



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Anchorage

on 05/29/2013

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

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

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	No rating
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory: 85.71%  
 Percent of indicators rated Limited: 0.00%  
 Percent of indicators rated Failed: 0.00%

### Standard 3: Shelter Care

3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	No rating

Percent of indicators rated Satisfactory: 88.89%  
 Percent of indicators rated Limited: 0.00%  
 Percent of indicators rated Failed: 0.00%

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

Percent of indicators rated Satisfactory: 89.29%  
 Percent of indicators rated Limited: 3.57%  
 Percent of indicators rated Failed: 0.00%

### Rating Definitions

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

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

### Review Team

#### Members

Latrice Covington, Contract Manager, Florida Department of Juvenile Justice

Keith D. Carr, Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services

Cheri Brandies, CEO, Arnette House, Inc.



## Quality Improvement Review

Anchorage - 05/29/2013

Lead Reviewer: Keith Carr

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Patricia Rock, Shelter Services Manager, Lutheran Services FL

**Persons Interviewed**

- |  |                          |                         |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 5 Case Managers          | 2 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor                 | 3 Clinical Staff         | 6 Program Supervisors   |
| <input type="checkbox"/> DHA or designee             | 1 Food Service Personnel | 6 Other                 |
| <input type="checkbox"/> DMHA or designee            | 0 Health Care Staff      |                         |

**Documents Reviewed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Grievance Process/Records                   | <input type="checkbox"/> Visitation Logs            |
| <input type="checkbox"/> CCC Reports                                  | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook  |
| <input type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 6 Health Records                                    |
| <input type="checkbox"/> Continuity of Operation Plan                 | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records                                     |
| <input type="checkbox"/> Contract Monitoring Reports                  | <input type="checkbox"/> PAR Reports                                 | 20 Personnel Records                                |
| <input checked="" type="checkbox"/> Contract Scope of Services        | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 18 Training Records/CORE                            |
| <input type="checkbox"/> Egress Plans                                 | <input checked="" type="checkbox"/> Program Schedules                | 14 Youth Records (Closed)                           |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 0 Youth Records (Open)                              |
| <input type="checkbox"/> Exposure Control Plan                        | <input type="checkbox"/> Supplemental Contracts                      | 0 Other   |
| <input type="checkbox"/> Fire Drill Log                               | <input type="checkbox"/> Table of Organization                       |   |
| <input type="checkbox"/> Fire Inspection Report                       | <input type="checkbox"/> Telephone Logs                              |   |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 9 Youth | 6 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

**Observations During Review**

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

**Comments**

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

Rating Narrative

## Strengths and Innovative Approaches

### Rating Narrative

#### Facility

Anchorage Children's Home, Hidle House, is located on a very spacious piece of property and has very well kept facilities. The agency continues to be blessed with a tremendous amount of community support. A recent example of the community's generosity was the donation of 20 new mattresses, mattress covers, and sheets to the shelter by the SleepCenter (local business).

#### Street Outreach

The agency lost its federal grant to conduct street outreach in September 2012. However, due to local community support, we were able to secure two (2) local grants to help continue a scaled down version of the Street Outreach program until we can reapply for the federal grant at the end of June 2013.

#### Shelter Management

The Shelter Manager and Assistant Shelter Manager have been in place for three years. This has provided a level of consistency to shelter operations. Additionally, the Shelter Manager recently enrolled in graduate school to obtain her Master's Degree in Social Work. The agency encourages all employees to advance their education and believes that this will add to the depth and quality of personnel that we have on staff.

#### Clinical Supervisor

Cindy Hetherington is the Clinical Supervisor and has been employed with the agency for over 20 years. She provides clinical oversight to residential and non-residential counselors providing a very thorough and professional continuity of therapeutic services.

#### Personnel Recognition

Anchorage Children's Home currently implements a monthly and quarterly recognition program. Employee of the month will receive a \$25 gift card and the employee of the quarter receives a \$75 gift card. Additionally, an employee of the year is recognized at the agency's annual dinner. Recognizing employees for their dedicated service is an integral part of maintaining employee morale.

#### Community Support

The agency is fortunate regarding the level of support from its community. In addition, the donation of the mattresses that was previously mentioned, that agency has received numerous donations such as groups donating gifts and money for our youth during the holiday season, new windows purchased for our bedrooms in shelter, and a local contractor (David Weekly Homes) renovating our waiting area and counseling offices in shelter.

## Standard 1: Management Accountability

### Overview

#### Narrative

The Anchorage Children's Home of Bay County, Inc. (ACH) provides both Residential and Non-Residential CINS/FINS services for youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson and Washington Counties in Florida. The program located at 2121 Lisenby Avenue in Panama City, Florida. The agency's executive Director oversees the residential and non-residential components of the program, including the volunteer and outreach initiatives. The agency's Program Administrator is responsible for supervising the operations and programming of the agency on a day to day basis. The shelter is licensed by the Department of Children and Families.

