Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House

on 02/27/2013

CINS/FINS Rating Profile

Standard 1: Management Accountability

Indicator	Rating
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Limited
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:85.71%
Percent of indicators rated Limited:14.29%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

Indicator	Rating
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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care

Indicator	Rating
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	Satisfactory

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

Standard 4: Mental Health/Health Services

Indicator	Rating
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%

Overall Rating Summary

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

Rating Definitions

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

Rating	Definition
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

Keith Carr, Compliance Monitor/Lead Reviewer, Florida Network of Youth and Family Services, Inc.

Latrice Covington, Contract Manager, Department of Juvenile Justice

Brent Musgrove, Contract Manager, DJJ

Raylene Coe, Street Outreach Coordinator, Crosswinds Youth Services, Inc.

Bethany Lacey, Supervisor Non-residential, Boys Town of Central Florida

Tracey Ousley, Regional Coordinator, CDS Family & Behavioral Health Services, Inc.

Persons Interviewed

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

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

1 Maintenance Personnel
2 Program Supervisors
8 Other

Documents Reviewed

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

5 Health Records
6 MH/SA Records
20 Personnel Records
27 Training Records/CORE
10 Youth Records (Closed)
24 Youth Records (Open)
2 Other

Surveys

4 Youth
6 Direct Care Staff
0 Other

Observations During Review

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

Comments

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

Arnette House staff members were extremely cooperative and provided timely response to questions and assistance during the review. The staff members possess good knowledge of their program and really seem to display genuine care about the youth they serve and the shelter in general.

Strengths and Innovative Approaches

Rating Narrative

The Arnette House, Inc. is private not-for-profit social services provider. Arnette provides services through a direct local service provider contract with the Florida Network of Youth and Family Services (FNYFS). The Arnette House primarily provides CINS/FINS services in Marion and nearby surrounding counties such as Lake County. The program is located at 2310 Northeast 24th Street, Ocala, Florida is under the leadership of the Cheri Brandies, Chief Executive Officer and a Board of Directors.

The agency's CEO is also a Licensed Mental Health Clinician and oversees all counseling and mental health services provided to youth and families delivered by the agency. The agency has professional staff members that oversee and handle all personnel and financial matters. The Arnette House program agency conducts screenings prior to hiring of all staff members. All staff members receive training that meets the annual training and internal professional development requirements.

The agency has restructured some of its program operations to deliver services more effectively. The agency has re-located counseling staff to the offices that are now located inside the residential youth shelter. The relocation of these staff has helped increase counselors access to residents and has initially reduced resident behavior problems and incidents.

The agency has increased its outreach efforts to the community. The agency's non-residential staff members have increased partnerships with local schools to increase awareness of CINS/FINS services. A non-residential staff member has increased the agency's role in delivering anti-bullying presentation and education support services. The agency operated a Summer Camp in 2012 for local youth in program and surround area. This camp featured numerous recreational activities, as well as offerred a two (2) week session with various courses and activities.

The agency has been awarded contract/grant funds for program services from other funding services. Contract/grant awards from other services include residential group care services from Kids Central; Basic Center grant award for shelter services for runaway and homeless youth; Food and Nutrition contract to provide breakfst and lunch for clients; and FEMA funding for food and kitchen products. The agency has also received local grant funds from the United Way in Ocala, Florida.

Standard 1: Management Accountability

Overview

Narrative

The program management team is comprised of a Chief Executive Officer, a Chief Financial Officer, A Shelter Program Manager, a Human Resources Officer and an Assistant Program Manager. In addition to the Shelter Program Manager, the residential component of the program is staff by one (1) Shelter Care Manager, four (4) Team Leaders, nine (9) full-time Direct Care Workers (DCW), 4 part-time DCW staff, a Education Specialist, a Food Service Coordinator and a Maintenance Technician. In addition, the Non-Residential staff includes 4 Family Counselors, 1, CINS Case Manager and 1 Intake Coordinator. The program is operated around three eight-hour work shifts. The shift times are: 7 a.m. to 3 p.m., 3 p.m. to 11 a.m., and 11 p.m. to 7 a.m. The clinical component of the program includes one (1) Licensed Mental Health Counselor, and a mix of Master's and Bachelor's level counseling staff. One of the Masters level Counselors is assigned to the Residential program that is currently working toward licensure. The program has also utilized the services of ten (10) volunteers for the current 2012-2013 fiscal year. The program maintains an individual training file for each employee, with live instructor led training provided by the Florida Network Trainer and on-line training provided through the Florida Network, computer-based trainings and by Orange County staff. Upon attending outside trainings. Annual training is tracked according to the employee's date of hire. At the time of the quality improvement review, the program had one (1) vacant full-time Team Leader, two (2) vacant Direct Care Workers and 1 vacant Youth Development Specialist. There is also a Community Outreach Development Specialist that conducts out reach activities, delivers presentations and marketing information related to programs services and establishes with local areas system partners and community organizations.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Arnette House has a concise policy that complies with the requirements for background screening of employees, volunteers, mentors, and interns. All persons working or volunteering at Arnette House are background screened prior to having contact with youth. The agency also does local law enforcement and driver's license checks for all employees. For this indicator, nine (9) files were reviewed – seven (7) were hired within the past year and two (2) were in-service employees. All files have documented evidence that background screens were completed prior to hire dates with no exemptions required. One employee file had a completed five (5) year rescreen, which was completed prior to the hire date. The annual affidavit of compliance with Good Moral Character was submitted prior to the January 31st deadline.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a detailed policy that upon review addresses the general requirements of this indicator. The agency has a code of conduct that requires all staff members to report any instance past or current abuse related incidents witnessed or reported by residents or staff. All youth admitted to the program are informed of the program's Grievance Policy and their right to call the Abuse Hotline. The Abuse Hotline number is posted in the day room and the number is also provided in the program client handbook.

