Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources-Manatee

on 03/07/2019

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

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

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	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:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

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

Rating Definitions

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

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

Review Team

Members

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David Gray, Training Coordinator, Hillsborough County Children's Services

Nitara LaTouche, Consultant, Forefront LLC

Diane Lindsay, Program Manager, Tampa Housing Authority

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Persons Interviewed

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

0 Case Managers
2 Program Supervisors
0 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

1 Clinical Staff
1 Other

Documents Reviewed

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

4 # Health Records
3 # MH/SA Records
14 # Personnel Records
6 # Training Records
12 # Youth Records (Closed)
1 # Youth Records (Open)
3 # Other

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

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 CINS/FINS shelters are 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 include:

* The camera system in the shelter was updated during the past year. The video camera system includes 16 cameras that can capture and retain video images and has the capability to zoom to allow close up facial recognition. The system also allows for video to be reviewed remotely via an offsite computer or mobile device.

* 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 artistic themed murals by a local artist Loy Khambray-Correa and volunteers

Staffing

* Joe Mabry is currently serving as the interim supervisor

* As a result of a case manager vacancy, the program has decided to fill the vacancy with a counseling position instead of a case manager and will have a total of 2 counselors in the shelter

* A new non-residential counselor was hired for the Manatee program

Other

The program conducted a successful teddy bear drive and was able to obtain a large donation of teddy bears which are given to youth admitted into all of the agency's shelters

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 Financial Officer, and Chief Human Resources Officer. 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 residential shelter staff is under the supervision of the Senior Director for Residential Services and non-residential staff are overseen by the Senior Director of Community and Clinical Services. Each shelter component position such as Youth Development Specialists (YDS), cook, and part time nurse is supervised by the residential supervisor. Similarly, counseling/case management staff are supervised by Community Services Supervisors at each program location.

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

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The 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 Director. 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.

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.

A total of fifteen background screening files were reviewed for 14 new staff. All fourteen 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. There was no applicable 5-year re-screening due for any staff during the review period.

The program did not have an intern or other volunteer providing service during the review. There was a prior MSW intern who was recently hired by the agency while continuing to complete her internship and the screening was reviewed along with new staff hired.

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 29, 2019 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 fourteen new staff reviewed. Three of the fourteen new hires received a low suitability rating on the Berke, suggesting a low fit with certain traits required for the job. The VP of Residential Services indicated that prior to February 2019, youth care candidates would be hired at the discretion of the hiring supervisor if the results showed a low fit as long as they had prior experience working with youth; however, the agency has made a decision to not hire low scoring applicants as of February 2019. 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.

No exceptions were noted for this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written Provision of an Abuse Free Environment policy number 1.02 and procedure that was approved and signed by the CEO on March 2017. The agency has a written Grievance Process policy and procedure approved and signed March 2018.

Staff are required to adhere to a code of conduct that forbids them from using physical abuse, profanity, threats or intimidation and 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 to immediately report all cases of suspected abuse, abandonment or neglect to the appropriate Hotlines. All staff are required to complete child abuse reporting training within 120 days of hire.

The Florida Abuse Hotline 1-800 number is posted in numerous locations throughout the shelter. Youth are given immediate access to a telephone if a report needs to be made. A child abuse report logbook is maintained documenting all calls made to the Abuse Hotline.

Management will take the necessary actions to discipline staff who violates the agency's code of conduct policy.

The program has a code of conduct that forbids staff from using physical abuse, profanity, threats or intimidation, and to provide an environment in which youth feel safe. The code of conduct outlines the agency's expectations with regards to interactions with 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. All staff are required to sign an affidavit of compliance with the code of conduct acknowledging their awareness soon after employment.

A grievance box is located in an accessible area. The grievance forms and the grievance policy are available and accessible in the dining area of the shelter. Youth care staff do not directly handle grievances filed. The grievance box is checked daily by the shelter manager. There were four grievances since the last review, two involving the loud noise from staff and television at bedtime and the client not being able to sleep therefore, waking up late and not earning their points. The other two grievances were about disrespect by the client to staff and staff to the client. All were responded to and resolved by the residential supervisor within 24 hours of submission.

A review of staff training files showed all staff has been trained in Child Abuse reporting. Interviews with youth indicated that they knew about the abuse hotline and felt comfortable and respected by staff. The program maintains a list of abuse calls.

While reviewing incident reporting, the reviewer observed a CCC report in which staff allegedly made judgmental comments toward a client regarding her sexuality. After an investigation was conducted by management, the staff was terminated.

There no exceptions noted for this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has an Incident Reporting policy and procedure, #1.03, as well as a CCC Incident Reporting policy and procedure. The policies and procedures meet the requirement of the indicator and were signed and approved by the CEO in July 2017 and March 2017, respectively.

It is the policy of the agency to comply with the Department of Juvenile Justice policy 8000 “Central Communications Center” on incident reporting. Types of incidents that are required to be reported are described in detail along with the process for reporting and required time frames. Per the policy, immediate notification to senior management is to occur when a critical incident occurs. Critical incidents include: 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.

There were eleven incidents reported during the review period as follows: five (5) medical incidents, one (1) program disruption, four (4) complaint against staff, and one (1) miscellaneous. All eleven incidents were accepted by the CCC during this review time frame and were closed with appropriate action taken. Eight (8) of the eleven (11) incidents were reported during the 2 hour time frame required. The agency maintains all incident report documents in a three-ring binder sorted by date of incident. Incidents are also noted in the log book.

Three of the reportable incidents called in to CCC were reported after the two hour time limit.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy and procedure 1.04, Training Requirements, that addresses all requirements of the indicator. The policy and procedure was signed and dated March 2017 by the Chief Executive Director.

In addition to policy 1.04, the agency has an Annual Training Plan that highlights the requirements for all direct care staff with time frames for completion. Training is set up through Dexdocs which is a data base that tabulates the training and monitors training topics completed by staff. An orientation agenda and checklist is utilized to capture all training required during the orientation for new staff and an in-service training form is used to capture on the job training. Current procedures require specific training topics 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.

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.

Six training files were reviewed three first year employees and three in-service staff. Three of the first year employees were all past the first 120 days of hire. Two of the three staff had completed all of the mandatory training topics required during the first 120 days of employment. Two of the three staff had exceeded the 80 hours required in the first year (117.75 hours and 93 hours) and the third staff had 33.5 hours but still has 7 months to complete the annual training.

The three in-service staff were on target for completing the 40 hours of annual training required. In addition, all of the mandatory training topics required annually for the in-service staff were completed by all three staff.

As of the date of the QI review, one staff, date of hire 10-16-18, had not completed the Managing Aggressive Behavior training which is required within the first 120- days.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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.

Peer record reviews are conducted quarterly in all programs during 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 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.

A review of peer record reviews for FY 18-19 was conducted. Evidence of peer record reviews for the past two quarters was observed to be conducted in November 2018 and February 2019. 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 completes quarterly Risk Management Analysis. Risk Management Analysis for the FY 2017-2018 and 2nd quarter 2018-2019 was reviewed. Incident reports are reviewed and analyzed by the committee in terms of incident total by program; agency-wide incident totals by type; comparison of incident types across programs; and medication and mental health emergencies by program. The report also aggregates data for grievances and workers compensation claims. The 2nd quarter 2018-2019 analysis also included a comparison of the trends between the 1st and 2nd quarters.

