements, including individualized and prioritized goals identified by the youth's needs assessment, the service type, frequency and location, the person(s) responsible, target dates for completion, the actual dates of goal completion, the youth's signature, the parent/guardian's signature, the counselor's signature, the supervisor's signature and the date the plan was initiated. None of the plans a required thirty day review. All three files were compliant with the indicator.

Exception
No exceptions were noted for this indicator

2.04 Case Management and Service Delivery

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a policy in place to address Case Management and Service Delivery (Family Resource: 2.04). The policy was reviewed and signed in July 2018 by the program's Chief Executive Officer.

Procedure
The policy is implemented by the following procedures: a counselor/case manager is assigned to each youth who enters the residential or the non-residential program. The assigned counselor/case manager will follow the youth's case to ensure delivery of services through direct supervision and counseling sessions. The case management process includes establishing referral needs, and completing referrals, coordinating the service plan implementation, monitoring the youth and the family's progress in services, providing overall support for the family, completing referrals to the Case Staffing Committee for applicable youth, accompanying the youth and parent/guardian to court hearings and applicable appointments as necessary and completing case termination with follow-up.

Practice
A census roster for youth who received non-residential and residential services in the past six months was requested; six youth (three non-residential and three residential) were randomly selected for review. Of the three non-residential files selected, all were closed. For the three non-residential files, a counselor/case manager was assigned for the youth. There was documentation to support the counselor/case manager established the youth's needs, through the development of the case plan. For one youth, there were referrals to community agencies; for two youth, there was no demonstrated need for referrals to a community agency. The counselor/case manager coordinated the case plan implementation, monitored the progress made by the youth and their family, and provided support to the youth's families. There was no out of home placement to monitor, nor was there a need to accompany the youth to court hearings or additional appointments. In all three files, there was documentation of case termination. There was documentation to support the program conducted follow-up to all three youth within thirty days of the termination of services. One youth required follow-up sixty days after termination of services; this was completed as required. All three files were compliant with the indicator.

Two of the residential files were open and one was closed. The counselor/case manager coordinated the case plan implementation, monitored the progress made by

the youth and their family, and provided support to the youth's families. The youth's out of home placement was monitored by the case manager/counselor. There were referrals for community services provided for two youth; there was no demonstrated need for a referral for the third youth. One youth went to court; he was accompanied by the case manager. There was termination documented in one file; the program attempted to conduct thirty day and sixty day follow-up. There were three telephone calls made at the thirty day mark, and three telephone calls made at the sixty day mark, however there was no contact made with the youth's family. All three files were compliant with the indicator.

Exception
No exceptions were noted for this indicator.

2.05 Counseling Services

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a policy in place to address Counseling Services (Family Resource: 2.05). The policy was reviewed and signed in July 2018 by the program's Chief Executive Officer.

Procedure
The policy is implemented by the following procedure: all information contained in the case file on the youth and family will conform to all laws regarding confidentiality. All case files are to reflect the coordination between presenting problems of the youth and family, the needs assessment, the case/service plan that is developed, the applicable case plan reviews, counseling and case management notes and follow-up with the youth and family. The program maintains chronological notes on the youth's progress throughout the youth's duration of the program. The non-residential counseling includes crisis intervention, assessment and screening of the youth, individual, group and family counseling. The non-residential program accepts referrals from school guidance counselors, school resource officers, local law enforcement agencies, the Department of Juvenile Justice, and any other concerned adult within the youth's life. Self referrals can also be accepted from the youth.

The residential counseling is responsible for engaging the family in a variety of services. The counselors are required to make at least two attempts at family counseling. All youth are offered the opportunity for counseling sessions, along with family sessions. The primary goal of the residential counselor is to develop family reunification and to explore options, with the approval of the youth and family, for appropriate placement (if necessary for additional respite) to ensure the safety of the youth. Family counseling is offered to bring the youth and family together to resolve the issues which originally

separated the family. Upon family reunification, additional counseling will be recommended. The counselor will assist the family in the referral process to community agencies.

Practice
A census roster for youth who received non-residential and residential services in the past six months was requested; six youth (three non-residential and three residential) were randomly selected for review. Of the three non-residential files selected, all were closed. In each file, the youth's presenting problem, such as truancy, anger, depression, and domestic violence, was addressed in the needs assessment, service plan and in the service plan reviews. There were case notes to document all services provided, as well as the youth's progress. There was an on-going internal process to ensure clinical reviews of case files; the supervisor and clinical director reviewed and signed to document their case review. Two youth received counseling services in accordance with the youth's service plan. For two youth, the program provided individual and family counseling. For the third youth, services were terminated by the family after the youth attended two sessions. All three files were compliant with the indicator.