The reviewer documented that the agency records both DJJ Central Communicator Center (CCC) Incidents and internal incidents. Of these documents there were a total of thirty-nine (39) internal incidents and three (3) DJJ CCC incidents. The program did not have program participants that submitted grievances between August 2012 and February 2013. To assess this indicator, a sample of grievances from February 2012 and August 2012 was reviewed to assess this standard. A total of ten (10) grievances were documented during this period.

A total of five (5) staff members and four (4) resident surveys were completed onsite during onsite review. Four (4) Youth survey results indicate that the residents indicate that they feel safe and rate mental health services provided here good. Youth surveys also indicate that three (3) out of four (4) reported that staff are respectful and do not use curse words. Five (5) out of 5 staff surveys indicate that staff reported that they have not observed any threats, harm or intimidating behaviors being used towards clients. Nor do staff report any use profanity by staff towards shelter residents. None of these documents, reports or survey results indicated evidence abuse, threats or intimidation in the shelter environment. Further, no residents or staff members indicate that they have either experienced of witnessed participants being deprived of basic needs, such as food, clothing, shelter medical care and security.

The agency provided copies of all personnel action forms related violations of code of conduct or work performance related issues. The agency provided a total of eight (8) cases that involved a range of work place and code of conduct issues. These staff members were cited for work-related issues and not performing the requirements of their jobs. The documents provided by the agency indicate that some staff received written warnings, reprimands and consultation regarding the employees' performance. Some employees were retrained, placed on the suspension or terminated as a result of their respective issues.

At the time of this onsite program review, there were two (2) DJJ CCC incidents indicate a youth behavior incident occurred January 2013 that is currently under investigation. An additional incident involving a complaint against staff incident for an alleged Code of Conduct violation for

exposing himself to a female client in November 2013 is also under investigation. The staff member involved in the latter incident was terminated from their position and is no longer employed with the agency.

One (1) youth survey reported the use of strong profanity by a staff member in a confrontation with a resident.

1.03 Incident Reporting

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. Arnette House has a policy on abuse reporting that includes incident reporting for staff, which meets the reporting requirements. Onsite documentation of internal reports was available and most typed making them easy to read. There were thirty-nine (39) internal incidents and unusual event reports for the past six (6) months and three (3) were reported to the Department of Juvenile Justice (DJJ) Central Communications Center (CCC). There were five (5) incidents documented in the agency's internal incident and unusual event reports that were CCC reportable. There is sufficient information that the three incidents were reported within the two hour time requirement.

It was recommended the agency update their incident report form and CCC reporting requirements.

Two (2) internal incident reports of youth injury and medication error were not reported to the CCC.

Three (3) unusual event reports of youth battery arrest were not reported to the CCC.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Arnette House has a detailed training policy that requires 80 hours of training for first year employees and 40 hours annually for on-going staff. All employees have an individual training file that includes a training, plan, annual tracking form, and supporting documentation. A total of thirteen employee training files were reviewed. Of the thirteen files reviewed, seven were first year employees and six were on-going employees. Six first year employees have exceeded 80 hours of training. Two of these six have completed their first year training and are missing core training topics required by the Florida Network for first year employees such as signs/symptoms of mental health and substance abuse, universal precautions, and cultural competency. All other first year employees are on track to completed the required training. The training files have documentation of CPR and first aid training.

Six (6) of the seven (7) on-going employees exceeded the 40 hours of required training. There was no documentation of signs/symptoms of Mental Health and Substance Abuse training for on-going employees. One on-going employee had no documentation of cultural competency training.

Two (2) first year employees that completed the required training are missing signs/symptoms of mental health and substance abuse, universal precautions, and cultural competency trainings.

One (1) on-going employee did not receive the reqired 40 hours of training.

There was no documentation of signs/symptoms of mental health and substance abuse training for all on-going employees.

1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. The program has a Service Agreement policy, last updated March 6, 2011; which meets the indicator requirement for designating an "Outreach and Prevention Specialist" to be responsible for securing Interagency Agreements that clarify the process for accessing services of an outside agency for program clients and for referrals from outside agencies of youth into the program. There is also a Referral policy, but it does not indicate or refer back to the Service Agreement policy.

The program meets the requirements of the indicator in maintaining its written agreements in an "Interagency Agreement Notebook 2011-2012". The agreements contained in the notebook are categorized as 'Prevention Programs', 'Medical', 'Educational', 'Clinical' and 'Recreational'. The notebook provides an index of the agreements contained therein, which has columns indicating the date the program sent out the agreement, the date program received the signed agreement back and the purported date of renewal for the agreement.

The program meets the requirements of the indicator because the majority of the agreements are current in that they were executed within the last 3 years. However, given that the dates reflected in the program's Interagency Agreement Notebook index show expired or soon to expire dates, it was necessary to review the execution date on each agreement.

The program uses a standard written agreement most of the time; which provides the services to be provided by each agency and the referral process involved. Eight (8) of the 'Prevention Program' agreements used this standardized format. All but one (JAC) of the eleven (11) total 'Prevention Program' agreements in the notebook were signed. The program's standard written agreement was also used for 'Medical' agreements and all but one (Munroe Regional Medical Center) was signed. Three of the four (4) 'Educational' agreements in the program's notebook were signed and all the 'Clinical' and 'Recreational' agreements were signed.

This reviewer asked Program CEO, Cheri Brandies, who was the program's designated lead staff person to oversee the interagency agreements and provision of community outreach. Ms. Brandies referred me to Adam Copenhaver, Community Development Coordinator. I asked Mr. Copenhaver about the notebook's index reflecting that most of the program's Interagency Agreements appeared to be expired or soon to expire. He confirmed that the agreements are valid for one year from the date of execution. The unsigned agreements are in the notebook with a correspondence copy of the program's request for agency execution and Mr. Copenhaver indicated that the executed agreements should be arriving soon.

