



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House

on 03/11/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition 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 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Ramona Salazar, Program Monitor, Department of Juvenile Justice

Felecia Wells, Program Director, Youth Advocate Programs, Inc.



Quality Improvement Review

Arnette House - 03/11/2015

Lead Reviewer: Ashley Davies

Cynthia Starling, Regional Coordinator Interface East, CDS Family and Behavioral Health Services, Inc.

Amy Gierhahn, Clinical Supervisor, Hillsborough County Department of Children's Services

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers | 1 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 0 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 checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" 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 | 5 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 23 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 5 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 5 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

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

Observations During Review

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

During the Quality Improvement review the program was in the process of replacing twenty-two bedroom doors in the shelter with steel fire doors. The county has been supportive of the shelter and the agency received the Community Block Grant to replace the doors.

The shelter also received a new walk-in freezer that was donated by the local Sheriff's office.

The agency also re-vamped the group room in the shelter used for therapy. A wall was torn down to open up the room and the room was given a more "homey" feel. Also a punch bag was placed in the room, as well as, a sand table and other therapeutic activities.

The weekend following the on-site review the agency will host its annual Benefit Auction. This is the agency's main fundraiser for the year and consist of a live and silent auction and a dinner.

The agency reported CINS/FINS numbers have been down the last couple months.

The agency received its COA recertification in July 2014.

The agency has provided all their counselors and case managers with Surface Pros which has helped them when out in the community and at schools, to be able to quickly access and input information.

The agency also reported they are going to be going to on-line files for their non-residential services.

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 a Clinical Supervisor. In addition to the Shelter Program Manager, the residential component of the program is staffed by one (1) Shelter Care Manager, four (4) Team Leaders, nine (9) full-time Direct Care Workers (DCW), and three (3) part-time DCW staff, an Education Specialist, a Food Service Coordinator, an Intake Coordinator, and a Maintenance Technician. In addition, the Non-Residential staff includes four (4) Family Counselors. 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. At the time of the quality improvement review, the program had two (2) vacant part-time Direct Care Worker positions.

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 shelter maintains individual training files for each employee. Annual training is tracked according to the employee's date of hire. There is also a Community Outreach Development Coordinator that conducts outreach activities, delivers presentations and marketing information related to programs services and establishes relationships with local areas system partners and community organizations.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

There were twelve staff hired since the last annual compliance review. The background screening for all twelve files were completed before the staff's date of hire. There are eleven volunteers/interns currently at the program. These files were also reviewed and all background screenings were conducted prior to volunteer/intern placement. Of the 23 background screenings reviewed, all were eligible or eligible with charges. Only one screening required approval by the Deputy Secretary and the approval was found in the file. There were no staff requiring the five year rescreen and the annual affidavit was completed and submitted to BSU on January 20, 2015.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

There are abuse hotline postings throughout the dorm living units, multi-purpose rooms and the dining halls which include the hotline phone number. There were six youth surveyed regarding the abuse hotline, access, staff language towards youth and feeling safe in the program. All youth responded that they are aware of using the abuse hotline and how to access the hotline number if needed. Five of the six youth responded that they have never been denied access to call; one youth did not respond. Youth surveyed indicated staff are respectful and only one youth indicated (s)he has heard a staff curse but could not remember who it was. Youth feel safe at the program however one reported that (s) he was extremely homesick and needs to contact dad. All youth are aware of the grievance process and how to access.

Youth rated the grievance process as good or very good.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The Arnette House has a policy and procedure for incident reporting. The operating procedure provides staff with a process for incident reporting which includes notification, calls and documentation. The process provides direction for the completion of an incident report form upon having immediate or thorough knowledge of an occurrence involving property, a client or staff member. Incident reports are to be completed, they are to be thorough and detailed to include documentation of law enforcement, EMS or DCF or DJJ involvement information as indicated per policy. A review of the CCC system and applicable incidents were found in the incident binder and all incidents were called into the CCC reported within the required 2.0 hour timeframe. There were a total of eight incidents within the last six months.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. They have a training plan that is reviewed and updated annually. The CEO, CFO, HR Officer, Shelter/Group Home Manager and Clinical Supervisor all sign off on the plan. All full time employees are required to obtain a minimum of 80 hours the first year and 40 hours annually after that. Supervisors are required to have 12 hours of their 40 annual hours in management theory and management skills training. Non-residential staff are required to also have 40 hours of training annually after the first year. They have outlined in the plan specific required training for direct service staff, orientation, Florida Network training, DJJ and DCF training.