The program's Emergency Disaster Plan has been approved by the Florida Network. The Florida Network received the program's emergency response plan and hurricane plan that did have major revision in 2012. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the agency representative in 2012. The agency administrative offices and youth shelters are recently built structures and the shelter other building on campus can be utilized up to a level three and four hurricane category.

The agency maintains key partnerships in the community with major local service providers, as well as community base program and agencies. The agency has key partnerships with the local school system, law enforcement, social services and cultural and arts programs.

The program maintains an individual training file for each employee, with training provided through a broad array of local service provider options and sources. The agency does utilize the Florida Network, computer-based trainings and training delivered in house by ACH staff members and other. Annual training is tracked according to the employee's date of hire.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

Anchorage Children's Home – Hidle House has a comprehensive policy that requires all prospective employees, interns, and volunteers to be appropriately screened and that current employees receive five year rescreens. The agency provided the current roster of all Residential and Non-Residential employees.

Ten (10) employee personnel files were reviewed for compliance with this indicator. Seven (7) of the ten (10) files were new hires and three (3) were for five (5) year rescreens. The review of the three (3) five year rescreens documented that the screenings were completed prior to each employee's five (5) year anniversary date. All background screenings for new hires were completed prior to employment. Two additional files were reviewed for this indicator for compliance, one intern and one volunteer. The intern and volunteer files documented background screenings were completed prior to working in the shelter. The agency also conducts local law enforcement records and driver's license checks each year on all employees.

The agency provided documentation that the Annual Affidavit of Good Moral Character was submitted to the DJJ Background Unit prior to the January 31<sup>st</sup> deadline.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a detailed policy to address the general requirements of this indicator. A review of the Grievances reported by youth admitted to the youth shelter in the last six (6) months was conducted. A total of nine (9) grievances submitted by youth were reviewed on site to determine their adherence to agency policy. These documented grievances encompassed reports citing client issues regarding their dissatisfaction with the agency's practice of waking youth up in the morning, minor comments regarding the manner in which staff members speak to youth, following program rules, not complying with the behavior management system. One comment was found to be offensive regarding a staff person comments regarding the youth's sexual orientation and their alleged interest in staff and other residents. The process for resolving grievances involves the agency policy that requires a response to a submitted grievance by a resident within seventy-two (72) hours of receiving the written resident grievance. All documented grievances were addressed within the specified timeframe. Eight (8) out of 9 grievances are related to issues that youth have with staff members. A total of Four (4) out of the 9 grievances are documented report regarding one staff person.

A total of six (6) randomly selected Direct Care staff members across all work shifts were selected to complete the Florida Network online Quality Improvement survey. Of these completed surveys, 6 out of 6 surveys reported that they never witnessed youth ever been sent to their room or an isolation room for punishment. Staff report that they never observed a co-worker telling a youth that they could not call the Abuse Hotline or ever seen a youth being sent to their room or an isolation room for punishment. In addition, staff reported that they never observed a co-worker using profanity when speaking to youth or observed a co-worker using threats, intimidation, or humiliation when interacting with the

youth.

At this time of this onsite QI Review, a total of nine (9) CINS/FINS youth were available to complete an online QI youth survey. Of these completed surveys, 6 out of 9 surveys reported that they felt safe in the youth survey and knew about the Abuse Hotline. Nine out of 9 youth surveyed reported that they have not heard staff use profanity. Eight (8) out of Nine (9) youth surveyed reported that adults are respectful when talking to them or other youth. Six (6) out of 9 youth reported that they are familiar with the Grievance Process. Eight out of 9 reported that they feel safe in the program. Eight (8) out of Nine (9) youth surveyed that they have never been sent to their room for punishment.

A total of five (5) DJJ CCC incidents were documented in the DJJ CCC database over the last six (6) months. Of these incidents none contained evidence of events related to program participants being subjected threat, intimidation, humiliation or abuse. Incidents are specifically related to medication errors and items four during searches and a program disruption issue. Four (4) out of 5 incidents were related to medication errors of missed medication.

The agency provided evidence of all administrative reported documented for the last six (6) months for violations of code of conduct and below acceptable work performance. These reports included two (2) administrative written reports due to work performance issues involving two (2) staff members. Both administrative write ups include written notification and 1 of the 2 required the agency to officially place the staff member on Leave and implement a Performance Improvement Plan.

One (1) grievance reported by a client was found to have involved a staff person that made offensive remarks about a client due to their sexual orientation. The agency provided a documented report citing this grievance as a violation of agency policy and the staff person was placed on leave and put on a Performance Improvement Plan.