Mr. Copenhaver regularly attends community meetings for local organizations such as: Non-profit Business Council, Marion County Homeless Coalition, Tobacco-Free Partnership, and United Way. He also attends grant writing seminars, local chamber of commerce meetings and is on the Board of Advisors for Life South (blood donation center). He is getting involved in the local Appleton Museum as he believes it would be helpful to the program. Mr. Copenhaver indicated that he enters his attendance and/or participation in regularly scheduled community events into NetMIS Outreach.

Ms. Brandies showed this reviewer the program's "Outreach Event Forms" notebook, wherein the program documents its outreach and retains agendas of meetings attended. NetMIS is updated regularly based on the information stored in this notebook.

Ms. Cindy Hayes, CINS Case Manager for the program indicated that she has developed an anti-bullying treatment plan that Juvenile Probation Officers refer youth to. When asked for a copy of the training materials, Ms. Hayes provided a case plan (developed in April 2012) that included, as a part of requried anger management treatment, a plan to address bullying behavior. Ms. Hayes indicated that she recently developed and gave an 'Anti-bullying' presentation to a student assembly at a local school and provided a print out copy of the presentation for review. The presentation appears to effectively engage youth and provides them with avoidance techniques and alternatives to engaging bullying behavior. Ms. Hayes indicated that she frequently gives verbal presentations to students, guidance counselors and other groups in the community regarding the services available from the program. Ms. Hayes provided this reviewer with the written materials the program frequently hands out, but indicated that most of her information is conveyed verbally.

Many personnel at the program participate in the program's community outreach efforts. Ms. Hayes indicated that the program's approach to outreach is more collaborative/team-based in that Mr. Copenhaver does not direct the outreach activities, but instead ensures consistency.

1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. The program meets the requirements of the standard for disaster planning by providing access to its written disaster plan procedures in a clearly designated notebook beside each exit of every building on its campus. The program's written disaster plan contains the required producures to follow in the case of: hurricane watch, hurricane warning, tornado, fire, flood, youth riot, hostage taking , shooting, terroristic acts, chemical spills, and bomb threats. Each disaster plan in every notebook reviewed indicated, by signature of the program's CEO, that it was reviewed annually.

The program's disaster plan designates a chain of command and provides the protocols for phone notification to the Florida Network and even lists the phone number. All personnel training files reviewed indicated that the program's staff receive annual training in the program's disaster plan and disaster preparedness procedures.

The program's disaster plan explains the conditions under which an evacuation would occur and, in such a case, provides instructions and procedures concerning the transport of youth, food, medicines, log books, case files, radios, and other necessities (e.g. a pillow and blanket for each person). This reviewer met with Shelter Manager, Mark Shearon, who pulled the emergency case file and medication transport container, as well as two (2) Emergency Kits (labeled as "Emergency Kit #1" and Emergency Kit #2), which contained necessities (batteries, flash lights, radios, over-the-counter medications and bandages) in case of an evacuation. These items were photographed.

The program met the requirements for secure transport and monitoring of shelter youth in case of an evacutation by specifying in each contingency under its disaster plan the procedures to be followed to ensure safe transport of youth and requires constant youth monitoring throughout the course of transport and housing at the designated evacuation facility. The program also has an established "Recovery Plan" that explains the process and procedures for return of youth and staff to the shelter.

The program meets the requirement for participation in the Universal Agreement Emergency Disaster Shelter plan, a signed copy of which is in the program's Interagency Agreement notebook.

1.07 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Arnette House operates several internal committees that have specific functions related to reviewing information and data, identifying trends and patterns and implementing interventions accordingly. The committees and sub-committees are: Safety, Health and Risk Management Sub-Committee addresses all safety, health, security and risk management issues.

The agency also has a Program Quality Improvement Council. Clinical Committee is comprised of agency Clinical and Counseling staff members. This group primarily discusses client behaviors, clinic

The agency tracks information in several categories that include: Clients Satisfied with Services, Number of Baker Acts, Number of Physical Aggression, Achieved Goals at discharge, Improved Daniel Memorial to Discharge, Incidents of Substance Abuse, Achieved Case Plan Goals, Runaways, Medication Errors, Client Satisfaction, Baker Acts, Physical Aggression Incidents, Achieved Goals at Discharge, Achieved Case Plan Goals. The agency also tracks, Residential Grievances and the number of clients that became adjudicated.

The agency provides bar graph charts on each of the aforementioned program performance areas. The agency provided copies of minutes from the three (3) aforementioned committees. The Safety, Health and Risk Management meeting minutes are maintained on a monthly basis. Meeting minutes are documented and forward to agency leadership to assess implications such as staff changes, funding decisions and potential liability or risks.

The bar charts in some program areas are not populated and ratios seem to not reflect an actual number of items to give the reviewer rates per the category. The agency tracks goals and trends. However, the agency makes few or limited references to the percentage or goal to reduce or address risks, trends or patterns over a designated period of time. The meeting minutes should include more information regarding the detailed meeting minutes, outcome, assignments and next steps.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Arnette House non-residential counseling program provides non-residential services for youth and their families in primarily Marion and Lake Counties. The non-residential component consists of a four Family Counselors, a CINS Case Manager and an Intake Counselor.   The program's intake and screening counselor initially handles calls from the public, as well as calls through the crisis intervention and screening services. 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. Arnette House counselors coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. Of the eight (8) files reviewed, eight indicated that each client received available service options, rights and responsibilities, and grievance procedures.

Of the 8 files reviewed, eight showed no documentation that the parents received a parent brochure or that the parent/family was provided information on the CINS/FINS Case staffing and petition process.