Of the three residential files, two were open and one was closed. In each file, the youth's presenting problem, such as truancy, anger, depression, and violence, was addressed in the needs assessment, service plan and in the service plan reviews. There were case notes to document all services provided, as well as the youth's progress. There was an on-going internal process to ensure clinical reviews of case files; the supervisor and clinical director reviewed and signed to document their case review. Each youth received counseling services in accordance with the youth's service plan. The program provided individual and family counseling. The three youth were involved in group counseling or life skills groups five times per week. The group counseling topics included hygiene, 'what I value', healthy relationships, tutoring, social media and substance abuse. In addition, there were social activities including games, ice cream socials and learning about African animals. Each group session was at least thirty minutes in duration, documented a group facilitator, and provided opportunities for the youth to be engaged. All three files were compliant with the indicator.

Exception
No exceptions were noted for this indicator.

2.06 Adjudication / Petition Process

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a policy in place to address the Adjudication/Petition Process (Family Resource: 2.06). The policy was reviewed and signed in July 2018 by the program's Chief Executive Officer.

Procedure
The policy is implemented by the following procedure: The program is the designated centralized intake agency, therefore is the agent for the Department of Juvenile Justice as it serves the local CINS/FINS population. In cases in which the counselor is unable to assist in resolving the problem, or the youth and their family have not demonstrated substantial progress in achieving goals in the service plan, the case can be referred to the Case Staffing Committee (CSC). The CSC will be comprised of representatives from the local provider, the school board, and the youth and parent/guardian. Additional members may include the Office of the State Attorney, the alternative sanctions coordinator, mental health and social service providers, and law enforcement. The CSC is established to review cases, and to identify services and treatment. The CSC shall determine whether to file Children in Need of Services of Families in Need of Services petitions. The petitions shall be prepared and filed by the Department of Juvenile Justice attorneys.

Practice
There were no cases during the review period that were referred to the CSC for review. All of the applicable cases are handled by the program's Clearwater office.

Exception
No exceptions were noted for this indicator

2.07 Youth Records

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has a policy in place to address Youth Records (Family Resource: 2.07). The policy was reviewed and signed in July 2018 by the program's Chief Executive Officer.

Procedure
The policy is implemented by the following procedures: all client records will be housed in a physically secure area, or in locked cabinets, under the control of the supervisor. Client records are to be maintained on the premises, with the following exceptions: the case is being transferred to another program site, or for court. Any records being transported shall be maintained in a locked, opaque container; the container shall be marked 'confidential'.

Practice
A census roster for youth who received non-residential and residential services in the past six months was requested; six youth (three non-residential and three residential) were randomly selected for review. All of the case files were marked 'confidential'. The

cases were maintained in locked cabinets when not in use; the cabinets were also marked ‘confidential’. The program has a large container to transport files; the container is opaque, is able to be locked, and was marked ‘confidential’. The program also uses a briefcase and a lock box when transporting files for court appearances. At the time of the review, these items were not labeled ‘confidential’. This was resolved upon bringing this to the program’s attention. The program was in compliance with the requirements of the indicator.

Exception
No exceptions were noted for this indicator.

2.08 SOGIE

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a written policy, 5.08, for Indicator 2.08, Sexual Orientation, Gender Identity, and Gender Expression. The policy was last reviewed in July 2018 and signed by the Chief Executive Officer.

Procedure
The program seeks to provide a safe environment and therapeutic case planning for all youth regardless of actual or perceived sexual orientation, gender identity, or gender expression. As such, the provider has implemented specific procedures to comply with its policy with regards to addressing youth by their preferred name/gender pronouns; ensuring all staff and volunteers receive training and is familiar with the requirements; maintaining youth records that consistently documented with the names and pronouns preferred by youth; assigning youth to rooms that align with their gender identity and prohibit isolation based on sexual orientation, gender identity/expression; providing youth with clothing/products they need/request.

Practice
During a tour of the facility, “hate free” and “safe place” rainbow signs were posted throughout the facility in all common areas signifying that youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The program also has printed material entitled I Deserve Respect, Support, and Safety accessible for youth in the lobby, staff offices, and on the tables in the day room.