There were six training files reviewed, three for first year required training and three for annual ongoing training. The three files reviewed for first year required training all documented more than the required 80 hours with 136.75, 125.5, and 122.5, respectively. All three files documented all required trainings with the exception of Trauma Informed Care.

There were three training files reviewed for ongoing annual training. One staff made the 40 hour requirement with 61 hours and the other two did not, one had 28 and one had 36.5. All files documented all required trainings with the exception of one staff who did not document Fire Safety Equipment Training for that training year.

The agency's training files are very organized and easy to navigate through. Each staff had an Individualized Training Plan for their job position that listed mandatory training topics, hours completed, date completed, and total hours completed.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

There is analytical data and reporting information that is collected and provided through the NetMIS system. The data analysis is compiled through several data reporting sources to include outcome data, quarterly review of incidents, accidents and grievances, annual customer satisfaction survey results and case record reviews. The data can be found in the facility binders for each of the areas noted. Findings, recommendations and action needed are provided to staff as a guide on the different data sources that need action. This includes a review of data by the Board of Directors as found in the meeting minutes. A review of meeting minutes includes Performance Quality Improvement recommendation, census information, and upcoming events/important dates. There is also a Council Committee Meeting Minutes binder which includes implementation of QI plan, review of sub-committee reports, corrective action plans, client grievances and monthly benchmarks. There is a sign in sheet for those in attendance with the start and end time of meeting. The minutes provides details about topics discussed and recommendations. There are subsections and sub-committee minutes such in the following areas; safety, clinical, finance, review client grievances - recommendations, and an HR committee. Data is inclusive of youth demographics such as youth admissions, exits, ethnicity, gender, residential and non-residential youth services, risk factors and length of stay. Annual surveys were also available and were reviewed for FY 13-14.



Quality Improvement Review

Arnette House - 03/11/2015

Lead Reviewer: Ashley Davies

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Arnette House is contracted to provide both CINS/FINS residential and non-residential services for youth and their families in Marion and Lake Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week for status offenders including runaways, truants, ungovernable and lockout youth. A three level assessment is offered, Intake, Basic, and Comprehensive, depending on the specific needs and services provided to the youth and family. Case plans, based on the findings of the assessment, involving the participation of the youth and the parent/guardian, are developed for the purpose of identifying the services and treatments that will be needed to assist the youth/family in achieving their goals.

Residential services include individual, family and group services. Case management and substance use prevention education are also offered. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance. Non-residential services include individual and family counseling and case management services provided in both Marion and Lake Counties. School based and office based services are offered. Roughly 70% are school based and 30% are office based. Arnette House works closely with the public school system in both Marion and Lake Counties. In Lake County, Arnette House works closely with Truancy Court.

The non-residential program case management service is responsible for coordinating the Case Staffing Committee, a statutory mandated committee that develops a plan for persistent habitual truant, lockout, ungovernable and runaway youth when other services have been exhausted or upon the request of the parents/guardians. The Case Staffing Committee may/may not also recommend the filing of a Children In Need of Services (CINS) petition with the circuit court. The CINS case manager tracks each case through the Case Staffing Committee, implementing the plan developed by the Case Staffing Committee and, if needed, track each case that is referred for a CINS petition throughout the duration of the judicial process.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. Youth and parent/guardian receive information during intake for available service options and the Rights and Responsibilities of youth and parent/guardian.

A total of four files were reviewed; one closed residential, one closed non-residential, and two open non-residential. All four screenings met the eligibility within seven days. All four had the grievance process forms signed by the youth, parent/guardian, and staff.

Two files were missing signatures of youth and Parent/Guardian. The documents should include all parties signatures or an explanation why there is no signature to ensure it is documented that all parties have received the required information.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy. The program has a three part assessment; Assessment, Assessment-Basic, Assessment-Comprehensive.