The program tracks client satisfaction survey results on a quarterly basis and reports them in the quarterly Risk Management Analysis Reports. The survey results for Q1 and Q2 of the current fiscal year was reviewed. The report shows a comparison of the rate of satisfaction across programs as well as across quarters.

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, the 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 1/20/19.

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

No exceptions were noted for Indicator 1.05.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy that addresses all the key elements of the CQI indicator. The policy was reviewed and signed by CEO Lisa Davis on March 2017.

The agency policy states that each agency vehicle will be inspected by a certified mechanic at least once a year. The agency policy states that each vehicle shall contain: a first aid kit, fire extinguisher, seatbelt cutter, window punch, and securely anchored seatbelts. Having a 3rd party presence is best practice to prevent any danger or perceived harm. The policy is to ensure all regular full time and part-time employees have a Valid driver's license issued by the state of Florida, maintain a clear motor vehicle history and carry current automobile insurance.

The agency staff is responsible for letting the Residential Supervisor know of any mechanical or safety concerns they see with the vehicles.

The Program Director must be notified prior to any individual staff transporting a single youth. In the event a 3rd party presence is or cannot be obtained, the following criteria are considered: the youth's history, personality, recent behaviors and length of stay in the program; the transporting employee's work performance, history, and length of employment; a trip plan must be documented to include the destination, approximate mileage and anticipated time of arrival; the transporting employee will check-in by phone at agreed-upon intervals with senior program leader or designee, and documented by said senior program leader or designee; a driver with concerns regarding safety can call any agency personnel and maintain an open phone line to act as an audio witness. The 3rd party presence can be any of the following: another staff member, volunteers, interns, clinical or administrative staff, or another youth.

Vehicle logs completed have the following information: date, driver's initials, and destination/purpose of travel, approximate miles, and number of occupants, time leaving, starting miles, anticipated time of arrival, actual time of arrival, ending miles, supervisory approval received from (Including date and time). The Residential Supervisor will review the vehicle logs once a month. Regular full time and part time employees will be authorized by a supervisor to drive on behalf of the agency. They must possess a valid driver's license issued by the state of Florida,

Maintain a clear motor vehicle history and carry current automobile insurance. Staff that are approved are also required to take a driving safety course.

The agency provides a commercial automobile insurance policy for those who drive agency vehicles. Human resources will be the ones to identify employees eligible to drive on behalf of the agency upon hire. Human resources will also be responsible for notifying the insurance

carrier and receive authorization for driving privileges. The agency will conduct an annual check of all regular full time and part-time employees'motor vehicle history.

The vehicle logs are easy to follow. If there is a 3rd party involved, it is documented by the staff. The 3rd party can be an approved staff member, volunteer, intern, clinical or administrative personnel. The agency vehicle is very clean and has all the necessary items kept inside.

There was a clear policy on having agency drivers approved by administration personnel upon hiring. They have a very detailed policy to ensure the safety of the youth and staff. When a 3rd party cannot be obtained, it is approved by a supervisor beforehand and signed off for on the vehicle logs. They also call the shelter to do an open line while completing the single youth transport. The staff back at the shelter does an amazing job documenting the open line single youth transports in the logbooks as well, this is not a policy but best practice for the agency!

The staff that are doing any transport in the agency vehicle are documenting in the vehicle log the date, driver's initials, destination/purpose of travel, approximate miles, number of occupants, time leaving, starting miles, anticipated time of arrival, the actual time of arrival, ending miles, supervisory approval received on occasion. The approval by a supervisor is being signed off on, but there are no dates or times as mentioned in the agency policy and procedures as well as documented on the vehicle logs.

In reviewing the vehicle logs from March 2019 through November 2018, there were 32 times in which there was a single transport of youth requiring prior approval by a supervisor for the single transport; however, no approval was found indicating a Supervisor signed approval on the van mileage log. There was documentation in the log book of the open phone call but no prior approval was documented in the logbook.

Also, van mileage logs for September and October of 2018 were not provided/available by the program.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy 1.11 that addresses all the key elements of the QI indicator. The policy was reviewed by the CEO and signed in March 2017.

It is written in policy that the agency will participate in local DJJ Board and Council Meetings to ensure CINS/FINS services are represented in coordinated approach to increase public safety for juveniles. Staff is required to attend the DJJ circuit meetings and obtain copies of the minutes to the meetings to supply to agency leadership and provide verification of attendance.

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. It is also written in policy that the agency will maintain written agreements with community partners that include services provided and a comprehensive referral process.

The agency staff that attends the meetings are to obtain copies of the minutes to the meetings and supply to the agency leadership. The agency staff that attend the meetings will also provide verification of attendance to the DJJ Board and Council Meetings.

There were four outreach services documented by the agency, two were the Manatee Juvenile Justice Council Meeting. These council meetings had the agenda, minutes, and clear evidence that someone from the agency was present. The remaining two were PATH Meetings and the program provided the meeting minutes for both of them. The program maintains several inter-agency agreements with community partners, which was documented and signed by all necessary parties.

There were no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Through a contract with the Florida Network, Family Resources, Inc. operates SafePlace 2B Manatee. The program which is in Bradenton, Florida provides CINS/FINS residential and non-residential services to youth and their families in Manatee 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 two full-time Master's level counselors.

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 conducts Case Staffing Committee meetings. 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 counselors as well.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The current policy 2.01 was reviewed and approved July 2018 by the CEO. The agency's policy meets the requirement of the Florida Network standards. The policy outlines that the Family Resources, Inc. will provide centralized intake services for youth in need in services 24 hours a day/7 days a week. An initial screening for eligibility must occur within a seven (7) calendar days of referral, preferably immediately. The screener will conduct an initial screening at the time of the first contact to determine if Family Resources can best meet the youth's needs. If not, other community partners would be identified and an external referral would be made.

The following procedures will be maintained by the staff: the extent of the issues or crisis will be determined, the precipitating stress factors and related risk factors will be identified, and eligibility for Family Resources programs based on the information gathered will be established.

Upon initial contact, an eligibility screening will be conducted to determine whether or not the shelter program or out-client program can best meet the needs of the youth. The following criteria will be used to determine eligibility:

- The youth must be between the ages of 10 and 17 years old
- The youth may not be currently adjudicated delinquent (unless a Probation Respite youth) or dependent
- The youth may not be a danger to self or others
- The youth may not be in need of detoxification
- The youth's mental health issues must be under control
- The youth must be in need of immediate medical care
- Youth with a history of arson, sexual or violent offences may not be eligible and must be approved by a supervisor

Documentation is made of the provision of services including where services will be provided, by whom, what time, and initial assessment date. If the youth is not eligible for services, the youth and the family are referred to alternative services either within the agency or community. If eligibility is determined for shelter, the youth is placed in the residential program and a family session is offered to the parent/legal guardian. The screening will also include a preliminary overview of the presenting issues, sexual orientation, gender identity, and expression (SOGI) aspects, and any history that might help identify what course of action is in the best interest of the youth. Screening may occur by telephone, at program sites or the Juvenile Assessment Center.

At the admission intake, the youth and parent/guardian receives a copy of the "Rights and Responsibilities", including the grievance policy, and available service options, as well as the Florida Network publication describing their system of care. A copy of the grievance policy and forms are also prominently posted in each facility.

There were (4) non-residential and (3) residential case files that were reviewed that reflected that the eligibility screening was within the 7 calendar days of the referral. The parents/guardians received the available service options, rights and responsibilities of youth and parents/guardians and the parent/guardian brochure. The files documented that they had the option to participate in the CINS/FINS services, inclusive of the case staffing committee and CINS petition. In addition, the rights and responsibilities reflect their grievance procedures.