One youth survey reported that they did not know about the Abuse Hotline and where the Abuse Hotline was located to report abuse. One youth survey reported that they heard an adult threaten them or other youth during their shelter stay. One youth surveyed reported that they did not feel safe in the youth shelter. One youth survey reported that they were not instructed what to do in case of a fire.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy and procedure on incident reporting that agrees with the Department of Juvenile Justice reporting requirements. The policy requires all employees to report eligible incidents to the DJJ CCC within two (2) hours of becoming aware of the incident. The Office of Prevention and Victim Services conducted a search for all ACH of Bay County related incidents occurring within the last six (6) months.

Five (5) reported DJJ CCC incidents and sixteen (16) ACH Internal Incidents were reviewed for this indicator. The DJJ CCC incident types included four (4) Medical Incidents (Medication Errors) and a Program Disruption Incident (Contraband). All five reported incidents were reported within the two-hour requirement. Since the last review, training records document that the DJJ Office of Health Services trained employees on medication distribution. There is also documentation that employees are trained on abuse and incident reporting for DCF and DJJ. These changes demonstrate the agency better identifies incidents that require reporting to the DJJ CCC, specifically medication errors.

The agency has a form for reporting incidents that must be completed by each employee that witnesses the incident. The incident forms are legible and describe the incident. Employees are familiar with the reporting requirements and procedures, the Abuse Registry number, and the CCC number. Not all youth are aware of the Abuse Registry or the CCC number, which is posted in the shelter.

There was one incident of a youth not receiving medications because of a baker act that was not reported to the CCC.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place that states the minimum CINS/FINS training requirements on an annual basis for residential and non-residential employees. The policy includes training topics and hours for first year and on-going staff members.

The agency records and tracks all training hours for each employee by the calendar year (January – December). The agency's Program Administrator maintains training. Each employee has an individual training log that is maintained on a database and was provided for this review in a 3-ring binder that includes topics, hours, and trainer. Supporting documentation such as sign-in sheets and training records are kept by the month in the Program Administrator's office in a file cabinet. Training certificates are kept in each employee's personnel file. The agency conducts orientation training to new residential and non-residential employees throughout the year via the Florida Network, the local area, and in-house trainers.

Eight (8) employee training files were reviewed to assess the agency's adherence to the first year and on-going employee training topics and hours. A review of five (5) first year training files contained evidence of employees participating in all major training topics including crisis

intervention/safety, suicide prevention, CINS/FINS Core Training, Title IV-E Procedures, fire safety equipment, CPR, first aid, in-service component, signs and symptoms of mental health and substance abuse, universal precautions, and cultural competency. All new hires have evidence of training hours and topics that exceed the 80-hour requirement. The review of the on-going employee training files document 3 out of 3 employees has topics and hours that exceed the annual 40-hour training requirement. All staff members have evidence of the required training topics and hours including CPR and First Aid training. The agency does not require new hires to receive priority training topics by a certain date such as within 30, 60 or 90 days of hire.

### 1.05 Interagency Agreements and Outreach

Satisfactory                       Limited                       Failed

Rating Narrative

The agency's policy on outreach and partnerships was reviewed for this indicator while onsite. The review for this indicator included the agency's publication that lists all services the agency provides and a resource guide of all services in the area. The publications are distributed during outreach events. The CINS/FINS Guide that is available in English and Spanish is provided to parents.

The most recent partnership agreements signed by the agency were reviewed. There are interagency agreements with various agencies for alcohol and other drug use/abuse, adolescence/adolescent behavior, parenting classes/family functioning, and youth educational issues. There are various community service agreements for community-based educational and extracurricular activities for residents at the shelter.

The agency has a designated employee to coordinate and provide outreach services. Outreach is documented in NetMIS and includes various community events, Church groups, and television advertisements. The agency provided outreach and services to Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties.

### 1.06 Disaster Planning

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a written Emergency Preparedness Plan that addresses the requirements listed for this indicator. The current disaster plan is reviewed, updated, and sent to the FNYFS on an annual basis. The agency's plan has procedures for disasters such as hurricane, tornado, fire, flooding, youth riots, taking of hostages, chemical spills, terrorist acts, etc. The agency has maps/egress plans posted in the dormitory areas and at specific exit points throughout the youth shelter and the building. The agency participates in the Universal Agreement Emergency Disaster Shelter and has a current signed copy.

The shelter can withstand up to a category 3 hurricane and has a generator. Employee training files document yearly training on emergency preparedness and the use of the generator. The plan states when and where to evacuate with directions to evacuation locations. There is a process for bringing medications, log books, cell phones, and other necessities if evacuating. There are several supply lists to ensure there are enough items for youth and employees when evacuating. The supplies are located in the laundry room with checklists on the outside container and are checked prior to hurricane season. The agency has a process for notifying employees and the Florida Network.