The program has not served any youth during the annual review period who met the criteria for the indicator. However, staff interviewed during the visit stated applicable youth are addressed by pronouns, name, and gender they prefer and room assignment is made accordingly.

Exception

There is no exception noted for Indicator 2.08.

Standard 3: Shelter Care

Overview

The SafePlace2B is a youth shelter located in St. Petersburg that is licensed to serve the Department of Children and Families (DCF) and Children in Needs of Services/Family in Needs of Services (CINS/FINS). The shelter is licensed by the DCF license effective through December 2018. There were 6 CINS/FINS youth residing at the shelter at the time of review. The agency operates 24 hours, 7 days a week and serves both residential and nonresidential youth. Since the last QI review, the provider served special populations such as Domestic Violence, Probation Respite, and FYRAC youth and has not served any youth admitted as a Staff Secure or DMST.

The agency recently received funding to renovate and remodel the facility; some of the renovations had begun and was evident during the tour. The program has adequate space for all indoor activities and a nice outdoor space for youth to exercise and play basketball. The facility, kitchen, bedrooms, restrooms and common areas were observed to be clean during the visit. The female and male youth rooms were assigned on opposite sides of the lounge, and there were a total of four bedrooms- three beds each with an individual bed, linens, and pillows.

All youth who are admitted to the program receive a copy of the Resident Handbook and an orientation to the facility. During the admission's process, each youth receives a new CINS/FINS intake screening to identify any medical, mental health, and/or substance abuse condition and this information is provided to the assigned clinical staff. The program provides individual, group, and family counseling, as needed. Group sessions are scheduled at least five times per week. The program also has a Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services in place. Interagency Agreements have been established for the provision of health education, leadership development, and substance abuse, mental health, and medical services.

3.01 Shelter Environment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The Agency has several clear and precise policies and procedures for this standard: 1.06- Comprehensive Safety and Emergency/ Disaster Preparedness; 1.07- Flammable, Toxic, and Poisonous Control; 1.09a- Key Control; 1.09b- Personal Belongings (Staff); 3.01- Shelter Environment; 3.09- Special Diets; 3.10- Youth Hygiene; 3.11- Visitation/ Correspondence/ Telephone Calls; and 3.12- Parental Notifications. These policies were last reviewed and signed by the CEO in March 2017.

Procedure

After reviewing all the agency's policies and procedures for this standard, they are very clear and precise and meet all requirements for this indicator. The Residential Supervisor or their designee will conduct, supervise, coordinate and manage all aspects of the shelter environment to include wear and tear on the facility, maintenance, and inspections from fire, health and safety organizations. They will also ensure the shelter is equipped with clean and useable linens and towels and youth has a safe lockable place to store their belongings.

Practice

The Agency has repainted the shelter in June or July of this year and a local artist has come in and painted murals in all of the rooms and mounted several vinyl canvas throughout the facility. The agency's last fire inspection was satisfactorily completed on 5/3/18 and all the fire and mock drills were completed according to standard requirements; however, the evacuation time for one fire drill was completed in 3 minutes in excess of the 2 minutes required. The following is a list of inspections that were also successfully completed during the review period: sprinkler system was last completed on 9/16/18; the kitchen hood was completed on 2/9/18; and the residential Group Care Inspection was last done on 10/10/18. The program's detailed map and egress plans of facility, general client rules, grievances forms, and hotline information are posted throughout the facility. The daily schedule is also posted.

The agency also met standard requirements regarding agency vehicles being equipped with major safety equipment including first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter, air bag deflator.

Each Sunday the staff asks youth who want to go to church and those who don't want to go stay at the shelter doing alternate activities.

Exception

No exceptions were noted for this indicator.

3.02 Program Orientation

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy

The agency has policies in place to address this standard as follows: 3.02- Program Orientation, and 3.08- Grievance Process. These policies were last reviewed and signed by the CEO on March 2017.

Procedure

The agency captures this information on the Youth Orientation Form as well as the Residential- CINS/FINS Intake Form. The staff will within the first 24 hours of admission give the youth a tour of the facility, give them a copy of the youth handbook, explain the behavior management system, explain what to do if youth needs medical or mental health help, and what actions they can do with a grievance.