On 1 file, youth was admitted to Non-Residential services however updated consents were not identified and there is no documentation in the file as to the date of the intake for Non-Res.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. Of the eight (8) files reviewed, seven (7) files had psychosocial assessment completed within required time-frames.

Of the 8 files reviewed, one file did not have a current psychosocial assessment within the last six months.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. Of the eight (8) files reviewed, all seven (7) files had service plans which identified needs and goals, type, frequency, and location, person's responsible, target dates for completion, actual completion dates, signature of youth, parent/guardian, counselor, and supervisor, and the date the plan was initiated.

Of the 8 files reviewed, One file reviewed had a Non-Res service plan completed two days prior to the intake into Non-Residential services.

Of the 8 files reviewed, six of the files did not designate what each review was (i.e. was it the 30 day review or the 60 day review, etc).

Of the 8 files reviewed, four of the files appeared to have the service plan reviews completed/reviewed late (not within 30, 60, 90, 180 day time-frame).

Of the 8 files reviewed, one file was missing the youth signature on the initial service plan and the parent signed the 60 day review late. On one file youth did not date the signature on the initial service plan. On one file, the counselor did not date the signature on the service plan. On one file, the youth did not date the signature on the 14 day review.

On three (3) files the tab on the outside of the file lists different intake dates which do not apply to the Non-Res intake.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. Of eight (8) files reviewed, all files indicated that each youth/family had an assigned counselor/case manager. Each client had a variety of services provided to them which include Individual Counseling, Family Counseling, Case Management, monitoring of out of home placement, and referrals to other agencies as applicable. Services provided are documented in case notes and on the contact log. In addition to these services, Arnette House offers parenting classes, group counseling, bully prevention, Case staffing and petitions, anger management (both group and individual), SURF program (basic living skills group completed once per week with all youth on site), On site school, Cooking classes, summer camps, outdoors program which includes kayaking and camping, and therapy dogs which come twice per month.

Of four (4) discharge files reviewed, all indicated that a discharge summary had been completed and provided to the family within required time-frames. Parent, youth, counselor, and supervisor all signed each discharge summary.

180 follow-ups are being completed regularly and were organized and stored in a binder. Florida Network benchmarks reviewed indicated that Arnette House is completing 180 days reviews at least 98% of the time since July 1, 2012 to this present date. Also documented is that Arnette House also completes 30 day reviews for both Res and Non-Res which exceeds the standard.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. All files reviewed (both Res and Non-Res) indicate good threading of service plans addressing presenting problems and issues notated on the psychosocial are included in the service plan.

The Group log for the last three (3) months was reviewed which indicated that groups are being held for the youth in the shelter on a consistent basis with some exceptions.

Of files reviewed, there is evidence that individual case files are maintained for each youth and chronological case notes on the youth's progress are documented in the file.

Clinical reviews of the files is being completed by staff since August 2012, with some exceptions noted. Monitoring of staff performance is conducted on the yearly evaluation as evidenced in the staff personnel files.

The Group log for the last three months was reviewed which indicated that groups are being held for the youth in the shelter on a consistent basis with the followig exceptions: For the weeks of 12/16/12 , 12/23/12, and 12/30/12 no groups were held at the shelter (it was notated that this was because of "Christmas break" though staff reported youth were in the shelter at this time). Group was not held the required 5 days for the weeks of 1/13/13 and 1/20/13 (it was notated that this was due to "no school").

Clinical chart reviews has limited documentation of review. A summary of the chart review was only available for the last two (2) months as, per staff, it was not being completed before that. That documentation does not provide feedback about youth management or staff performance/development as outlined in the standard.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. The program meets the requirments for establishing policies related to case staffing and CINS petitions. The program has a Case Staffing policy, which sets forth the required staffing members (CINS representative and a school district representative) and lists non-exhaustive optional members. The policy also requires that parents must be notified by certified mail no less than 5 working days before a committee staffing and that parents receive a copy of committee staffing recommendations no less than 5 working days after the staffing. The Case Staffing policy indicates that the program must provide services to the family before referral to a case staffing. The program also has a policy related to the CINS Petition, which outlines procedures leading up to the filing of such a petition; which is the result of a recommendation from the Case Staffing. The program's CINS policy also establishes case review timelines.

The program meets the requriement for establishement of an internal procedure for the case staffing process. Cindy Hayes, CINS Case Manager, provided this reviewer with a copy of the program's "Referral Checklist for Case Staffing"; which has attached a NetMIS screening form and CINS/FINS Risk Factor Form. Per Ms. Hayes, the checklist is routinely used by the program staff.

This reviewer reviewed six (6) non-residential case files for compliance with the indicators for this standard. Of the files reviewed, only one reflected that a parent had requested a case staffing. In this instance, the staffing was convened within seven days of the parent's request and the the committee members were notified in no less than five (5) days before the staffing. The other five (5) files reviewed indicated that the program's CINS manager initiated the case staffing and provided notice to the parent/family and other committee members no less than five (5) working days before the staffing. A case treatment plan was either established or revised as a result of each staffing reviewed. The program meets the requirements for this indicator.

A review of the Case Staffing recommendations in each of the six (6) files indicated that the program's CINS case manager and a school district representative were always in attendance at the staffings. Although no state attorney or law enforcement representative attended any of the staffings in the files reviewed, other attendees included, as relevant, parents/guardians, a substance abuse treatment representative (two (2) cases), mental health representative (three (3) cases) and a DCF representative (one (1) case). The program meets the requirements of the indicator regarding membership of the case staffing committee.