### 1.07 Analyzing and Reporting Information

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has developed a policy to address the provisions of the requirements of this Quality Improvement indicator. The agency conducts regularly scheduled Quality Improvement meetings across its entire department. These areas include both Residential and Non-Residential CINS/FINS program components.

The agency conducted monthly reviews of Netmis data to assess its progress in key performance areas. The agency reviews risk management, operations and program issues to ensure that major trends and patterns are identified and solutions are developed and implemented to address the problem. The agency had a recent series of medication errors during the 2011-2012 contract year. Major medication deficiencies were noted related to medication errors and non-reporting of medication incidents to the DJJ CCC. The agency analyzed these issues and addressed the issue by conducting a training of all staff by the agency's ARNP to all CINS/FINS staff. This training included a comprehensive training on all major medication distribution practices.

Agency also reviews several teams that review trends and patterns related to risk management, operations and programming. Hidle House conducted quarterly Continuous Quarterly meetings and the agency conducts file reviews. The agency also conducts several reviews per year related to Risk Management that includes runaway events; incidents; Grievances; Suicide Risk Assessments; Emergency Drills, and Accidents. All events are put in to formal reports and reviewed each month and quarterly.

The agency did not make reference to the percentage or its effort to reduce certain risks related to addressing a certain outcome. For example, the agency could develop a plan to address the problem and set a target goal to address the identified problem. At the time of this onsite review, the internal oversight process used by the agency demonstrates general awareness of issues. The agency should utilize focus on increasing its efforts to document the various intervention and strategies it uses to address a problem in more detail.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

The ACH Non-Residential Counseling Program provides non-residential services for youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson and Washington Counties in Florida. The program has partnerships with agencies to have office space at various community sites in the Florida Panhandle area. Primary services delivered include a full range of individual and family Counseling. The Non-residential services component includes a Clinical Director and additional staff members that include several Non-Residential Treatment Counselors. The Clinical Supervisor is a Licensed Mental Health Counselor.

Screenings are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. The program's intake and screening unit screens calls for service from the public and its partners. The screening counselor will either refer the youth and family to one of the program's counselors, or will make a referral for the family to another appropriate community agency, according to the youth's zip code. Case management and substance abuse prevention education are also offered. Referral and aftercare services begin when the youth are admitted for services.

A case plan is developed for each client. In addition, home visits are conducted on a case by case basis to offer support the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by ACH with shelter care as a possible option for youth that need additional support services.

The non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist resolve issues faced by the youth and their family.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

2.01 Agency has policy and procedure that thoroughly describes the intake process, screening, available service options, and client rights and responsibilities.

The agency also has policy and procedure describing their centralized intake/on-call process. Support and provision of written and verbal explanation of rights and responsibilities is also documented in the agencies policy and procedures.

Screenings were completed in 7 days of referral where a referral was available. 4 of 5 non-residential files were self-referrals and the screening was done at the time of the call for services.

Clients and families were provided with handbooks and CINS/FINS brochures which is documented on the Informed Consent form and the Voluntary Placement form.

4 of 5 files for residential and non-residential services document the client and family receiving the required information.

### 2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

#### Rating Narrative

2.02 The agencies policy and procedures comprehensively describes the process for developing the psychosocial assessment.

5 of 5 non-residential files fulfilled all requirements of the standard and the agencies policy and procedures.

4 of 5 residential files fulfilled all the requirements of the standard and the agencies policy and procedures-one file was not signed by the supervisor.

The psychosocial assessments were easy to read and provided relevant and appropriate information for case plan development.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

2.03 The agencies policy and procedures adequately covers the standard requirements for Case Plan development. However, the policy and procedure did not state that the Case Plan must be completed within 7 days of the psychosocial assessment.

2 of 5 non-residential Case Plans had completion dates entered-otherwise requirements of standard were satisfied.

1 of 5 residential Case Plans had no person responsible, target date, or completion date documented.

1 of 5 residential Case Plans had the target date written in -3 of 5 had a place for a target date to be documented and they were appropriately documented. It appeared that there were two different forms used and one had a target date added and one did not.

1 of 5 residential Case Plans had no supervisors signature

1 of 5 residential Case Plans had the Case Plan dated prior to the date on the psychosocial assessment.

Recommendation: add initiation date to the non-residential Case Plan. As it is currently the reviewer has to assume the initiation date by the counselor signature date.

All but one Case Plan was developed from the psychosocial assesment and were easily tied to the client's presenting problem.

The Case Plan Reviews are consistently completed in the required time frame (one was not dated however in the content it stated "14 dat review)

Residential Case Plan reviews were not consistently signed by client and parents.