Practice
This reviewer reviewed 4 charts, 2 open and 2 closed. All charts were clearly marked and easy to navigate. Also the Agency has a very precise Youth Handbook that is given to the youth upon admit and there is a Grievance Box placed in the Dayroom of the shelter. The orientation provided an opportunity for the youth to learn about the disciplinary action, grievance procedure, emergency /disaster procedures, contraband and rules, physical facility layout, daily activities, room assigned and suicide alert notification. The orientation includes obtaining the signature of the youth and parent /guardian present for each file.

Exception
There are no exceptions found for this indicator.

3.03 Youth Room Assignment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The Agency has a policy 3.03- Youth Room Assignments that addresses the requirement of this indicator. The policy was last reviewed and signed by the CEO in March 2017.

Procedure
The information for this indicator is captured on the Residential- CINS/FINS Intake Form. During the intake process the staff will observe the youth to make the most appropriate room assignment. Staff will examine client's age, sex, height, weight, level of maturity, gang affiliation, current alleged offenses, prior delinquency background, level of aggression, ability to act responsibly, attitude upon admission, past involvement in assaultive or aggressive behavior, and current emotional state to ensure proper room assignments are given.

Practice
There were 4 youth charts reviewed for 2 open charts and 2 closed charts. All the charts contained all required information indicating the youth room assignment; one chart with intake date 8/9/18 that did not include the Collateral Contact form. The charts were very

clear and information was easy to find. All files contained the youth's age; gender; history of violence; disabilities-if any; physical size; suicide risk; as well as any known criminal offenses; assault or aggressive behavior; and gang involvement. Initial interactions and observations are also reviewed.

Exception
There are no exceptions found for this indicator.

3.04 Log Books

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a very clear policy and procedures, 3.04- Log Books, that meets the requirement of the indicator. This policy was last reviewed and signed by the CEO in June 2018.

Procedure
The agency uses the electronic log book. The log book shall contain observations on general atmosphere of the milieu and notable behavior of clients and staff. At a minimum, the agency will document: 1) emergency situations; 2) incidents; 3) events; 4) drills; 5) medication administration; 6) when a youth is placed on and off a specified form of supervision; 7) special instructions for supervision and monitoring of youth; 8) youth group movement (e.g. group, homework, meals, recreation); 9) head counts at the beginning and end of each shift and any other head counts conducted during a shift; 10) transports away from the facility, including the names of staff and youth involved and the destination plus expected time of return; 11) searches, security checks and overnight bed checks conducted by direct care staff; 12) supervisory reviews of video surveillance; 13) requests by any person to access any youth and their relation to the youth; 14) admissions and discharges, including the name, date and time of anticipated arrival or departure, and mode of transportation; and 15) information relating to absconds or attempted absconds incidents.

Practice
The electronic log books were reviewed or the review period. The program's safety and security issues were documented; all entries are brief and legibly written. Incidents with youth and staff involved were written with date, time, and signature are clearly documented. All recording errors are appropriately corrected with clear indication of staff making correction and date. The agency supervisors and all staff reviews the logbook for the previous two shifts. The supervisor's reviews are conducted weekly, dated, and signed. Supervision and resident counts are documented consistently as well as visitation and home visits.

Exception
There are no exceptions found for this indicator.

3.05 Behavior Management Strategies

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a clear policies and procedures for this indicator, 3.05- Behavior Management Strategies and 3.05A- Behavior Interventions, as well as the Family Resources Behavior Motivation System Implementation Handbook. These policies were last reviewed and signed by the CEO in March 2017.

Procedure
The goals of the BMS are to increase positive interactions between the staff and the program residents, and to shape appropriate behavior through these interactions. The program provides structured daily opportunities for residents to earn points. The agency has a very clear procedure on how this should be carried out and there are signs posted throughout the facility for the youth and staff to see. In addition, the behavior management procedure is included in the youth handbooks that they receive upon arriving at the facility. The residential handbook also describes the level system and the consequences of good or poor behavior. Residents discuss levels achieved as a group each day. Staff, in discussion with the group, determines the level of performance off each item and designates a resident as being on one of the following levels: Orientation, Citizenship, Leadership, or Ownership. Rewards commensurate with the level of performance.

Practice
There were 6 personnel files reviewed and all 6 had evidence that the staff received training in the Behavior Management System. The residential supervisor reviews the behavior system with the staff during his staff meeting and changes are made at that time. There is a snack store that the youth can access to purchase things if their behaviors are appropriate. The youth are aware of the system and can let you know how it works.

Exception
No exceptions were noted for this indicator.