In each of the two (2) cases referred for judicial intervention, the program's CINS Case Manager completed a review summary informing the court with details of about the youth and making recommendations for the court's information. The program incorporated judicial involvment to improve effectiveness of intervention services in both cases reviewed that involved such judicial referral. The program meets the requirements of the indicator for provision of a review summary to the court prior to the review hearing.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy that addresses the genearl requirements of this indicator. Sample of sixteen (16) client files were assessed for adherance to this indicator. Of 16 files reviewed (8 Res and 8 Non-Res), all files were marked confidential. All files are kept locked in a secure room and are accessible to approved staff. Active Residential files are stored in Direct Care Worker Office in the shelter and the rest of the files are stored in the file room in the shelter (both are locked at all times).

Of 8 Non-Res files reviewed, all had documents which appeared old and over copied.

Of 16 files reviewed (8 Res and 8 Non-Res) all files reviewed were not maintained in a neat and/or orderly fashion as evidenced by the fact that Residential and Non-Residential files were combined into one folder. In addition to both programs being combined, if a youth had multiple intakes into each program, all were combined into the same file and the paperwork was disorganized and mixed together in each file.

Of files 16 reviewed, six files (both for Res and Non-Res) the date of intake written on the outside of the file was not correct and/or updated with the most recent intake date.

Of 8 Non-Res files reviewed, three (3) files did not have sufficient information in the file to determine the intake date for Non-Res. This data had to be retrieved by staff from Netmis to confirm.

Overall all information was challenging to locate overall, but sufficient information was to found determine this indicator as satisfactory.

Standard 3: Shelter Care

Overview

Rating Narrative

The Arnette House youth shelter is located in Marion County. The facility is in operation twenty-four hours per day, seven days per week, every day of the year and is licensed by the Department of Children and families for thirty (30) beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of seven (7) youth in the shelter. The shelter is comprised of a large central building that has two (2) separate hallways on opposite sides of the building, to house female youth on one hallway, and male youth on the other. Each hallway can house up to fifteen (15) youth. The hallways are separated by a dayroom, a kitchen and Direct Care Work Station. When not in school, the youth spend a majority of their free time in the dayroom either engaged in group activities, playing video games, watching television or completing homework assignments on the computers. Youth attend local area schools if they are not on suspension, expulsion or suffering from an illness. There is an industrial kitchen onsite where all meals are prepared. The large day room also acts as a cafeteria where the youth eat their meals. The program's Continuity of Operations Plan (COOP) has been approved by the Florida Network. The Florida Network received the program's emergency response plan and hurricane plan that was revised on November 11, 2012. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the Program Director.

The shelter staff includes a Shelter Program Manager, a Shelter Care Manager, four (4) Team Leaders, nine (9) full-time Direct Care Workers, 4 part-time Direct Care Workers, an Education Specialist, a Food Services Coordinator and a Maintenance Technician. A minimum of two (2) counselors are assigned to the residential youth shelter.

The Direct Care Worker staff are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The shelter's direct care staff are trained to provide the following services for the youth: screening, medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR) and referrals. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis.

The medication and first aid supplies are stored in the staff office in a locked desk behind a locked door in the Direct Care Worker Office. The Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The counseling also now are located in the youth shelter. Residential services, including individual, family, and group services, are provided to youth and families. Case management and substance abuse prevention education are also offered. The shelter has a color-coded medical and mental health alert system in place. The program also has an effective grievance process. When submitted grievances are responded to within twenty-four hours of being submitted to management. No grievances have been submitted in the last six (6) month. At the time of the quality improvement review, the shelter was providing services to seven (7) CINS/FINS youth. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

The shelter's direct care staff are trained to provide the following services for the youth: screening, medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR) and referrals. The Direct Care Worker staff are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. Youth admitted in the shelter program are provided a review of the youth handbook with the staff, and time to ask questions and take a tour of the shelter. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis.

3.01 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program (Arnette House) demonstrates the goal of Youth Room Assignment by effectively following Policy and Procedures Manual for CINS/FINS, Florida Network of Youth and Family Services, 4.01 (2012) to protect youth through an effective classification process that ensures the most appropriate room assignments for youth.

The program (Arnette House) provides and utilizes a teen screening assessment form for each youth admitted to the program. The teen screening assessment form provides the necessary information for the program to effective assess the youth and assign the youth a bedroom.

The program (Arnette House) has eight factors in determining Youth Room Assignments such as:

- Physical characteristics, which include age, sex, height, weight and general physical stature.
- Level of maturity and its effect on his/her needs.
- Gang affiliation, if applicable.
- Current alleged offense, including whether or not the offense was against person or property.

- Prior delinquent history and background.
- Level of aggression and ability to act responsibility.
- Attitude upon admission to the program.
- Past involvement in assaultive or aggressive behavior, sexual misconduct or demonstration of emotional disturbance.

Other factors staff consider for Youth Room Assignment

- Cots will be used and placed by staff station if a youth is admitted during the night if program is at capacity.
- Rooms closest to staff station are assigned first. In addition, younger youth may be placed closer to staff station.
- Costs will be used and placed by staff station is youth is in need of constant supervisor for own safety and/or safety of others.

The Reviewer was able to review four (4) youth files for the program (Arnette House) while on site on February 27, 2013. The program files were constant with the required information with each youth file in accordance with the Policy and Procedures Manual for CINS/FINS, Florida Network of Youth and Family Services, 4.01 (2012).

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program (Arnette House) provides job training for staff with an emphasizes on youth orientation. The Reviewer was able to evaluate four (4) youth files for the program (Arnette House) while on site on February 27, 2013. The program files were constant with the mandatory information with each youth file in accordance with the Policy and Procedures Manual for CINS/FINS, Florida Network of Youth and Family Services, 4.01 (2012).