Recommendation: staff date signatures on clinical supervision form.

The non-residential Case Plans do not have completion dates consistently entered.

5 of 10 Residential Case Plan Reviews were not signed by the client and parent.

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

#### Rating Narrative

2.04 The agency has policy and procedure that addresses each component of the Case Management and Services Delivery indicator.

4 of 4 of the files the counselor made referrals for additional treatment. The counselor followed up to determine if the client was following through with the referral. In one instance the counselor followed up with the client but not the family.

Review of the files indicates that the counselors are establishing referral needs based on the youth's/family's problems and needs. They coordinate service plan implementation, monitor the youth/family's progress in services, provide support for families, refer additional services, and terminate cases with follow-up.

There was no evidence of need for monitoring of out of home placement.

There was no evidence of referrals to the case staff committee, recommendation and pursuit of judicial intervention, accompaniment of youth and parent to court hearings, or continued case monitoring and review of court orders.

There is no evidence of Case Management services as referenced in Florida Statute 984.12 being provided by the agency in the past review cycle.

### 2.05 Counseling Services

Satisfactory

Limited

Failed

#### Rating Narrative

2.05 The agency has policy and procedure that describes the ongoing internal process for clinical supervision, review of case records, youth management, and staff performance regarding CINS/FINS.

Policy and procedure documents process of ensuring confidentiality-reviewers signed visitor confidentiality agreement. Case record storage was addressed.

Non-residential and residential counseling services are provided in accordance with psychosocial assessment and case plan-documentation indicates caring and comprehensive counseling services.

Clinical supervision is documented for case staffing and counselor performance however no documentation for case record review was found.

Consistent 5 day/week groups was not documented in Individual case files.

No documentation noted for case record review.

### 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

#### Rating Narrative

Not Applicable-no cases in the past year

### 2.07 Youth Records

Satisfactory

Limited

Failed

#### Rating Narrative

2.07 The agency policy and procedure ACH-CS-SP-004 states that the files are kept in a locked room inside a locked file cabinet. (which is not currently consistently in practice) Policy and procedure ACH-HH-DR-001 states that files are in the presence of authorized personnel or in a locked room. (which is being consistently met). This policy also states that all files are marked "confidential".

Open shelter files are stored on a cart in the Case Managers office and the open non-residential files are stored in the filing cabinets in the Counselors office.

All closed files are stored in a locked filing cabinet in a locked room.

All files reviewed were marked "confidential".

The agency policy and procedure details the organization of the client files.

All files reviewed were neat and orderly making documentation easily accessible.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The ACH program provides residential CINS/FINS services through a contract with the Florida Network of Youth and Family Services. The Hide House Youth Shelter is located in metropolitan area of Panama City, Florida. At the time of this Quality Improvement review, the residential program is staffed with a Licensed Residential Supervisor (LMHC) that reports to the agency's Program Administrator. The residential shelter houses a twenty (20) bed emergency shelter. The shelter has eight (4) large bed rooms that house two (2) beds in room. The facility has a dayroom area that is adjacent to the youth work station. The facility also includes an activity room, computer room, reading area and a snack or sitting area. All medications are housed in secure locking cabinets inside a converted closet next to the youth care worker station. The agency maintains an updated video camera system. The agency has a general alert board for immediate notification of the resident's status and general information board that notifies the residents of rights, rules and the Abuse Registry number.

The Hide House shelter is operated by an Residential Shelter Manager, an Assistant Shelter Manager, a Clinical Supervisor/Licensed Mental Health Counselor, four (4) Residential Case Managers, a Life Skills Coordinator, a Maintenance Coordinator and a Maintenance Specialist and thirteen (13) Youth Care Specialist and an Administrative Assistant. The Residential Supervisor oversees the day-to-day operations of the youth shelter. The program provides group sessions to clients a minimum of five (5) days a week on various topics that address issues including substance abuse prevention, anger management, effective communication, leadership skill building and many others. The agency utilizes a behavior management system that is used consistently across all off its residential programs.

### 3.01 Youth Room Assignment

Satisfactory                       Limited                       Failed

#### Rating Narrative

Review of six files (4 open and 2 closed). All files indicate appropriate sleeping room assignment. Youth are assigned rooms based on demographic/history of the youth (i.e. age, gender, developmental maturity, history of physical or sexual acting out, aggression, gang affiliation, presenting problems, special needs, etc.). An alert system for special needs is in place and indicated on the binder of the file, under Progress section, and the shelter YS board. An interview was conducted with the Shelter Manager and tour of facility. The layout of the youth sleeping area and dayroom: Male's bedrooms are on the opposite side from the female bedrooms, with the dayroom in the center.