3.06 Staffing and Youth Supervision

☐Satisfactory ☒ Limited ☐Failed

Rating Narrative

Policy
The agency has a policy and procedure 3.06 for Staffing and Youth Supervision. This policy was last reviewed and signed by the CEO in March 2017.

Procedure
It is the policy of Family Resources to have two staff members on duty in each residential program at all hours of the day, one male and one female. During times of critical staff shortages, direct care staff may be the same gender if the Supervisor can demonstrate a continued effort to hire the right combination of staff gender for shifts. The staff schedule is posted in an accessible area for staff and is prepared in advance. An on call roster is maintained including contact information for staff who may be called to provide coverage when needed. Staff will observe youth every 15 min while they are in the rooms sleeping or during illness or room restrictions. This observation log will be documented via the daily log.

Practice
Upon reviewing the last six months of schedules, it was observed that the agency does not consistently have a male staff on duty. The Director of Residential Services stated that the agency is trying to recruit male staff but has not been successful in hiring them. Of the 21 shifts in one week period there are 9 shifts that are covered by 2 female staff on duty at the same time, at times when the program has male youth on the roster.

Exception
Although the agency has clear and precise policies and procedures for this standard and the schedule meets all requirements for the 1 to 6 ratio they do not meet the requirement for maintaining staff on duty of the same gender as youth. During a one week period there is 21 shifts to be filled and of those 9 shifts only have female staff.

3.07 Special Populations

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The program has written policies and procedures 3.07 for Special Populations, outlining services to Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite, Probation Respite Youth, Intensive Case Management, and Family/Youth Respite Aftercare services. The policy was last reviewed and signed by the CEO in October 2018.

Procedure

The program provides services to the special population youth relating to Staff Secure, Domestic Minor Sex Trafficking (DMST), Domestic Violence Respite, Probation Respite, and Family/Youth Respite Aftercare Services (FYRAC) only. Intensive Case Management services are not contracted for the Family Resources St Petersburg program location. All of the procedures were reviewed onsite and have been established to correspond with the requirements of the QI indicator with regard to referral source/eligibility; obtaining approval from the Florida Network, if necessary; engagement in services; case plan development; types of services provided; and length of stay/approval if longer time is needed. The program completes case plans which includes goals focusing on aggression management, family coping skills, and other interventions designed to reduce reoccurrence of violence in the home. In applicable cases, youth are transitioned to CINS/FINS with corresponding documentation maintained in Netmis.

Practice
During the review period, there were no applicable Staff Secure or DMST youth placement in the program.

A review of three closed youth records for Domestic Violence Respite was conducted. Reviewed documentation found the youth were screened by the Juvenile Assessment Center (JAC) and had pending charges of Domestic Violence (DV), but does not meet criteria for secure detention. The youths' stay did not exceed the twenty-one day length of stay in the DV respite placement. The case management records included documentation of transition to CINS/FINS in the 2 applicable cases. The case plans included goals focusing on aggression management, family coping skills, and other interventions designed to reduce reoccurrence of violence in the home in all 3 cases. Reviewed documentation validated all services provided to domestic violence respite youth were consistent with all other general CINS/FINS program requirements.

A review of three closed records found all three youth had a Probation Respite referral from Department of Juvenile Justice (DJJ). Reviewed documentation found the length of stay to be less than 30 days for all 3 youth, and approval to extend was not required. All case management and counseling needs were considered and addressed in the goals. Reviewed documentation validated all services provided to probation respite youth were consistent with all other general CINS/FINS program requirements.

The program served on applicable youth in the program for Family/Youth Respite Aftercare Services (FYRAC) during the annual compliance review. The youth was referred by DJJ for a domestic violence charge and was on probation. Evidence on the FN dashboard shows the referral was approved. Intake and assessment services documented face-to-face sessions with completed needs assessment; however, the case manager was not able to develop a service plan due to multiple documented failed attempts to reach the youth/family resulting in case closure.

Exception
No exceptions were noted for this indicator.

3.08 Video Surveillance System

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a policy and procedure 4.13 for Video Surveillance. This policy was last reviewed and signed by the CEO in March 2017.