There were a total of four files reviewed. Each file contained a completed three part assessment. Each assessment was completed on the same day as the intake. All were signed by a Master level staff. All were reviewed by a supervisor upon completion. No client record reviewed identified an elevated risk of suicide. Therefore no youth was referred for a suicide risk assessment.

There was one file where the youth transferred from non-residential to residential. The Assessment was reviewed; however, it was difficult for the reviewer to follow the updated/revised changes and the original. It is recommended that a different color ink be utilized if there will be no new assessment.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. There were a total of four files reviewed for this indicator. All case plans were initiated within seven days of the psychosocial assessment. All were individualized according to the needs and goals identified on the psychosocial assessment. All had type, frequency, location, person responsible and target completion dates. All case plans were reviewed as required.

All files had Counselor/Case Manager and Supervisor Signatures when needed.

One file only had Parent's signature for the initial case plan. There were a total of five case plan reviews; three had parents signature, there were none with client's signature.

One file had two reviews with only the Counselor/Case Manager's Signature.

One file was missing the Client's Signature on initial plan, three reviews were missing the parent/guardian's Signature.

It is recommend that all signatures are obtained at the time of review or documentation why the signature is absent from Case/Service Plan and/or reviews.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. In all four youth records reviewed the youth were assigned a counselor/case manager. All youth records showed the service plan implementation and monitored the progress in services. All four youth records also showed that support was being provided to the family.

In all the non-residential files reviewed, referral needs were established with coordinated referrals to services based upon the on-going assessment of the youth/family's problems and needs were evident. The case manager coordinated service plan implementation, monitored the youth's/family's progress in services, provided support for families, and monitored out-of-home placement, if necessary.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. Shelter Programs provide individual and family counseling, as well as, group counseling sessions held a minimum of five days per week.

There were a total of four files reviewed, one residential and three non-residential.

The one residential did not have documentation of group counseling. After reviewing the youth file and "Daily Group Log School" book there was no documentation for group counseling in the youth file. While reviewing the log book there were multiple days missing participating youths signature. It is recommended that youth sign in the log book on a daily basis when in attendance of group counseling to ensure documentation.

Case notes were maintained for all counseling services provided, in the non-residential files, and documentation of youth's progress. In all cases, an on-going internal process was in place to insure clinical reviews of case records and staff performance.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

A written policy is in place. For this indicator a total of four files were reviewed; two from Marion County and two from Lake County.

Two case staffing's were requested by the parents/guardians. The case staffing's were held within seven days of the notice.

All case staffing/CINS petition cases are managed by a CINS case manager. The case staffing included a local school district representative and a DJJ representative or CINS/FINS provider. In all four cases, as a result of the case staffing committee meeting, the youth and family were provided a new or revised plan for services; a written report was provided to the parent/guardian within seven days of the case staffing committee, outlining recommendations and reasons behind the recommendations. When applicable, the program works with the DJJ attorney and the circuit court for judicial intervention for the youth/family. In all four cases, the CINS case manager completed a review summary prior to the court hearing.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The facility has file room that is locked which contains the client files in secured file cabinets. There were a total of eight files were reviewed. Each file was marked "confidential". The open files for the non-residential program are organized by counselor and then are filed alphabetically when the cases are closed. The open shelter files are maintained in a locked box in the 'master control' area of the shelter dorm and then are stored alphabetically when the file is closed.

The confidential stamp does not show up well on all the files, either the entire stamp does not show up on the folder or it is difficult to read the entire stamp because of the color of the stamp.

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 six (6) 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 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 offices 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.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The "Safe and Secure" policy and procedure was reviewed and meets the requirements of the Florida Network. A tour of the facility was provided by program staff. The buildings and grounds were clean, neat, organized and very well maintained. The facility promotes the feeling of a very safe place. The following items were reviewed: Facility Inspections, Fire/Episodic Drill Logs, Sharps inventory, Emergency Disaster Plan, and Chemical Inventory.

The facility inspections consisted of: Fire Extinguishers inspected on 6/6/14, sprinkler system inspected on 2/14/15, kitchen hood inspected 3/5/15, alarm system, fire inspection, health department (food) inspected on 10/24/14, fire hydrant, back flow, kitchen hood cleaning, and diesel generator. All inspections were completed in a timely manner. The Fire and Emergency Disaster Plan was reviewed and approved by the Ocala Fire Inspector on October 10, 2014. The Fire Prevention Plan –Residential Alarm System was reviewed by the Executive Director on June 21, 2014.