There were no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy 2.02 that meets the requirement of the QI indicator for the needs assessment. The policy was reviewed March 2017 and approved by the CEO.

The policy outlines that a psychosocial/needs assessment will be initiated within (72) hours of a youth's admission into the shelter setting. For a youth who is receiving non-residential services, a needs assessment should be completed within 2 -3 face-to-face contacts following the initial contact or updated if the most recent needs assessment is over six months old. If there are exceptions, it must be documented.

The needs assessments must be completed by Bachelor's or Master's level staff and signed by a supervisor. If the suicide risk component of the assessment is required (as a result of suicide risk screening), it must be reviewed (signed and dated) by a licensed clinical supervisor or written by licensed clinical staff. Needs assessments should include some of the following:

- Demographic information
- Dates of Assessment
- Reason for referral – presenting problem
- Family history and involvement
- Legal history – DJJ, DCF
- Medications taken
- Mental, physical and emotional status
- Educational history
- Developmental history
- Peer relationships
- Substance abuse – client and family
- Strengths of youth and family
- Case manager/counselor impressions

The assessment must be signed by the case manager or counselor and a supervisor. If a suicide risk assessment is required as a result of the screening, this must be reviewed and signed by a licensed clinical supervisor or written and signed by a licensed clinical staff.

There were (4) non-residential and (3) residential case files reviewed for the needs assessment indicator. Six applicable case files documented completion of the needs assessments on the same day as the admission date, meeting the requirement for completion within the required time frames. One youth was a re-admission and the case file had a copy of a previous needs assessment with an updated 2–page addendum.

Two of the non-residential files and two of the residential files clearly reflected that the needs assessment was conducted by a Bachelor's level or Master's level staff member. However, two of the non-residential and one of the non-residential files did not reflect any credentials. In speaking with the Community Services Supervisor, she stated that the protocol for interns is for them to document "registered intern" along with their intern number but there is little space to write everything (i.e. on the intake form signature line). The supervisor states that she looks over the needs assessments and signs with her credentials to signify her review process. All of the needs assessments include a supervisor review signature upon completion.

Two residential youth identified with an elevated risk of suicide as a result of the Needs Assessment and intake and were referred for an assessment of Suicide Risk under the direct supervision of a licensed mental health professional.

No exceptions were noted for this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided a policy 2.03 that reflects the requirement of the indicator. The policy was reviewed on March 2017 and approved by the CEO.

Per the agency's policy, an individualized service plan (ISP) will be developed for every youth who enters their CINS/FINS services. The plan is developed based on information gathered from the initial screening, intake, and assessment and should involve both the family and youth in the development of the service plan that will affect them.

Each initial service plan will include some of the following:

- Identified needs of the youth and family
- Goals and completion dates
- Persons responsible to assist the youth/family in goal completion
- Services and counseling to be provided, to include: type; frequency; & location
- Date the plan is initiated

The youth and family agree to participate in services by signing the treatment plan. In the event that a needed service is not offered by the agency, the staff will not hesitate to facilitate a referral to another agency in the community, in order to meet the needs of their client.

RESIDENTIAL: In the shelter setting, staff will immediately complete an assessment and a service plan will be developed within seven working days of the completion of the assessment to address the prioritized needs of the youth and family, inclusive of realistic and measurable goals and objectives. The shelter counselor will be responsible for implementing and reviewing the plan with the youth and for contact with the family members/guardians for input into the plan. The plan will be reviewed for a minimum of 30, 60, and 90 days to assess progress towards the stated goals.

FAMILY COUNSELING: The service plan will be completed based on the findings on the needs assessment and will address the specific needs of the youth and the family. The service plan will include measurable goals, timeliness, persons responsible, location of services and services to be provided. The service plan will be signed by the youth and the parents. The family counselor assigned to the family will be responsible for conducting the psychosocial assessment/needs assessment, development of the plan with the family and for the regular review of the plan with the family. The service plan should be reviewed with the family every 30 days for progress in achieving goals and for making any necessary revisions to the plans, if indicated.

There were (4) non-residential and (3) residential case files reviewed in reference to the case/service plan indicator. All of the case plans were developed within (7) working days of the needs assessment. All case plans documented individualized and prioritized need(s) and goal(s) identified by the needs assessment as well as the service type, frequency, and location. All case plans except one residential file documented the person(s) responsible. All case plans included the target date(s) of completion and actual completion days, documenting if they were incomplete due to family withdrawing from the program. All case plans reflected signatures from the youth, the counselor, the supervisor, and included the plan it was initiated. For one residential case plan, the parent/guardian's initial signature was missing but the counselor documented that they withdrew their youth from services prior to starting the family sessions.

Timely case plan reviews were observed in one of four applicable files reviewed. The three residential files were not applicable because two of the youth were discharged prior to the 30 day review dates and one active youth was in care for less than 30 days during the QI review.

Although there were documented reviews for progress by the counselors and parent (if available) every 30 days, there were three of the non-residential cases reviewed where there were instances where the reviews were not completed on time. For one non-residential file, the date initiated was 8/27/18, the reviews were completed as follows: 30 day – 10/3/18 (progress notes does not indicate reason for late review), 60 day – 10/31/18 (mother sick), 90 – 12/7/18 (youth sick). Another non-residential file reflects the date initiated as 9/27/18 and the reviews as the following: 30 day – 10/30/18 (progress note reports an appointment on 10/23/18 but did not indicate why it was cancelled), 60 day – 12/11/18 (case closed but had prior sessions on 11/21, 11/27, 12/3 with no service plan review conducted/notated). On a third non-residential case plan, the date initiated was 12/7/18 and the 30 day review was completed late on 1/9/19.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided a policy that reflects the requirement of indicator 2.04 that was reviewed and approved on March 2017 by the CEO.

The agency states that they will provide service coordination on behalf of clients which includes: information gathering, supportive linking, coordination and monitoring of services; case review and termination, with appropriate referral when Family Resources direct service is no longer needed. It is the policy of the agency to assign a counselor/case manager to each youth who enters the shelter or non-residential services who will follow the youth's case and insure delivery of services through direct provision or referral.

The process of case management includes:

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

· Monitoring youth's/family's progress in services

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

· Referral to additional services, if needed

· Case termination with follow-up

All contacts on behalf of a youth or family, actions taken, discussion with other service providers, etc. will be documented in the case notes as they occur. Properly executed release of information forms will precede any referral or discussion of a case with an outside agency.

There were (4) non-residential and (3) residential case files reviewed for the case management and service delivery indicator. Each file clearly reflects that a counselor was assigned to each case. The counselor was able to establish a referral needs and coordinate referrals to services based upon the on-going assessment of the youth/family's problems and needs. The counselor coordinated the service plan implementation, monitored the youth/family's progress in services, provided support for families, and monitor out-of-home placement, when necessary.

Referrals for the youth/family were made for additional services when appropriate; case termination notes were documented and 30 and 60 day follow-ups were completed after exit.

No exceptions were noted for this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided policy 2.05 that reflects the requirement of indicator and was reviewed on March 2017 and approved by the CEO.