Procedure
The agency's has procedures in place outlines everyone's responsibility when it comes to the surveillance system. The system is only reviewed by authorized staff and access is limited offsite to viewing by key personnel only. The system has a 30 day plus backup capability and is connected to a battery back-up onsite. The existence of this policy does not mandate cameras to be monitored 24 hours a day, 7 days a week but video recording is imperative. At minimum, the agency has: cameras placed in interior and exterior areas to cover general locations of the shelter to include hallways for sleeping rooms, where youth and staff congregate, and where visitors enter and exit; placement of cameras does not include bathrooms or sleeping quarters; visibility of cameras to persons in the area (no covert cameras) and a written notice is conspicuously posted on the premises for the purpose of security; the requesting of video recordings is granted to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident; a method to retain video and images in a hard drive or designated secured network storage; restricted access to personnel determined by the program administrator(s); and storage of recorded video for a minimum of 30 days (90 days preferred) unless video is associated with a specific incident that is requested for review. In that case, video shall be stored for the length of time needed to complete investigation. Video clips that could become evidence in civil or criminal proceedings are kept indefinitely unless otherwise directed by the Department. Designated staff is trained to handle the equipment and monitor or review footage in a professional, ethical, and legal manner. Supervisory review of video is to be conducted bi-weekly and documented to assess the activities of the facility to include a review of a random sample of overnight shifts. The cameras installed have the capability to: record date, time, and location; maintain resolution that enables facial recognition; and back-up capabilities that enable cameras to operate during power outage.

Practice
The Residential Supervisor keeps a logbook in his office which shows reviews of the camera system, sometimes on a daily basis, but at least the contractual requirements. Also, the CEO, Senior Director, Residential Director, and Residential Supervisor are all authorized to access the cameras offsite. There were 3 random days of overnight shifts reviewed for bed checks and of those 3 days, bed checks were found to be completed

on time each time. The camera system's time is currently off by 19 minutes and needs to be corrected to correspond with actual time.

Exception
There are no exceptions noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

The SafePlace2B St. Petersburg youth shelter provides screening, counseling, and mental health assessment services. The shelter staff are trained to screen, assess, and notify all staff of the conditions and risks of all youth admitted to both the residential and non-residential CINS/FINS programs. The shelter provides risk screening and identification methods to detect youth referred to their program with mental health and/or health related risks. The shelter utilizes screening and a CINS Intake form to determine eligibility and presence of risks in the youth's past mental health status, as well as, their status at intake. The shelter also screens for the presence of acute health issues and the shelter's ability to address these existing health issues. The shelter uses an alert board and colored dot system to inform staff members on each shift of the health and mental health status of all youth in the residential youth program. Trained shelter staff assists in the delivery of medication to all youth admitted to the residential youth program. The shelter has a detailed medication distribution system and utilizes the Pyxis Med-cart. The agency provides medication training to all direct care staff as well as training in CPR, first aid, fire safety, emergency drills, suicide prevention, and observation and intervention techniques. Shelter staff members are also required to notify parents/guardians if a resident has a health injury.

4.01 Healthcare Admission Screening

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The Program has health care admissions screening policy and procedure that was reviewed and signed by the CEO in March of 2017.

Procedure
The program performs a preliminary physical health screening through the completion of the CINS/FINS intake assessment form at the time of admission to the shelter for each youth. If there is a significant medical issue the client will be referred to their physician, emergency room or to the public health care department. If present during the scheduled working hours, the agency nurse will conduct the health screening. If the nurse isn't present during admission of a youth, a non-health care staff may perform this screening. The nurse must review the screening within 5 days if not present during the admission of the youth. The screening will include current medications, allergies, existing (acute and chronic) medical conditions, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty moving, observation for presence of scars, tattoos, or other skin markings. Family Resources ensure medical care for the youth admitted with chronic

medical conditions. Family Resources provides all clients unimpeded access to emergency medical care. Staff documents the presence of any of the following conditions and will provide appropriate medical follow up as needed. The program has procedures in place for medical emergencies. All health concerns are documented, and all referrals will be noted in a daily log.

Practice
There were four cases observed- two open and two closed. One out of the four cases reported youth being on medication. Four out of four youth have existing (acute and chronic) medical conditions. None of the youth have allergies. None of the youth files observed reported having any recent injuries or illness, or any current evidence of illness, injury, pain, physical distress, or difficulty moving. One of the four youth has presence of skin markings. None of the youth have diabetes, is pregnant, have a seizure disorder or cardiac disorder. None of the youth have asthma. None of the youth have tuberculosis, hemophilia (bleeding disorders) nor do they have head injuries, occurring during the previous 2 weeks. In all four cases, when needed the parent was involved with the coordination and scheduling of follow-up medical appointments.

Exception
No exceptions noted for this indicator.