The kitchen was found to be very clean and food was properly stored. The menu is posted in the kitchen and dayroom. The menu was approved and signed by a licensed dietician on 1/20/15. The program was expecting to receive a new walk-in freezer during the review that was donated by the local Sheriff's Office.

The fire drills were completed on a monthly basis and were completed by all three shifts. All but three fire drills were completed within the two-minute time frame. The episodic drills were completed on a monthly basis with all three shifts completing at least one or more. During the time of the review, the shelter was installing twenty-two new steel fire doors on the shelter bedrooms. The new doors were obtained through a community development block grant. The six episodic drills reviewed were completed on the following topics: medical emergency, youth injury (2), youth inappropriate behaviors, "out-of-control youth" (3). It is recommended that the episodic drills include more varied types of drills as reflected in the emergency disaster plan.

The shelter has emergency plans located at main exits throughout the building. The Emergency Disaster Plan covers numerous types of emergencies including: Bomb threat, Chemical Spills, Fires, Hurricane, Weather, Power Outages, Chemical Spills and others. The plan explains what to do in the event of any of these emergencies.

The knife-for-life and wire cutters were in a locked box and first aid kits were located in the staff office. All three vans were observed to have first aid kits, fire extinguishers, flash light, glass breaker, and seat belt cutter.

The bedrooms and bathrooms were well-lit, clean, and odor free. The beds were equipped with sheets, spreads, hand-made quilts, and pillows.

The furnishings were in good condition and minimal graffiti was observed. No contraband or hazardous materials were observed within the interior areas. MSDS sheets and inventory were reviewed and appeared to be in compliance. Washers and dryers are provided so that the youth have an opportunity to complete their personal laundry. The boys and girls each have a room with individual lockers for personal items. All doors were secure at the facility and twenty-four cameras appeared to be operational. The program also has several cameras that are equipped with audio. These audio cameras are placed in the classrooms, therapy room, and front of the boys and girls bedroom hallways. The outside is well maintained and there is ample space for outside activities which include basketball court, volleyball, challenge course and a rock-climbing wall. There is a daily shelter schedule posted throughout the facility as well as grievance procedures. Both are posted/located for youth to see/obtain.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The shelter has policy and procedures in place to ensure all youth receive an orientation and are familiar with the program rules. The client handbook contains information on all aspects of the program to include: program overview, frequently asked questions, information on contraband, behavior plan, grievance policy, shelter rules, RAPS sessions, daily goals, points, confidentiality, searches, important telephone numbers, and evacuation plan. The youth receives a copy of the handbook at orientation. Five residential files were reviewed (three open and two closed). All five files had the signatures of the youth, parent/guardian, and staff on the Orientation Checklist which indicates that the Orientation was explained in full and that the youth received a copy of the handbook. In all five files, the youth were screened for suicide risk. The appropriate alerts were indicated.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy and procedure in place to ensure the appropriate room assignment. The rooms are assigned based on information obtained from the CINS/FINS intake form. The youth room assignment process takes into consideration sex, age, size, suicide risk, aggressive behaviors/assaultive behaviors. Five files (three open, two closed) were reviewed and found to have completed the intake assessment. It appeared that all pertinent information was taken into consideration when assigning rooms/beds. Two of the youth were assigned to sleep separately on cots during their stay at the shelter due to one youth having a history of auditory hallucinations and the other youth had a history of inappropriate behaviors. The youth were placed on this status by the Licensed Mental Health Counselor.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The shelter has policy and procedures in place to ensure all contractual requirements are met. The log book is the permanent record of the life of the program. The policy was reviewed by the CEO on March 12, 2015. The shift log is maintained and reviewed by staff in order to provide staff from each shift with important information. The log books are kept in the Direct Care Workers office. Three log books were reviewed which covered dates from October 10, 2014 through February 8, 2015. All entries were brief, legible, and written in ink. The shelter uses a Color Coded system. Entries highlighted in yellow reflect incidents and important information; red highlights indicates, medical issues, suicide, and mental health information; green highlights offsite activities and trips; blue highlights group and volunteers; orange highlights screenings, intakes, or discharges; purple highlights fire drills and emergency drills. The staff provide their signature and initials in the front of each log book. The staff only put their initials after each entry within the log book. It was noted that errors are struck through with a single line and marked "void" but do not have the date or staff initials as required. It was also noted that the bed-checks were consistently documented in the same 15 minute intervals on every quarter hour (12:00, 12:15, 12:30, 12:45 ect.). It is recommended that bed checks are done in "real-time". The staff appear to be consistent with reviewing the logbook every shift but it seems that the supervisor reviews are not completed on a consistent weekly basis.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a "Behavior Management System" policy and procedures in place that states the shelter utilizes a "Point System". The plan was reviewed by the CEO on January 26, 2015 and was last updated on December 5, 2013. The agency also has a "Behavior Intervention" policy and procedure in place to ensure a safe living environment for the youth, staff, and families when behavioral interventions are necessary. The Arnette House prohibits the use of any type of punishment. Counseling, verbal interventions and de-escalation techniques are used. The point system allows the clients to make choices in what and how they will perform their daily task. The shelter has five area wherein the youth have the opportunity to earn a total of 18 points daily. If a youth earns his/her maximum daily points, he can earn 25 "bonus points" also.