The shelter provides individual and family counseling, as well as group counseling sessions held a minimum of five days a week, based on an established group process and procedures. Non-residential services are provided at the Family Resource office to provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services, and prevent involvement of youth and families in the delinquency and dependency systems. Extensive efforts are made to engage the families, guardians, and significant others in the planning and service activities of the youth served. All case files will reflect coordination between the presenting problem, psychosocial assessment, service plan, service plan reviews (as appropriate), counseling and case management notes, and follow-up. Chronological notes are kept on the youth's progress.

SHELTER COUNSELING

All youth are offered the opportunity for family counseling sessions. Family counselors will make every attempt to conduct at least two family counseling sessions prior to discharge. An internal peer review process and regular review of files by the clinical supervisor assures proper documentation, quality and appropriate services being provided and staff performance being up to standards.

NON-RESIDENTIAL COUNSELING

The services include but are not limited to crisis intervention, assessment and screening, individual, group and family counseling. Family Resources will accept referrals from sources i.e. school guidance counselors, school resource officers, and the youth themselves. Full-time non-residential staff are expected to carry a minimum annual caseload of (69) cases. Non-residential programs must have an annual average of twelve sessions per family.

FAMILY INVOLVEMENT

All youth served in family counseling services are encouraged to include the family in all aspects of services provided. With this model of counseling, the youth is not in treatment separate from the family, but is instead, considered an individual member of a family community. The primary goal for the family of the sheltered youth is the provision of clinical services in order to reunite the family. Family counseling is offered to bring the youth and their family together in order to resolve the conflict or dispute causing the separation of the family. The primary counselor or clinical staff is available 24 hours a day, 7 days a week through on-call or at the shelter to dialogue with the family with the family regarding issues of concern.

There were (4) non-residential and (3) residential case files reviewed for the counseling services indicator. The youths' presenting problems were addressed in the needs assessment, case/service plan, and case/service plan reviews (when completed). The case notes were maintained for all counseling services provided and documents youth's progress. There is an on-going progress that ensures clinical reviews of case records and staff performance. In reviewing the files, there is a blue form that reflects a monthly supervisor signature page for monthly case file reviews. The Community Services Supervisor reported that the staff reviews each other's files for compliance and accuracy. In addition, there is an online share drive used internally for their file review process. The progress notes and file documentation reflects that youth and families receive counseling services in accordance with the case/service plan and provides individual and/family counseling, as needed.

All (3) residential case files reflected that group counseling is provided at least (5) days per week at the shelter. The staff confirmed that the group sessions are at least 30 minutes per day (normally 1 hour sessions), a clear leader is identified (i.e. a youth care worker, other staff person, a Why Try facilitator, etc.), and a clear and relevant topic is chosen (including Fitness, Cooking, Why Try). Each youth file has a group log that outlines the group activity the youth attended for the day and their level of participation (i.e. low, moderate, high).

No exceptions were noted for this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided policy 2.06 that meets the requirement of the indicator for adjudication/ petition process. The policy and procedures were reviewed on March 2017 and approved by the CEO.

The policy outlines that case staffing is available to review the case of any youth or family that the program determines is in need of services or treatment if:

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

It is the program's policy to convene a case staffing within (7) days excluding weekends and holidays, after the receipt of a written request from a parent/guardian for a case staffing. Staff will document when a case staffing is scheduled and arrange the time and place that is convenient for the youth and family. The family and staffing committee is contacted within five working days to confirm scheduling times of the meeting. A written report is provided to the parent/guardian immediately following the case staffing or within seven days of the case staffing committee meeting, if the parent/guardian was not present at the meeting. The report will outline the reasons for the committee's recommendations for or against a petition being filed, additional services and/or referrals recommended.

The Family Resources Case Staffing Coordinator or designee will chair the Case Staffing Committee. Clients will be reviewed by a case-by-case basis with committee members receiving in writing summaries of clients' histories, Family Resources recommendations, and case materials orally presented sufficient in content to allow for considered judgment by the Committee.

Upon receipt of a written request from a parent/guardian for a case staffing, Family Resources will contact the family by phone and/or mail to be advised of date, time and location of the case staffing.

There were (3) active case staffing files reviewed. All were referred differently: one was referred by a school social worker, another by truancy court, and the third by a school attendance secretary. For each case, the family was notified no less than (5) working days prior to the staffing (most were informed in person and documented in the progress notes) and the committee was notified no less than (5) working days prior to the staffing (proof of emails sent to committee were reviewed in "Case Staffing" binder and provided by Community Services Supervisor). All of the meetings included a local school district representative, a DJJ representative, a CINS/FINS provider (Family Resources), the youth, and parent/guardian. For two of the three cases, a representative with the State Attorney's office was in attendance. For one of the cases, another representative was at the meeting who was significant in the youth's referral to the case staffing committee. As a result of the case staffing committee, a new plan for services was initiated. A copy of the written report that was provided to the families was included in each case file inclusive of recommendations and reasons for the recommendations. The program has established a case staffing committee and has regular communication with committee members (proof of email communications was reviewed in "Case Staffing" binder and provided by Community Services Supervisor). The program has an internal procedure for the case staffing process (as outlined in their policy and

procedures) and a schedule of regular case staffing committee meetings held every 3rd Thursday of the month from 2:00 pm – 5:00 pm) was reviewed.

No exceptions were noted for this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided policy 2.07 that reflects the requirement of the indicator for youth records. The policy and procedures were reviewed on March 2017 and approved by the CEO. The policy states that it is the agency's goal to protect the confidentiality of client records.

The agency maintains a file for each client served and organizes files in a consistent way. The handling of client records will be limited to authorized personnel and will be maintained when not in use in a locked cabinet or in a locked room with controlled access which is centrally located and available to program staff. All files will be marked "confidential" on the outside of the front cover of the file. Each file will include: chronological sheet and youth demographic information, psychosocial information, service plans, and case management information.

All client records will be housed in physically secured areas or within locking cabinets, under the control of the Supervisor. This area must be approved by the facility and records may be removed for staff access. All records are to be returned to the secured areas at the end of the work day. Client records will be available and accessible at all times for use within the facility for direct client care by all authorized personnel. All client records shall be retained according to legal, accrediting or regulatory requirements, then destroyed according to the approved agency retention schedule, unless there is a specific need for preservation of those records. The method of destruction shall be specified and the actual destruction witnessed and attested to in writing.

There were (4) non-residential, (3) residential, and (3) active case staffing committee case files reviewed for the youth records indicator. All case files were marked "confidential". All records are kept in a locked file cabinet that is marked "confidential". When in transport, all records are locked in an opaque container marked. All records are maintained in a neat and orderly manner.

No exceptions were noted for this indicator.

2.08 Sexual Orientation, Gender Identity/Expression

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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 August 2018 and signed by the Chief Executive Director.

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.

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, intake office, and counseling office. The program served one non-residential youth, intake date 8/23/18, during the annual review period who met the criteria for the indicator. The youth's request for gender/pronoun preferences was initiated during a counseling session on 10/26/18, 2 months after intake. Counseling and case notes document the use of the preferred name and pronoun from that time forward. No specialized services were requested and discharge plan includes continuation of services to assist youth with anger management and self-acceptance. There were no residential youth who met the SOGIE criteria; however, shelter staff interviewed during the visit stated applicable youth are addressed by pronouns, name, and gender they prefer and room assignment is made accordingly.

Training files for three new staff reviewed demonstrated staff received training on the Florida Network policies and procedures, including guidelines outlined in policy 5.08, during orientation. The program conducted SOGIE policy training with staff in August 2018 upon implementation of the new policy and procedure and a sign-in sheet documented staff participating in the training. A recent training was also conducted in March 2019. There are no applicable volunteers in the program to receive the training.