### 3.02 Program Orientation

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has a policy in place that explains the Intake/Orientation Process, admission criteria and what they will not exclude (i.e. race, ethnicity, gender, nationality, religion and disability). Review of six files (4 open and 2 closed). All files indicate youth are oriented on the programs rules and behavior management strategies and conducted one-on-one at intake. Interview was conducted with the Shelter Manager regarding program orientation. Each youth is given a youth handbook at intake that includes program rules and behavior management strategies. The youth's rights, the grievance procedure, to include how to contact the Abuse Hotline is explained by the Youth Care Staff.

### 3.03 Shelter Environment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The shelter environment is neat, clean and well maintained, evident by observation. Observation of Health and Safety Inspections indicate up-to-date. Furniture is in good repair, one youth restroom needs minor painting. Grounds are landscaped nicely, no graffiti on walls, doors and windows, youth have their own bed with linen and blankets, lighting is adequate and you have a safe and lockable place for personal belongings, if requested.

### 3.04 Log Books

Satisfactory                       Limited                       Failed

#### Rating Narrative

A process is in place to document daily activities, events, and other major occurrences. Professional log book indicates safety and security, entries brief and written in ink, recording errors struck through with staff initial and date, supervision and resident counts are documented, visitation and home visits, no erasures and white-out areas. Direct Care Staff initial that they have read the professional book. The Shelter Manager and Assistant Shelter Manager review the professional log book daily, making notes as needed of areas that need addressing (progress, improvements or deficiencies).

Rating Narrative

The program has a structured daily, holiday, weekend, and summer schedule to engage youth in activities that foster development. The agency program policy indicates that a variety of indoor leisure activities are provided daily in the facility and community. Educational services are provided by enrolling the youth in school or providing educational tutors to work with the youth while in shelter. One or more hours of physical activity is scheduled in the day, based on weather conditions. Quiet time is also scheduled in the day for things like reading, writing, crafts, etc.

**3.06 Behavior Management Strategies**

Satisfactory                       Limited                       Failed

Rating Narrative

The program has a behavior management policy in place, and strategy to identify, gain compliance and help reinforce good behavior and change negative behaviors of the youth. It is designed to be an educational process, not punitive, while maintaining order. The agency's behavior management (Self Management Point System) is taken from the "Boys Town Model" and fitted for the program. Staff receive training at "New Hire Orientation", approximately three hours, during their forty hour training (1-2 day shadow), and once a year formal training (pretest and post test given). Youth can earn Resident of the Day (ROD) or Resident of the Week (ROW), based on number of points earned for good behavior. Monetary rewards are given for ROD & ROW. Some outings are privilege base, therefore, some youth may stay back if not in compliance with good behavior. Youth are able to buy items from a "Point Store" with points earned. The monitor observed the Assistant Manager and Direct Care, to include Dietary Specialist interacting with youth and Assist Manager modeling Behavior Management System. The monitor observed youth during scheduled time for returning from school.

**3.07 Behavior Interventions**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a policy in place that states youth receive consequences for their behavior such as restitution- being held accountable by repayment of some sort (i.e. replaces or fixes the item) if property is damaged. Repentance – Youth admits what he/she has done wrong and apologize either verbally or in writing and forms an act of opposite behavior. Restriction – Youth loses privileges for a period of time not to exceed one day. Privileges are related to the point card and documented. Room restriction is not used for punishment, but may be suggested as "time out" no longer than one minute beyond the number the youth is old. If the youth is physical, the youth loses all privileges until remaining calm or a determined period of time. Reality – Youth must face the natural effects of negative behavior. Repetition – Youth repeats appropriate behavior expected multiple times to demonstrate and practice. Redirection – Reminders from staff of program expectations and Rethinking – Youth takes a set amount of time to re-think a poor decision or negative behavior on how they may better handle similar situation. Policy states that discipline procedures and suspension of privileges do not include the loss of client rights. Corporal punishment or physical, sexual, emotional or verbal abuse, and ill-treatment are prohibited. Interviewed Joel and Assistant Shelter Manager who indicated they use verbal de-escalation for intervention. They receive intervention training, Crisis Intervention Training (CIT) from Florida Network, Training Director.

**3.08 Staffing and Youth Supervision**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a policy in place under Daily Operation indicate that Youth Specialists provide 24 hour wake supervision to youth in the shelter. In view of the staff schedule, April and May, 2013, there are 3 staff on first shift, 2 staff on second shift, 2 on third shift and 1 staff who staggers between second and third shift. On 5/30/13, there are 15 youth in shelter. Staff to youth ratio is 2 or more during wake hours and 2 during sleep hours. Staff schedule is posted in place visible to staff. On-call, supervisors, counselors and YCS telephone numbers are accessible to each staff, however, not accessible to youth. Very rare occasions, there may not be a staff of same gender on shift. Staff observes youth at least every 10 minutes while in sleeping room, during sleep period or at other times (i.e. illness or room restriction). Staff schedule indicate staff ratio and gender.