Upon review of each file the program was able to illustrate:

- Handbooks were provided within 24hours.
- Disciplinary actions were explained to each youth.
- Grievance procedures were explained to each youth.
- Emergency/Disaster procedures were explained to each youth.
- Contraband rules were provided to each youth.
- Physical/Facility layout map were provided to each youth.
- Room Assigned to each youth.
- Suicide prevention-Alert notification (if applicable)
- Dress code rules explained were explained to each youth.
- Signatures of youth with parent/guardian obtained.
- Daily activity scheduled was provided.
- Abuse Hotline number was provided.

3.03 Shelter Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Arnette House Shelter was observed to be very clean and attractive in appearance. There is a girls' hallway and a boys' hallway. Each room has two beds, two dressers, a closet and a bathroom that is shared with the adjoining room. Each youth has their own bed with sheets, pillow and a bedspread. Youth are allowed to decorate their rooms and they are able to secure personal belongings in lockers located in a closet in each hallway. Bathrooms were recently renovated and appeared clean functional. Shelter furnishings are in good repair and no graffiti was seen in the facility. The kitchen and dining area is well maintained. Cycle menus covering a four week period are posted in the kitchen. A Food Service Health inspection was conducted on 2/19/13 with no deficiencies. A Group Care Health Inspection was done on 12/17/12 with no deficiencies noted. There is monthly pest control service and no insect infestation was observed. The shelter has adequate lighting throughout the facility. Disaster Plans were located at exits throughout the facility. Evacuation routes were display in each room. A Grievance Box as well as Grievance forms are n the wall in the dining area/dayroom. The grounds are clean and nicely landscaped. There is an attractive garden area located between the shelter building and the Brannen building. The grounds also contain a basketball court, volley ball and football areas and a picnic area/pavilion.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Log Books were reviewed for the time period of August 13, 2012 through February 27, 2013. All of the books were completed in a consistent format. They use a color code for highlighted items documented in the log book. There is consistent formating of staff entries acroww work shifts. The agency is capturing all major events and activities as required. The agency Shelter Program Manager documents summaries that give direction praise. These entries made by Managers also disseminate crucial program information and grive direction on areas of focus. The agency also uses an attractive color-coded highlight system that identifies major programmatic and operational issues.

Some entries are not signby the staff making them following certain entries. Some weekly reviews by the Program Manager fall outside weekly logbook review timeframe. Previous work shifts are not being reviewed by all Direct Care staff rather Team Leaders review the logbook and pass it on to Direct Care workers on shift. All staff on shift should document that they are reviewed a minimum of the past two (2) work shifts.

Rating Narrative

A review of the shelter schedule, discussion with staff member and observation of some shelter activities confirms that the program provides a variety of structured activities. A minimum of one (1) hour of physical activity daily is provided through outside activities such as basketball, football, volleyball, some canoeing events and swimming in the summer months. A Wii game is also used for exercise or low rate activity. Youth from the local area attend their regular off site school while others attend the on-site school. Nutrition classes are regularly held at the shelter. Outside agencies and individuals come regularly to provide activities such as substance abuse education, baking classes, interaction with therapy dogs and bible study. Alternate activities are offered for youth not wishing to participate in faith based activities. The program recently began providing homework time daily as a direct result of poor grades on report cards. This occurs around 4:00pm when youth attending off site schools return. The program has a pool table, various board games, and cards for use during free time. A nightly group is held with youth to review their daily journals and to set goals for the next day. Quiet time is scheduled daily during which youth are allowed to read. The schedule is posted in the shelter where it is accessible to both youth and staff.

3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a current policy in place detailing the process and procedure. Arnette House utilizes the Point System. Youth have an opportunity to earn points throughout the day for 10 different functions/activities. They can earn 1 point for displaying appropriate behavior in waking up and at bedtime and 2 points for chores, breakfast, school, lunch, group, dinner, outdoor/free time, shower/hygiene for a total of 18 points per day. Each youth who earns all the daily points gets 25 bonus points added to their total. A male peer leader and a female peer leader are selected weekly and they determine the number of points earned by the other youth in shelter. Once earned, points cannot be taken away. Accrued points may be used to purchase items at the shelter store each week. Items for sale in the store include candy, sodas, hygiene items, clothing, stuffed animals, and jewelry among other things. Points are displayed on a dry erase board in the day room and on an individual point sheet maintained on the computer and tallied daily on the evening shift. Consequences for undesirable behavior include earning no points, to losing privileges such as going on off-site activities or losing pool table privileges. Under current practice, a Team Leader determines when lose of privilege is appropriate and privileges cannot be suspended for longer than one day.

In addition to the Point System, the program utilizes the RAPS problem solving process to determine the natural consequences of actions, rather than staff administering punitive consequences. The process involves recognizing the problem, admitting contribution to the problem, problem solving and solution. According to staff, this process is used when youth have issues with other youth in shelter. The youth

themselves are able to “call a RAPS” to bring up issues. The RAPS groups take place in the hallways with separate groups for the males and females. Training files reflect that staff receive training in the Behavior Management System. Staff evaluations rate implementation of behavior management system. Supervisors received additional training monitoring staff’s use of behavior management system.

3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A policy is in place to deal with behavior interventions. The policy dictates that the least amount of force necessary is utilized. Arnette House policy prohibits the use of identified prohibited discipline measures outlined in the indicator and identifies counseling, verbal intervention and de-escalation techniques as being used prior to physical intervention. It also prevents disciplinary measures from denying youth regular meals and snacks, clothing, sleep as well as the other basic rights listed in the indicator. The policy stipulates that the program only use natural consequences when dealing with the residents. Practice as reported by staff is that the program uses a “hands off” approach when dealing with program youth and that room restriction is not utilized. A review of the incident reports revealed no incidents where physical intervention or room restriction was used. This was confirmed by program staff. Training records reflect that staff members are trained in Crisis Intervention Skills.

3.08 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program (Arnette House) policy provides adequate staffing to ensure safety and security of the program, staff, and youth. The program policy follows the youth and staff ratios guidelines set in place by Florida Administrative Code.