There are no exceptions for this indicator

Standard 3: Shelter Care

Overview

Rating Narrative

The SafePlace2B Manatee youth shelter is licensed to serve the Department of Children and Families (DCF) and Children in Need of Services/Family in Need of Services (CINS/FINS). The shelter is licensed as an emergency runaway shelter for 12 beds effective through 5/31/2019. 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 meeting the criteria for Domestic Violence and Probation Respite only.

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. Inter-agency agreements have been established for the provision of health education, leadership development, and substance abuse, mental health, and medical services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Shelter Environment policy, policy number 3.01, that was reviewed March 2017 and approved by CEO Lisa Davis. The policy meets the requirements and addresses the elements of the indicator.

The agency has a policy that indicates there is a housekeeping and maintenance plan to ensure the facility remains clean, safe, and in good repair. The program supervisor or their supervised designee completes weekly preventative maintenance inspections to include checking fire safety equipment, communication equipment, and any other safety related equipment or supplies needed in an emergency or to prevent injury to staff and youth. Bathrooms for youth are to be clean and functional.

The interior facility and exterior landscaping appeared welcoming, friendly, safe, clean and well-maintained with no evidence of graffiti. The program uses vinyls to decorate the rooms with artwork or pictures from travels to create a warm and colorful environment. The interior of the facility had minor areas that had been touched up by paint and the leadership staff advised the facility would be getting a full interior paint of the main common areas. The youth's bedrooms were individually painted in different themes, for example; breakfast at tiffany's, superheroes, siesta key. It was observed that 1 youth's bedroom contained a poster with profanity which the program addressed the same day.

Kitchen refrigerator temperature observed to be at 40 degrees and freezer at -18 degrees. All of the cold food was properly stored and marked or labeled in the refrigerator. 2 frozen items were missing labels in the freezer but were properly wrapped in original plastic packaging and only missed the box or label with date of expiration. There was a variety of choices in snacks, meals and milk for youth to choose from, such as, 1% milk or almond milk (dairy free).

Observed facility and vehicles for security practice. There is evidence of key control compliance and it was noted that both front and back doors remained locked throughout and staff had keys to access any locked doors within building that is not for visitor or youth access.

Agency vehicles were observed and showed evidence of first aid kits and appeared to be well maintained. A fire extinguisher was located in both vehicles and was showing as 'full' but 1 was missing evidence of a fire safety inspection tag. 1 vehicle had 2 extinguishers but only 1 had a current inspection tag.

Agency vehicles were locked and accessible with vehicle keys kept at staff desk. 1 staff vehicle belonging to maintenance was checked and found to be unlocked. Equipment and aerosol can was visible and accessible on the front passenger floor of vehicle.

Reviewed 5 months of fire drills between Sept – Feb 2019. The month of January only reported 1 emergency drill but no evidence of a fire drill for that month.

Fire drills were reviewed for 2/19/19, 2/14/19, missing January, 12/12/18, 12/31/18, 11/14/18 x2, 11/9/18, 10/22/18, 10/22/18, 10/10/18, and 9/23/18. It was noted that some forms show a beginning and end time for the drill or indicate the length of evacuation was over 2 minutes but it is unclear if this time includes the time from evacuation until the drill ended. Some fire drill forms only include the time of the fire drill and other forms specifically include the start and end times for evacuation. It is recommended that the fire drill form have a start and end time on the form itself for consistency and to clearly show that the length of evacuation in real time.

The following dates were reviewed for the past 2 quarters for emergency drills:

2/3/19 7-3pm 1st shift

1/5/19 11-7pm 3rd shift

12/27/18 7-3pm 1st shift

11/20/18 3-11pm 2nd shift

10/20/18 11-7am 3rd shift

9/14/18 11-7pm 3rd shift

6 emergency drills were reviewed over a 6-month period. Emergency drills were evidenced of being completed every quarter but not every shift is completed during the quarter. The 2nd shift was missed during December – February and the 1st shift was missed during Sept – November.

Menu reviewed had date of 2009 and is required to be current, signed by licensed dietician annually. The VP stated they have been trying to locate a licensed dietician currently to review and approve the menu but haven't been successful

1 staff vehicle belonging to maintenance was checked and found to be unlocked. Equipment and an aerosol can was visible and accessible on the front passenger floor of the vehicle. This was brought to the attention of the program leadership and was to be addressed with staff at the time of the review.

Both vehicles were missing evidence of flashlight. 1 vehicle was missing evidence that the fire extinguisher has been inspected, 1 vehicle was missing evidence of the glass breaker, seat belt cutter, airbag deflator. Prior to the end of the onsite review, an emergency car escape tool was ordered for the other vehicle and supporting documentation was provided and program staff purchased 2 flashlights on the same day and placed them in the vehicles.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Program Orientation policy, policy number 3.02, that was reviewed March 2017 and approved by CEO Lisa Davis. The policy meets the requirements and addresses the elements of the indicator.

The agency has a procedure that includes the intake process that must take place within 24 hours from admission. Staff are required to introduce the clients to the program's philosophy, goals, services, and expectations. The agency procedure states that there may be occasion due to the time of arrival of youth during late hours, the Youth Orientation Checklist has orientation items marked with an (*) will require completion prior to the youth going to bed. The program requires an initial by staff and the client will show which items were done until the remainder are completed in full the next morning.

3 open and 2 closed files were reviewed for this indicator.

All files reviewed included a signed orientation form by youth and staff within 24 hours of admission. The Youth Orientation Checklist did not have any items marked with an asterisk as mentioned in the procedure but the form includes a place for each item to have a separate line to allow for youth and staff to check or initial when each item is discussed. 3 out 5 files reviewed included a check or individual initials on each line item to indicate all respective requirements during orientation was completed.

It is recommended that there is a consistent practice of staff and youth 'checking' to reflect that each requirement is discussed with the youth during orientation and documented in the youth's file.

No exceptions are noted for this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy 3.03 Youth room assignment that was reviewed on March 2017 and approved by Lisa Davis, CEO.

The agency has a policy that states youth will be interviewed upon admission into the program to determine the most appropriate sleeping arrangement and room for the youth. The program utilizes a classification process that includes all of the guidelines and requirements to assess each youth; review of the youth's history and status; exposure to trauma; initial collateral contacts and initial interactions and observations with the youth; history of violence; separation from younger or older youth; susceptibility of victimization including age, size, and status;

developmental disabilities or lacking in age maturity; medical, mental or physical disabilities; suicide risk; sexual aggression and predatory behavior; and gender identity. Youth deemed to need special accommodations for their own protection or the other youth will be assigned as appropriate. This special accommodation will be noted in the client file and approved by the Supervisor.

3 open and 2 closed residential files were reviewed for this indicator. 5 out of 5 files reviewed included evidence that youth was assigned to a room and included documentation on the intake form regarding the youth's age, gender, disabilities, physical size, and gender identification. In all 5 files reviewed, the intake form does not indicate the youth's history, status, or exposure to trauma but upon an interview with the VP of Residential Services, it was explained that this information is captured on risk factor form that is completed by the staff during intake.

The intake form has places to indicate a way to classify youth for history or current experiences with gang affiliation, sexual assault or misconduct, chronic runner or previous client, alleged criminal offenses/delinquency, assault or aggressive behavior, or history of mental health/substance abuse use issues.

All 5 files included initial interactions and staff observations of the youth at intake that captured behavior, speech, date, and time.