4.02 Suicide Prevention

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a policy for Suicide Prevention called the Comprehensive Master Plan for Suicide Prevention and Response. The policy was last reviewed and signed by the agency's CEO in June 2017. The policy includes provisions for mental health and substance services, suicide prevention procedures, mental health crisis intervention and emergency response. The policy includes provision pertaining to both Residential and Non-Residential Services

Procedure
The agency's procedures require the organization to have measures in place to address youth admitted to the program that have a past or existing presence of suicide risk. The agency's procedures address Initial Mental Health and Substance Abuse; Suicide Risk Screening and Referral for Assessment; Clinical Assessment of Youth on Sight and Sound Supervision; Levels of Supervision (1 to 1, Constant Sight and Sound Supervision, Elevated Support, Standard Supervision); On-Going Staff Evaluation of Suicide Risk Behaviors; Notification of Agency Official; Outside Authorities and Parent/Guardians; Needs Assessment; Mental Health Alert Process; and Non-Residential Services. The policy includes training; referral and collaboration;

authorization to transport for emergency mental health or substance abuse services/law enforcement transport; notification of management, on-call staff, outside authorities, parents, guardians of mental health or substance abuse emergency.

The agency has a section in the policy that focuses on the procedures for documentation of mental health crisis or emergency situation. The agency requires that staff members be prepared to write a detailed incident report prior to the close of the end of the shift. The report must include signs and all relative symptoms that the youth was exhibiting, assessment procedures taken and results, other staff activities taken, notifications, and resolution of the problem. The written incident report must be produced within 24 hours of the incident. Collateral documentation must be documented in the client's file and include all measures taken to address the situation, referral made and the resolution of the crisis. The agency does not use an evaluation of imminent danger or suicide risk probability scale instrument. The agency completes the screening and automatically places youth on constant sight sound if the youth meets any of the six (6) suicide risks questions on the CINS/FINS Intake Form.

Practice

A review of the Suicide Prevention indicator was conducted onsite during the Quality Improvement review. The agency has a total of three Licensed Clinicians, and two registered interns. All clinician licenses are active and in effect.

A total of three client files were reviewed to assess the agency's adherence to the requirements of this indicator. The three files reviewed consisted of two closed and one open. A review of the selected files revealed that all files adhered to the requirements of the indicator. All three files had evidence of a completed risk screening that was completed during the admission or over the phone before admission. All three files have evidence of executing the suicide risk screening process by utilizing the risk screening section contained in the CINS/FINS Intake Form. Each of these forms was found in the client files and completed by a trained staff person and reviewed and signed by the supervisor.

All three client files had documentation indicating they had been placed on constant site and sound supervision as required. Actual client observation logs indicate that observation times were documented every 15 minutes or less on a Red observation log. The log captures the name, time of observation, mood/behavior and initials of the staff person that is conducting the observation. Each youth placed on supervision had evidence of an assessment. Each client's file was completed by a master's level counselor that had evidence of completing the Assessment training under the supervision of a Licensed Clinician. At the time of the review, each Assessment had evidence that it had been reviewed and signed by a Licensed Clinician. The clinicians document their credential directly on each assessment with the date and time of consultation verifying the decision to sustain the constant sight and sound status or to indicate a change to step down the level to a lower level of Elevated Supervision. All cases had evidence of documentation of changes to step youth down in four areas that

included assessment; progress note; client observation log form; and in the program log book.

Exception
No exceptions noted for this indicator.

4.03 Medications

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a policy for Medications that meets the general requirements of the indicator. The policy was last reviewed and signed in March 2017 by the CEO. The policy includes provisions that staff be trained in medication distribution. The policy references preparation for the agency to provide inventory, storage, security, distribution, documentation, verification, training, and disposal.

Procedure
Agency procedures require all staff to be aware of the steps to perform medication distribution to residents in the program. The agency has medication distribution training for the staff which is delivered during new employee orientation and the onboarding process. The medication distribution training is primarily delivered by the agency's registered nurse. The agency has a list of all staff authorized to distribute medication to residents accepted into the program during their shelter stay. The agency has a requirement that all medications be stored in the Pyxis Med cart. The policy requires that all medications be counted on a daily basis, narcotics and/or controlled medications must be counted on every shift and verification of medications when a youth is accepted into the program. The agency has one part time registered nurse. There are 3 super users that consist of the registered nurse, the residential supervisor, and overnight YDS. The nurse is the only person that administers medication when she is on shift.