Upon review of six (6) video work shifts and seven (7) work schedules the program was able to illustrate:

- The program was constant with mandatory ratios guidelines set in place by Florida Administrative Code of 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleeping period.
- The Reviewer was able to establish the program (Arnette House) had ampule staff scheduled for the program’s set schedules of 7AM-3PM, 3PM-11PM, 11PM-7AM.
- Staff was observed doing bed checks every fifteen minutes while on duty during the night shifts.
- Program has put in place a bed check form to ensure bed checks are completed and ensure “head counts” are properly recorded.
- Program is properly staff within its own policy to assure safety of youth with male/female staff on all program shifts.
- Program provides adequate staff on the night shift to accommodate “alerts” such as illness or suicides.
- Staff schedule is provided as well as posted post for staff. In addition, staff information is made available regarding telephone numbers for all staff if additional coverage is required for any work shift.

NOTE:

- Program has provided a monitoring tool for the Program Manager by having video surveillance of the facility 24 hours a day.
- Program Manager attempts to schedule staff in relationship to gender of management (ex-Female Supervisor Male treatment staff)
- Program was aware of time delay issue could occur on video feed once a week.

3.09 Staff Secure Shelter

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency is not designated by the Florida Network of Youth and Family Services as as Staff Secure service provider.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Arnette House program provides screening, counseling and mental health assessment services. The agency has a Shelter Program Manager that oversees the daily operations of the youth shelter. The Arnette House program has direct care staff members are that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency utilizes screening and risk factor identification techniques to detect youth referred to their programs with mental health and health related conditions. Specifically, the agency uses a multi-step screening form that combines the components of the initial screening and the CINS Intake form to determine CINS/FINS eligibility status and the presence of risks. The form also captures the youth's past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The agency also uses a general alert colored identification clip board system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The Arnette House residential program assists in the delivery of medications to all youth admitted to the youth shelter with medication or over the counter medications that are prescribed by a Physician. The agency operates a detailed medication distribution system. The agency provides medication distribution training to all direct care staff members including first aid, CPR, fire safety, emergency drills and exercises and training on suicide prevention, close watch observation and crisis intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health issue or injury during their shelter stay. At the time of this onsite Quality Improvement review, the agency's CEO is a LMHC and one other staff person is working towards their licensure. These staff members are primarily 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 the majority of work shift. At the time of this onsite review, the agency reported four (4) vacancies in full and part-time Direct Care Worker staff. During this onsite QI review, the agency provided an up to date list of eight (8) agency staff members that have been granted access and are authorized to assist in the delivery of medication to residential clients.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency/local service provider has written procedures called Health Screening on Admission to address the admission process to include an in-depth health screening through the completion of the CINS Intake Assessment form (03/16/11). The written procedures addressed the referral process and follow-up medical care. The health screening form addresses all elements of the indicator. The screening form is housed in Part 1: The Consent Section. That includes medical and mental health consent, visitor and visitation information and Consent for Emergency Shelter. The agency uses Medical and Mental Health Alert form is used to screen for acute health conditions. This form contains twenty (21) medical conditions categories for detail other acute health or medical issues (current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings). In the same section, the agency utilizes an Injury/Limitation Documentation. This form includes the opportunity to screen for scars, bruising, tattoos, broken or dislocated bones and other conditions. Residents are also screened for health issues in the Assessment section of the Psycho-social Assessment. This includes any conditions that the agency would need to be aware of such as respiratory, injuries, broken bones, on any medication or existing allergies. Health and mental also asked during the screening and assessment form prior to the child being considered for eligibility and admission to the program. The Arnette House Residential Admission Data form compiles information on the Injury Limitation form and the Medical/Mental Health Alert form.

The procedures indicate that staff would contact the parent/legal guardian to obtain information about pending appointments with medical professionals, current medications and general precautions in the case of an emergency. Documented in Logbook, notify parents and draft an incident report. All medical referrals are documented on a daily log.

All five (5) files (5open) reviewed contained documentation of the CINS/FINS Intake form that was completed the day of the youth's admission. The form addressed all elements of the indicator as required by the indicator. All 5 files reviewed contained the required forms.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter had a written plan that outlined the suicide prevention and response procedures. The plan indicated each youth admitted to the shelter will be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. The agency uses the Teen Screen to determine the presence or level of suicide risk and any type of MH symptoms (anxiety, depression, phobias, etc.). The Teen Screen is administered via a computer station. The Teen Screen is an automated electronic application the verbally asks youth to answer questions

regarding the current presence of suicide, substance abuse, phobia, panic attacks, obsessive compulsive, eating issues, ADHD, Oppositional Defiant Disorder, Conduct, Marijuana use and other substances in the last 6 month. If the youth answers “yes” to any of these conditions questions, then they will receive 1 point and a no response the youth receives zero points. At the end of the survey all points totaled. If there’s a yes response to any of the Suicide Risk questions in the last six months, the child is placed on constant sight or sound (Have you been Baker Acted, Felt like harming yourself, Actually harmed yourself, Thought harming yourself, but not acted on it in the last six months.). The agency places then places the resident on constant sight and sound and immediately the staff complete the suicide precaution log. This log requires staff to document their observation and time and initial every ten (10) minutes. A Master’s level Counselor meets with the client and administers an Assessment of Suicide Risk form. Four (4) different outcomes are possible related to the completion of this form that include Emergency Transport – Baker Act, Continue the Youth on Constant Sight and Sound and reassess in 24 hours, Discontinue Sight and Sound – and Remain on Cot for close supervision, Discontinue Constant Sight and Sound. If a youth is coming off a Baker Act within 24 hours to a week the agency immediately places the resident on constant sight and sound. The masters level counselor under the supervision of a Licensed Mental Health Counselor consults with the. Signatures to confirm a review of suicide prevention assessment are documented that the counselor consulted with the LMHC within 24-72 hours. Removal form constant sight and sound to regular supervision is verified within 24-72 hours. If a qualified mental health professional is not available the youth will be placed on Constant Sight and Sound supervision until a full suicide assessment can be completed by a qualified mental health professional. The 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. The reviewer met with Crystal Westman, MA, Residential Counselor/Clinical Supervisor to review.