1 file indicated that the youth had runaway and depression as a presenting problem that was reported by the mother on the screening form, but both of these items were left unchecked on the CINS FINS Intake form for the youth room assignment section. In discussion with the program leadership, it was identified that some staff may interpret this differently based on the frequency of the youth runaways and this can be addressed during staff meetings to ensure consistency. This file also missed documenting two alerts for medical issue for asthma and medication on the youth record.

4 out of 5 files left the 'other observations' section blank and it was discussed with the program leadership at the time of the review. Due to this being blank it was difficult to confirm if there may have been specific staff observations that may have assisted in guiding the staff decisions for room assignment for youth based on the youth's temperament and mood at the time of intake that assist with ongoing assessment of the youth.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Log Book policy, policy number 3.04, that was reviewed June 2018 and approved by CEO Lisa Davis. The policy meets the requirements and addresses the elements of the indicator.

The procedure requires that all direct care staff review at east 2 shifts with their signature and date upon arriving for their shift. All entries are to be written in ink and any recording errors are to be struck through with a single line. There should not be blank lines in the entry. House census and room assignments will be noted at the beginning of house shifts or when the count changes. Logbooks will be maintained for a minimum of 5 years. Logbook entries that impact security and safety should be highlighted.

Per the program's procedure, the Supervisor will review and sign the permanent logbook on a weekly basis for a supervisor review. At minimum, the logbook will contain the following: emergency situations, incidents, events, drills, medication administration, youth placed on a specific form of supervision, special instructions for monitoring youth, and headcounts at the beginning and end of each shift and any other head counts conducted during the shift.

The agency uses a paper logbook system, bed check log, and staff shift notes to capture the supervision of youth. The logbook includes documentation of safety and security issues but does not include highlights of the safety issues.

Safety and security issues are being documented in the logbook, however, they are not consistently being highlighted in the logbook for staff to easily review and be aware of potential concerns as required. The entries in the logbook appear to be legible and written in ink. There was evidence of incidents being documented in the logbook with date, time and signature of the staff entering the information. Errors are struck through once and have one line with staff initials. Youth residential headcounts and supervision of youth are being documented as required and there is no evidence of white-out that was noted at the time of the review.

Supervisory reviews are being documented weekly and are dated and signed. There is evidence that staff reviews the previous 2 shifts in the logbook, however, this is not consistently being documented by the designated supervisor.

The log book includes documentation of safety and security issues but does not include highlights of the safety issues.

There is no documentation in the logbook that the supervisor is reviewing the previous 2 shifts for the days they are onsite, however, this was discussed with the program leadership onsite and it was shared that this is partly due to a supervisor vacancy for approximately 8 months. January there was a newly hired supervisor but they left after a month in February.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has 2 policies called the Behavior Management Strategies 3.05 policy and the Behavioral Interventions 3.05a policy that was reviewed in March 2017 and approved by CEO Lisa Davis. The policies meet the requirements and address the elements of the indicator.

The agency has a policy that outlines the expectations for staff to utilize a behavioral approach that focuses on verbalizing and identifying strengths that a client may possess with a framework that incorporates residential clinical, behavioral aspects, and socialization. This framework model focuses primarily on safety, growth, and respect for the youth's individual goals and the daily community of the program. The procedure outlines the use of room restriction will not be used as a punishment but only be used on a voluntary basis. The behavioral intervention policy outlines that youth will not be denied access to food, education, exercise, corresponding privileges, contact with parents, probation officers or clergy, physical health or mental health services. The agency procedure outlines youth will receive policy and procedures in writing upon admission during orientation and be made aware of consequences or possible infractions that due to inappropriate behaviors.

The program has an excellent behavior management system practice in place called the Advancing Youth Development that utilizes 4 levels: leadership, citizenship, orientation, and ownership. In interviews with both youth care staff and youth, it was believed the system promotes order, safety, security, and respect. The program uses the points system to award incentives to youth. During the facility walkthrough, it was observed that the youth may purchase items in the point store on-site or other incentives that are geared towards motivating youth. Examples provided by program staff of possible incentives are later bedtime, increased phone time, and access to the 'leadership room' where youth can play video games, read, watch TV, etc. All staff are trained in administering rewards and consequences and managing aggressive behavior with only 1 staff member missing training on managing aggressive behavior. Supervisors review and sign off on the point system that youth specialist completes daily to award points for a range of program requirements including attending school, attending group, completing their chores after dinner, maintaining bedtime hygiene, and demonstrating respectful and safe behavior. Staff indicates in their daily shift notes when a youth does not receive compliance in a certain area and a checkmark is noted for each youth on the point sheet for compliance in each area during that shift.

During a face-to-face interview with 1 CINS FINS youth, the youth indicated that they feel that staff provide positive encouragement and are encouraged by wanting to achieve points.

No exceptions are noted to this indicator.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a Staffing and Youth Supervision policy that was reviewed March 2017 and approved by CEO Lisa Davis. The policy states if there is a critical staff shortage, 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 which is different from the requirements of the Florida Network policy.

The procedure states that the agency requires the staffing pattern to be met with 2 staff,1 male and 1 female, at all times. Staff unable to report to work due to illness, vacation, or extenuating circumstances will be responsible to have a replacement contacted and asked to work the designated hours. In the event that a direct staff member does not report for their designated shift, the worker on the current shift is required to contact the residential supervisor and will remain on site until a replacement is found and reports to work. The policy and procedure require staff to observe youth every 15 minutes while they are in their room either asleep or during other times such as illness or room restriction. Observation of youth is to be documented using a 'scan machine' or on a daily log in real-time. Staff will maintain constant sight and sound monitoring for youth requiring constant supervision due to the risk of suicide or other behavioral needs. The staff is prepared 1 week in advance and is posted in a visible location for all staff to access. The program maintains an on-call roster in the event that coverage is needed to allow access to home and work telephone numbers for on-call staff.

The program has functioning surveillance cameras and back up tapes to capture the last 30 days of surveillance. The schedule is posted for staff to access it and is visible in plain sight. There is documented on-call list that includes phone numbers for both part-time and full-time staff.

There is an electronic version of the schedule that since January 2019 has implemented a more in-depth color coded system which highlights a variety of categories: staff seeking coverage, newer staff shadowing shift, overtime, 11-7pm coverage that is staff specific, supervisory shift coverage, 'thank you' coded when someone picks up a shift and an (*) to indicate the medication lead on shift. The medication lead doesn't appear to be utilized but all other categories are color coded on the schedule.

The program reports that they are making efforts to recruit for male staff and are currently vacant a male staff position. The program reports having 2 full time male staff and 3 part time male staff with 1 male vacancy for full time position.

The staff schedules were reviewed from September 2018 – February 2019. A total of 57 out of 181 shifts reviewed indicated that male and female staff ratio was not met and 4 of those shifts did not document 2 staff on the staff schedule reviewed at the time of the review. While the program does appear to meet the Florida Administrative Code requirements for minimum staffing ratios, the program's procedure states that they will always have a staff ratio of 2 staff with 1 male and 1 female to meet the necessary staffing pattern including sleep time which is required per contract.

In reviewing a sample of the bed checks between February and March for verification, the 15-minute bed checks appear to be occurring as required, however, it was noted that only 1 was documented 22:40 on 2/23/19 but in comparison with the video recording of 22:45, which was slightly off by 5 minutes. Other shifts reviewed were documented and appeared to correspond with the video time. Program leadership advised that they utilize reviews of the video as a training recap to address concerns with overnight staff when necessary if documentation appears inconsistent with time noted in video surveillance.