**3.09 Staff Secure Shelter**

Satisfactory

Limited

Failed

Rating Narrative

No sample to review. Indicator not applicable.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The ACH program provides screening, counseling and mental health assessment services. The agency has a Program General Manager oversees the daily service duties and responsibilities of the program. The AFC Counselor staff are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. agency also uses a general alert board to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The ACH program assists in the delivery of medications to all youth admitted to the youth shelter. The agency provides assistance with youth that require medication and includes direct assistance from trained staff members. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. At the time of this onsite Quality Improvement review, the agency has a LMHC Clinical Supervisor and senior counselors. These staff members are involved in the review of all residential clients that screen positive for suicide risk.

The agency has a full complement of staff of both male and female staff members across all three (3) work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training. During this onsite QI review, the agency provided an up to date list of more than eight (8) agency staff members that have received medication distribution training and are authorized to provide distributed medication to residential clients.

### 4.01 Healthcare Admission Screening

Satisfactory
  Limited
  Failed

#### Rating Narrative

The agency has developed a policy to address the provisions of the requirements of this Quality Improvement indicator related to Healthcare Admission Screening. The current policy focuses on general health care and specifically medical care for routine, acute and chronic medical conditions. The agency current screens all youth admitted into the residential and non-residential CINS/FINS program for general health care issue. The agency policy is listed as ACH-HH-HC-008 and was last revised in 2008 and was recently signed by the agency Executive Director and representative of the Board of Directors on April 1, 2013. The agency has a medical alert system in place to ensure that all youth admitted to ACH programs are screened and assessed through screenings conducted by Residential Counselors from the client and or their parent/guardian. All clients are screened during intake and information is documented. Any medical treatment received during the shelter stay is documented in the client file and parent/guardian is notified. On-going medical observations are conducted by staff members through daily interaction with the clients.

A health screening form is completed on each youth at admission to determine any health, medical, mental health or dental needs or acute or chronic medical conditions a youth may have. Staff members are required to report any health/dental complaints or needs that arise during a resident's stay. Residential Case Managers make appointments and Youth Specialist transport to and supervise youth in appointments.

The agency screens for initial medical and health issues upon their admission to the program. This information is captured on the ACH Health Screening Form and Physical Health Screening Form. This form captures the current Medial Alert Status; Recent Condition (32 Conditions); Recent Hospitalizations; Current Medical, Dental, or Mental Health Complaints; Current Physician; Current Medications; Need for Auxiliary Aids, Assistive Technology, and Services or other Special Accommodations. This form is primarily used during screening. The agency also captures special dietary needs on the Special Dietary Needs Form. The agency also documents family medical history in the client's psycho-social assessment.

A randomly selected group of five (5) client files were reviewed to assess the agency's adherence to the requirements of this standard. A total of three (3) open and two (3) closed cases were selected.

### 4.02 Suicide Prevention

Satisfactory
  Limited
  Failed

#### Rating Narrative

The shelter had a written plan that outlined the suicide prevention and response procedures. The agency has developed a policy to address the provisions of the requirements of this Quality Improvement indicator related to Healthcare Admission Screening. The title of this policy is Suicide Prevention. The current policy focuses on general health care and specifically medical care for routine, acute and chronic medical conditions. The agency currently screens all youth admitted into the residential and non-residential CINS/FINS program for past and current

presence of suicide risk. The agency policy is listed as ACH-HH-SS-006 and was last revised in 2008 and was recently signed by the agency Executive Director and representative of the Board of Directors on April 1, 2013.

The shelter utilizes three (1) levels of supervision: one on one; constant Sight and Sound and Elevated supervision. Two (2) youth were placed on Elevated supervision. The agency's observation log sheets document counts every 10 minutes. There are no set or determined period for review prior to removal from this status. Counselors converse with direct care staff to determine current status, behavior and temperament prior to removing. The counselor also reviews each case with the licensed staff member prior to removing.

The agency's screening process for suicide risk involves several steps. The agency screens for suicide by completing an Evaluation of Imminent Danger for Suicide (EIDS) tool. If a any youth scores a positive answer in Criteria 1 of Suicide Risk Summary Scoring and/or scoring 5 or more positive answers in Criteria 2 must have an assessment of suicide risk completed immediately.

The agency has one (1) Licensed Mental Health Counselor whose license is in effect through March 31, 2015. One youth's case was initially screened for suicide and did not meet the requirement for Elevated Supervision of five (5) or more positive answers or risk categories and assessment of suicide risk is completed. In general the remaining plan addresses all elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS. This policy was approved prior to the current year, and has not been revised since the initial approval date.