Practice
The reviewer found that all medications are stored in the Pyxis Med cart. The Med cart is not accessible to residents unless they are accompanied by an authorized staff. All medications including OTC's were stored in the Pyxis Med cart. The agency has a total of 3 super users two of which were onsite for the review. The agency houses its sharps in a locked cabinet that is accessible only to authorized staff. The sharps which consist of scissors and razors are inventoried daily.

The agency has a medication distribution log that is used to document the process in which agency members assist in giving each resident their prescribed medication. Agency's medication distribution log is legal sized and color-coded. The agency does have a medication refrigerator that is set at the proper temperature settings and is

located in a locked room. The residential supervisors indicated that it has never been used due to never having a youth with refrigerated medications. The agency is completing inventory shift to shift counts on all controlled medications. These shift to shift counts are done three times a day. Other perpetual inventory is conducted one time per week or when distributed. All over the counter medications are counted one time per week by the registered nurse. Over the counter medication is also documented when it is given.

A review of the client files of residents currently on medication was conducted to determine the accuracy and completion of medication distribution process during the current shelter stay. The reviewer observed inventory of medication stored in the Pyxis Med cart. An assessment of medication discrepancies process and execution was also conducted. It was at this time the reviewer discovered that discrepancies are only being cleared by the nurse. This is typically happening once a day and sometimes discrepancies are left on the med cart through the weekend. Both the residential supervisor and registered nurse stated that discrepancies are not being cleared before the end of each shift. The program does run knowledge portal reports that are printed out and reviewed by the registered nurse weekly, with signed copies being given to the residential supervisors. The agency generally notifies parents and guardians when a resident's medication supplies are at seven days or less. The agency's disposal process includes a 30-day wait, three attempts to contact, and disposal with the nurse and a witness.

Exception
Although no discrepancies were currently on the med cart, the program's nurse indicated that discrepancies are not cleared from shift to shift. The nurse stated that discrepancies are typically cleared daily (Monday-Friday) and sometimes are left on the machine over the weekend until she arrives for duty on Monday morning.

4.04 Medical/Mental Health Alert Process

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has a policy 4.04, called Medical and Mental Health Alert Process, that requires the agency to make information discovered during the health intake screening process available to staff regarding the medical or mental health conditions of the client. The policy was reviewed and signed by the agency's CEO in March 2017. The policy meets the general requirements of the indicator.

Procedure
The agency is required to maintain a system that indicates an alert identification for monitoring during the resident shelter stay. Agency is required to use a series of color-

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

Practice
A review of a three client files was conducted to assess the agency's adherence to the medical and mental health alert process indicator. All three client files included an indicator for a medical/mental health behavior or food allergies condition. All three resident client files were correctly screened and marked on the program's alert system. All the alerts included the proper color coding concerning either medications, mental health, or behavior issues. The agency's staff members are provided information and instructions as required to screen, identify and notify all required parties of client with medical, mental health, behavior or food alerts.

Exception
No exceptions noted for this indicator.

4.05 Episodic/Emergency Care

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Policy
The agency has an Episodic Emergency policy, 4.05, that was last reviewed and signed by the agency's CEO in March of 2017. The policy includes provisions staff to be trained on certain safety and medical emergency situations. The policy references preparation for the agency to provide immediate on-site first aid and emergency care in case of injury, acute illness, suicide or homicide in all facilities. The policy adheres to the requirements of the indicator.

Procedure
The agency's procedure includes measures to ensure all staff members are trained and certified in first aid and CPR procedures within 90 days of hire. All staff members must document all incidents that involve youth receiving medical attention on or off site. All incidents are required to be documented on a standardized incident reporting form. Incidents forms must be filed in the official agency incident binder and logged by date of occurrence.

Practice
The agency has first aid equipment that is always available in the facility. First aid kits are checked by the supervisor and/or the Registered Nurse (RN) monthly. All staff

members are required to complete a series of emergency training during their orientation process that include CPR, First Aid, fire safety, Universal Precautions, and others. The agency also requires that all direct care staff members that work in the shelter facility to participate in fire drills, as well as mock emergency drills on a routine basis. The agency has safety equipment that includes three first aid kits in the building, 1 pair knife for life, 1 pair of wire cutters and automated defibrillator. The agency also has a first aid kit assigned solely for transportation purposes. The agency maintains an Episodic/Emergency Incident Binder to document all incidents. Incidents are documented and then placed in the binder in chronological order.

Exception
No exceptions noted for this indicator.