There is no documentation that was provided at the time of review to demonstrate consideration for each shifts that both male and female staff coverage could not be met demonstrating ongoing efforts to meet the male and female staff coverage requirement, however, during interview with program leadership it was stated that male staff do not work on weekends due to a male staff vacancy. Program reports that they currently have 1 male YDS vacancy since February 20, 2019.

The staff schedules were reviewed from September 2018 – February 2019. A total of 57 out of 181 shifts reviewed indicated that male and female staff ratio was not met and 4 of those shifts did not document 2 staff on the staff schedule reviewed at the time of the review. For example, the 3rd shift had 1 female staff listed on the staff schedule 9.1.18 and 4 youth were both male and female in the shelter.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policies and procedures 3.07 for Special Populations, outlining procedures for serving Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite, Probation Respite Youth, Intensive Case Management (ICM), and Family/Youth Respite Aftercare services. The policy was last reviewed and signed by the CEO in October 2018. Family Resources Manatee is not contracted to provide ICM services.

The program's current procedures meet the general requirements for serving all of its applicable special populations with the exception FYRAC. The FYRAC procedures reviewed onsite during the QI review did not address specific requirements of Florida Network's policy 4.121 with regards to content of services and duration of service deliverables.

The program provides services to special population youth meeting the criteria for Staff Secure, Domestic Minor Sex Trafficking (DMST), Domestic Violence (DV) Respite, Probation Respite (PR), and Family/Youth Respite Aftercare Services (FYRAC) only. Intensive Case Management services are not contracted for the Family Resources Manatee program location. All of the procedures reviewed onsite 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 and/or 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.

During the review period, there were no applicable Staff Secure, DMST, or FYRAC youth placement in the program since the last onsite visit. 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. One of the three youth's stay attained the twenty-one day length of stay in the DV respite placement and a new youth record was created to transition youth to CINS/FINS; however, the transition was not noted in the case management/counseling records and/or DV discharge notes or in the opening of CINS/FINS services. 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 the 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.

No exceptions were noted for this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Youth Surveillance System policy, policy number 4.13, which was reviewed in March 2017 and approved by CEO Lisa Davis. The policy meets the requirements and addresses the elements of the indicator.

The agency has a small written notice posted on the window near the front door indicating that video surveillance is occurring on the premises that is barely visible and many staff on site were unable to show this posting to the reviewer. There is no other signage or posting in the shelter

but all cameras are visible in the common areas.

The agency has a procedure that states all CINS FINS shelters will have a video surveillance system that operates 24 hours a day, 7 days a week to monitor and record all agency activities to assure safety to youth, staff and visitors.

Video cameras will be placed in interior and exterior locations to cover general areas including hallways for sleeping rooms, where youth and staff congregate, and areas that visitors have entry and exit access. According to the procedure, cameras are not to be placed in bathrooms or sleeping quarters. Cameras are to remain visible and will not be covert or hidden from plain view. There is to be a written notice that is conspicuously posted on the premise for security.

Videos are to be stored for a minimum of 30 days and the agency will grant access to a request for a video within 24-72 hours from program quality improvement visits or when an investigation is pursued after an allegation of an incident.

The program requires that the video surveillance system is only accessible by designated personnel per program policy. Supervisory reviews of video is to be conducted bi-weekly per program policy and include a random sample of overnight shifts.

There is no evidence of cameras placed in bathrooms or sleeping areas. There are 16 cameras covering both the exterior area and the interior area where youth and staff congregate and where visitors enter and exit.

The video camera system can capture and retain video images and has the capability to zoom to allow close up facial recognition. The system does allow for video to be reviewed remotely via a mobile device and the VP interviewed acknowledged using this feature. There is not a written list of staff that can access the surveillance system but only the VP and residential supervisor have access to the video system in the facility and on their mobile devices.

The supervisor is able to access the surveillance system to allow third party reviewing of the video recordings and if there is an investigation due to an allegation and/or incident.

There is currently a vacancy for the Residential Supervisor since February 2019. The interim Supervisor would document some supervisory reviews in the program logbook and the VP maintains an electronic version. VP provided a copy of the electronic log for dates between September 5, 2018 – March 2, 2019. The log included the date review is completed, the shift or times and date reviewed, and if there were any issues or concerns identified.

There are some instances that the 14 day requirement is not met on this electronic version and some entries were noted to be more frequent than the 14-day requirement. 15 entries were reviewed on the copy of the electronic log and 5 of those entries were outside of the 14 day requirement. However, the policy causes some slight confusion and the term used ‘bi-weekly’ could be interpreted to be twice per week instead of every 2 weeks. The VP shared that program leadership has 24/7 access to the cameras and she often reviews the videos at any time and often when she is off-site so there may be occurrences when she reviewed but did not log those events.

Exception:

The supervisory reviews were not consistently being documented every 14 days and on 5 occasions they were missed from 1 day to 7 days without documentation that a supervisor had reviewed the tape to identify any inconsistencies in practice. It would be useful to have the policy specify the exact number of days the supervisor will review the video surveillance and specify the location of where this information will be logged (e.g. program logbook versus electronic log) for accessibility to all supervisory staff and consistency in meeting the timeframe requirements.

During a walkthrough of the facility, there was no observation of the signposting video surveillance is occurring on site. When asking the staff, the majority were not able to indicate where the posting was located. The VP was able to locate a small written notice posted on the window near the front door indicating that video surveillance is occurring on the premises that is barely visible.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The SafePlace2B Manatee 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 4000 Med-station. 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

The program has a written policy and procedures for 4.01 Healthcare Admission Screening which was reviewed and approved on July 1, 2018 by the CEO.

The program performs a physical health screening for each youth at the time of admission. The screening is completed utilizing the CINS Intake Assessment Form which includes current medications, existing acute and/or chronic medical conditions, allergies, recent injuries, and observation of evidence of physical distress. If the youth presents a need for further evaluation the program will make a referral for necessary medical or mental health follow-up as needed. The program has procedures to include a thorough referral process for necessary follow-up care for the youth. All referrals are documented on a daily log. Alerts are tracked utilizing a color code system. During the intake screening, any youth screened with an alert are likewise identified with an appropriate color code dot to communicate the alert on the youth's file, and the white board located in the common area. The dots are to inform staff without breaching confidentiality. The program provided medical staffing seven days a week for two hours in the morning and two hours in the evening each day.

A total of four open residential youth files were reviewed for the initial health screening during the intake/admission process at the shelter. One youth was documented having taken medication. None of the four were found to have an existing acute and/or chronic medical condition, or recent injuries or illnesses. Two were found to have allergies, and two with observation for scars and/or tattoos. All of the alerts were correctly posted on the youths' files and on the white board. The program provides medical staffing seven days a week for two hours.

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures for 4.02 Suicide Prevention which was reviewed and approved on July 1, 2018 by the CEO.

The program performs an intake screening for each youth at the time of admission. The screening is completed utilizing the CINS Intake Assessment Form to identify any youth for suicide risk. If a youth is considered a high risk for suicide, the intake staff is to place the youth on sight and sound supervision until assessed by a licensed professional or non-licensed professional which is under the direct supervision of the licensed professional. There are four different levels of supervision used in the shelter. One-to-One Supervision, this is the most intense level of supervision and is used while waiting for a Baker Act. Constant Sight and Sound Supervision, this is used for youth who are identified as being at moderate risk of suicide but are not expressing current suicidal thoughts or threats. Elevated Support, this is a step-down alert, the youth was previously identified as a suicide risk but is no longer considered at-risk for suicide. Standard Supervision, is for youth who's screening of suicide risk did not indicate the need for further assessment and they may be placed in general population.