One (1) case involving youth with past history of five (5) suicide attempts and a recent Baker Act threat of self harm 2 weeks prior to admission to the program did not have evidence of required . There was no evidence of a Suicide Risk Assessment being completed and found. The agency stated that this was not required in this case. The agency utilized the EIDS in the process and it resulted in 4 positives and the agency policy requires 5 to be considered at risk to. Given the youth's history and recent Baker ACT, this youth was not placed on Elevated risk, and there is no evidence of a Suicide RA. There was evidence that the supervisor reviewed the psycho-social assessment that contained that history of past attempts and evidence of past Baker Act.

One (1) youth was placed on elevated supervision the entire time of the stay. The agency is not currently recommending an after plan once they are released. The agency should always have a referral plan for parents if a child stays on Elevated status the entire time of their shelter stay.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has detailed policies related to the delivery of medication to youth admitted to the youth shelter. The agency policies are highly structured and meet the general requirements of the current indicator. The agency had written procedures that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. The agency has a Advance Registered Nurse Practitioner overseeing the medication documentation and inventory of the agency's medication process.

The program had a list delineated in writing of staff that are designated to have access to secured medications, and limited access to controlled substances. All medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. There were no injectable medications on site, or identified as needed for any youth during the time of the review. The shelter has a system in place for refrigeration of medication if needed, however there was no medication that required refrigeration during the time of review.

Controlled medications are locked in large metal cabinets behind two (2) locks. One cabinet is designated for controlled/narcotic medications and prescribed medication. This cabinet features metal housing with a locking metal door and individual locks on each slotted shelf that houses a medication. The other cabinet houses over the counter medications. Shift-to-shift counts and a perpetual inventory is maintained, and documented for controlled and prescribed medications. Oral medications are stored separately from topical medications. When both medication are required, each is placed in a baggie or tray to ensure separation. Shift to shift counts are conducted and documented for controlled substances three (3) times per day once on each shift. Non-controlled is counted on a perpetual basis and when given. Over the counter (OTC) are accessed regularly and are inventoried weekly by maintaining a perpetual inventory.

The agency utilizes a Medication Distribution Record to capture major information related to each youth admitted to the youth shelter on a daily basis. The MDR includes name, date of birth, picture, allergies, side effects, staff initials, youth's full name and initials, staff member initials and name. The format of the MDR is function and user-friendly. The majority of the document has typed information to reduce legibility.

Sharps are secured as required. The agency maintains an inventory of three (3) sharps that include nail clippers, shaving razor, wire cutter, tweezers, scissors and a pill cutter. The agency also maintains six (6) first aid kits that are sealed with break-away tabs. The agency also inventories all creams/ointments; bandages; and miscellaneous that are counted weekly. A 1 page inventory sheet with each of the aforementioned items is listed and counted by the Registered Nurse on a weekly basis. The agency utilizes bio hazard waste disposal bags in each first aid kits and waste bin.

The agency's medication verification process is not in practice on a consistent basis. The agency is required to have practice in place that verifies and confirms all medications that enters the youth shelter with the licensed pharmacy that filled the prescription. See the FNYFS policy and procedure manual for guidance related to the medication verification policy. One youth's MDR reviewed onsite is missing initials and another MDR contains an incorrect date of birth is incorrect on 1 of 4 medication distribution records. The agency list of staff authorized to

assist in the delivery of medications should be updated in the MDR binder. The agency has two (2) medication error related incidents that involve the agency's direct care staff and the agency's Registered Nurse.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

4.04 The agency has policy and procedure that details the process for Medical/Mental Health Alerts.

5 files were reviewed-3 open and 2 closed

4 of 5 files had the alert in place on the file for the assessed needs of the client. One file had a psychosocial assessment that stated the child was in need of a green sticker and there was no sticker on the file. (one file had "none" marked for mental health/medical concerns however in the summary it was stated that the client had an allergy and the file was appropriately marked) It may be difficult to determine the reason for the alert in this instance.

Staff is trained on the alert system through the orientation process. Staff reads the policy and procedure on the alert system and follows up with a supervised hands on practice.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The shelter has a written procedure to address episodic/emergency care. There were two (2) episodic events within the last six (6) months.

Both episodic events were documented on the episodic log and in the program log book. There was documentation for the parent/guardian notification requirement and obtaining off-site emergency services i.e. EMS or the police for Baker Acts. A review of staff member training files indicated no on-going staff person was missing documentation for current CPR and First Aid certification. At the time of this review, the shelter had a first aid kit, wire cutters and a knife for life in the facility and in the transportation vehicles.

The agency did not document an event on 03/09/2013 that was required to be documented in the agency's episodic log.