A total of four (4) files reviewed (2 open files and 2 closed files) contained documentation that indicated a suicide risk screening and a positive Teen Screen resulted during the initial screening and intake process. All 4 files contained documentation that indicated that the Teen Screen, suicide screening results were reviewed and signed by the supervisor who was also the licensed clinical social worker. All applicable youth were placed on sight and sound supervision until assessed by a licensed professional or non-licensed staff under the direct supervision of the licensed professional. The supervision level was not changed or reduced until approved by a licensed professional. All four (4) files were applicable for requirements of a suicide risk assessment. All files contained the required documentation. All files 4 files were applicable for sight and sound supervision requirements. All youth were placed on the appropriate level of supervision based on the suicide risk assessment results. Supportive documentation was reviewed to include precautionary observation logs and thirty minute checks.

The agency observtion notes in one file in the sample indcated that this file had an incorrect date when the supervision level change date or removal from sight and sound supervision was ordered. The date listed 01-29-2013 instead of 01-30-2013. The correct date was found and the file was corrected accordingly.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Medication policy that addresses all major areas of medication distribution and assisting in the delivery of Medication. The agency medication policy was last approved/updated on July 1, 2012. The policy now requires that staff verify that all medication entering the shelter be from a licensed pharmacy. All medication of open cases reviewed onsite include documentation the recent verification procedure is documented as required.

The agency does not provide residents with over the counter (OTC) medications. All residents that have a need to take OTC medication must have a have doctor’s prescription accompanying the medication in order for it to Staff must also ensure that all youth taking over the counter medications ensure that these medications are approved for use by a physician.

A review of current youth in the shelter currently on Medications was conducted. A sample of the medication distribution records of four (4) current youth in the shelter and three (3) closed files were reviewed to assess the agency’s adherence to standard. All files have major sections completed including the client’s name, picture, medication dosage, allergies, side effects, staff initials, youth initials. The Medication Distribution Log (MDL) contains evidence of the staff member’s printed name, signature and initials. Youth initials are documented, but no full signatures are documented. The MDL on the majority of the files sampled indicates that youth medication records include most required documentation in the aforementioned areas.

Also this MDL did have a Verification Form that included all evidence of verification documented for each case file. One medication related incident documents that the agency contacted a youth’s guardian to inform them that the youth’s was close to being depleted of their current prescription. The agency contacted the guardian file had areas completed as required. There were no medication incidents reported to the DJJ CCC in the last six (6) months.

The medication distribution logs (MDL) of four (4) open client file cases and three (3) closed client cases were reviewed for accuracy. The review found that shift to shift counts in 3 out of 4 medication files contained no documentation errors. One (1) client file contained an initial error that revealed there were no staff member initials on the MDL confirming what staff assisted in the delivery of medication on the second shift. Two (2) out of 4 youth files did not have evidence of a staff member’s initials when assisting in the delivery of medications. Three (3) out of 3 MDL closed client records (Oct, Nov and Dec) each have evidence of at least one medication distribution session with missing staff initials and or youth initials on the 3:00PM-11:00PM medication shift count.

Staff signature column has a mix of staff signing and many staff leaving just initials in the signature column. Agency should require staff to initial where the column asks for initials and signatures when the column asks for signatures.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The shelter has operating procedures that identify youth with medical/mental health alerts. Five files were reviewed for medical/mental health alerts. The alert system includes an Alert System/Service Provider List that is found in the youth's chart, an alert system is located on a mobile clipboard and is located in Direct Care Work station. This clipboard includes a color key that coincides with the respective medical, health and behavior risks. The program logbook and pass down log also include updated changes in a youth's condition. Youth identified during the screening process as having a medical and/or mental health issue are identified with an alert.

The agency also includes alerts on and in the client file. These alerts indicate the current risks, health or mental issues detected during the program's screening and intake process. At the time of this onsite review, an assessment of 5 client files indicates all files reviewed were in adherence to agency's medical and mental health alert process.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program (Arnette House) follows written procedures that ensure the provision of emergency medical and dental care for youth. The program's procedures include the following mandatory components:

- Obtaining off-site emergency services.
- Parental notification requirements.
- Development and implementation of a daily log.

Upon review of the program (Arnette House) the program was able to provide proof of the following safety items:

- First aid kit in each building and vehicle.
- Knife For Life.
- Universal Precautions Bio Hazard disposal bags.
- Wire cutters.

Upon review of seven (7) program staff files regarding medical training with CPR, Bio Hazard, and First-Aid the program was able to provide the following items:

- CPR was successfully completed on 6 out 7 program staff files.
- First-Aid was successfully completed on 6 out 7 program staff files.
- Universal Precautions was successfully completed on 3 out 7 program staff files.

The program (Arnette House) provides an Episodic Emergency Care Log book for reporting incidents. Time periods that were reviewed were between August 2012, through February 2013 there were a total of three (3) episodes reported and properly filed in the Episodic Emergency Care Log. However, the program (Arnette House) provides an Incident Reports & Unusual Reports Log book for reporting incidents. There was one (1) episode reported that required off-site emergency services (1/16/13). Staff followed program requirements for off-site emergency services on (1/16/13). However, staff did not properly file incident report in the Episodic Emergency Care Log book. This was documented in Indicator 1.03.