There were three files reviewed for suicide risk. All three youth were identified as having a suicide risk and placed on a precautionary observation. One youth was placed on one-to-one, and interviewed by the Manatee County Sherriff deputy to assess the youth for the need to

Baker-Act. The other two youth were placed on sight and sound supervision due to answering yes to at least one of the six questions on the CINS Intake Assessment Form. All three youth were monitored and documented behavior at thirty minutes or less intervals on the constant sight and sound supervision observation log and in a chronological note in the youth's file. There was documentation in all three files the assessment was completed within twenty-four hours by the master's level counselor under direct supervision of the licensed professional. The youth were stepped down to elevated supervision after the assessment was completed by the licensed professional which made the decision to reduce the supervision level. The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures for 4.03 Medications which was reviewed and approved on July 1, 2018 by the CEO.

The program has a written policy and procedures which address the safe and secure storage of all medications. The program utilizes the Pyxis Med-Station 4000 which includes the storage and inventory of medications and is inaccessible to youth. The program's procedures include maintaining at least two super users trained to use the Pyxis med-station. Oral medication is not to be stored with injectable or topical medication. Medications that requires refrigeration are stored in a secured refrigerator that is only used for medication, and temperature are to stay within the 36-46 degrees F. Narcotics and controlled medication are stored within the Pyxis med-station under bio-metric control. The program maintains a perpetual inventory with running balances and shift to shift counts verified by a witness for all controlled substances. All over-the-counter medication are inventoried weekly.

There are procedures in place for the delivery or assisting in the self-administration of medications. The procedures also include distribution of medication for youth away from the shelter and the discharge of youth with medication as well as for disposal of medications. Non-controlled medications will be disposed of by crushing them, mixing them in coffee grounds or with bleach, and disposed in the trash in an inconspicuous bag. Controlled medications will be brought to a police station for disposal. The medication must be inventoried by two staff members and logged in the medication distribution log before being transported to the police station.

The program has a registered nurse (RN) on duty seven-days a week for two hours in the morning and two hours in the evening to administer medication. The program has twenty-four staff who are trained to deliver medication, seventeen of those are Super Users. The program ensures there is a super user scheduled for each shift. The RN provides all training on the use of the Pyxis med-station as well as on going re-training. The training consists of inputting all information correctly into the Pyxis med-station and maintaining inventories as well as. The staff must complete a training checklist and signed off by the RN before they can distribute medications. The RN maintains a list of all trained staff, and a calendar for re-trainings. There was an observation of several "cheat sheets" posted in the medical station to provide assistance for staff when using the Pyxis med-station. The RN runs and maintains all reports provided by the Pyxis med-station. There is also a discrepancy logbook maintained within the medical clinic for all discrepancies. Staff are required to be print and stapled in the book along with an explanation of why the discrepancy happened and how it was fixed. Trained staff complete an inventory every shift of all the controlled substances. This is completed by two staff members and is documented on the youth's Medication Distribution Log (MDL). A perpetual inventory is maintained on the youth's MDL each time a medication is given. Non-controlled medications are inventoried by maintaining a perpetual inventory each time it is given and inventoried one time each week by the RN. The shelter does not maintain any over-the-counter medications that would require a separate inventory. The shelter has a refrigerator for medication if needed; however, there was no medication that required refrigeration during the time of review. The RN maintains a log documenting the temperature of the refrigerator twice per day. There were four youth currently on medications during the review. All medications were verified at admission either by the RN or the pharmacy. The Consent for Self-Administration of Medication and Verification of Prescription Medication form was found for each youth documenting all medications the youth was taking. All the MDL's reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, times to be given, common side effects, reason, and the full printed name of each staff administering medication, as well as, the youth. A Client Medication Cover Page is front of the MDL in the medication binder. This sheet includes a picture of the youth, all medications the youth is taking with times to be given, the youth's name, date of birth, and any over-the-counter medications approved for the youth. All MDL's reviewed contained a perpetual inventory of counts with running balances and are being maintained on each medication. All MDL's reviewed for the youth also documented all medications were given at prescribed times. All inventories of the medications were documented on the MDL's. Four medications were controlled substances and the medications were inventoried each shift by two staff members. All non-controlled prescription medications were inventoried once per week by the RN and documented on the MDL's. Perpetual inventories were maintained on the MDL's for all medications. There was one CCC report for a medical incident within the last six months. A youth at the program did not receive prescribed medication within a timely manner. Staff responsible for the oversight received a reprimand for the oversight.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for 4.04 Medical and Mental Health Alert Process last reviewed and approved in March 2017 by the CEO.

The program has a policy and procedure in place to ensure any identify medical or mental health alerts discovered during the intake process are effectively communicated to all staff through a program alert system.

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

Four youth files were reviewed and indicated an alert was identified during intake process. Two of the four youth contained the applicable color-coded dot on the spine of the file. One youth was missing a red color-coded dot for precautionary observation; however, this alert was not required to be posted on the white board in the common area. The other youth was identified as having an allergy and taking a controlled medication, which would require an orange and black color-coded dot on the file and the white board, which neither was observed. This was brought to the program's attention and was corrected during the review.

All other alerts identified during the intake screening process were entered into the program's alert system.

One youth file was missing a red color-coded dot for precautionary observation; however, this alert was not required to be posted on the white board in the common area. The other youth was identified as having an allergy and taking a controlled medication, which would require an orange and black color-coded dot on the file and the white board, which neither was observed.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures for 4.05 – Episodic/Emergency Care which was last reviewed and approved in March 2017 by the CEO.

The program procedures are to ensure the provisions for emergency medical and dental care. The policy includes reporting all incidents to the CCC and Florida Network and the establishment of a daily episodic emergency care log to include follow-up, verification of medical clearance, and care upon youth returning to the program and notification to parent/guardians when applicable.

All staff shall be trained and certified CPR/First Aid and the use of emergency equipment (knife-for-life, wire cutters, first aid kit) procedures within three months of beginning work with youth. First aid kits will be in a designated area and accessible to staff. The kits will be examined and replenished after each use and inventoried at least once a week. There will be a "knife for life" and small wire cutters stored in the same area as the kit in a manner available to staff in the event a youth attempts suicide.

All staff have current training in CPR/First Aid and the use of emergency equipment (knife-for-life, wire cutters, first aid kit). There are four first aid kits one located in the medication room, a closet located in the common area, and one in each vehicle. The contents of all first aid kits are checked weekly by the RN. The knife-for-life and wire cutters are in a box, on a door, in the closet located in the common area. The shelter maintains an Episodic (First Aid/Emergency) Care Log. A review was conducted of three instances of episodic care, which required the youth to be taken off-site to the hospital. Those three incidents were reported to the CCC. All three instances were documented in the Episodic Care Log. All incidents documented the parent/guardian and Residential Supervisor were notified. An internal incident report was completed for all incidents. Follow-up instructions/care were also documented. All three incidents reported to the CCC were also found documented in the logbook, with further documentation of parental involvement and follow-up care. The program has completed a mock drill with staff for emergency care every month for the last six months.

There were no exceptions to this indicator.