However, once points are earned, they cannot be taken away. The point system provides rewards, privileges, and natural/logical consequences. The shelter has a very well stocked "store" where youth can "purchase" items once per week and at discharge. The goal of the point system is to motivate the youth to make appropriate choices and to follow the shelter rules.

Each youth is provided a handbook at orientation that explains the behavior management system. Also at intake, the behavior management plan is explained in detail to every youth by staff. The behavior plan covers Bed-time to Wake-up, Morning Chores, Breakfast, School Time, Lunch, Group/Free Time, Dinner, Outdoor Activities, and Shower time/Hygiene. Five shelter files were reviewed and each contained a copy of the Behavior Management Plan. The form in each file was signed by the youth and a staff member. The shelter manager explained that all staff are trained within their first year on the Behavior Management system and it is often reviewed in monthly staff meetings. The shelter supervisor is able to provide evaluation and feedback to staff on their implementation of the system through staff annual reviews and on-going supervision.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure for staffing and youth supervision with a ratio of 1:6 during the day and 1:12 at night. There is a male and female staff on-site at all times at a minimum per shift and a designated Team Leader (TL) and is documented in the logbook. The TL is assigned and is available for 24 hour supervision as indicated in policy. The program also has educational staff who provide direct care supervision and has the same training requirements for pre-service and in-service training as staff who provide direct care and supervision. A random selection of weekday and weekend log book entries were reviewed to ensure contracted youth to staff ratio is met. A review of the shift log book from December 2014 through February 2015 and the staff schedule verifies contracted ratio coverage. It is recommended that logbook entries for staff coverage consistently include the teacher who is counted as direct care staff to ensure appropriate ratio coverage.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Arnette House provided their Staff Secure policy revised on 2/10/2014 that stated that this location is not a Staff Secure location. However, the agency updated their policy while on-site to reflect that the program would provide Staff Secure Services.

Arnette House has a policy in place for Special Populations that includes youth with sexual assault and Domestic Violence charges. This policy includes guidelines for screening, safety planning, room designation, monitoring of clients, JJIS requirements, and the process for notifying JAC center of bed availability. The policy last updated 3/13/2014 did not include Probation Respite procedures, though this is a service the program provides. Program updated the policy to reflect the Probation Respite procedure in accordance with the Florid Network Requirements. There were three Domestic Violence Respite cases were reviewed from the last 6 months. All three of the cases reviewed showed evidence of receiving approval from the Florida Network and all three cases demonstrated that the youth were screened by the JAC and qualified for Domestic Violence Respite, as each youth had a current arrest for Domestic Violence.

Of the three cases, two were closed cases and one was an open case that had discharged from the Domestic Violence respite program and youth is currently in the CINS/FINS program. Of the three files reviewed, none exceeded a 14 day length of stay in Domestic Violence Respite and documentation clearly indicated the transition from Domestic Violence Respite to CINS/FINS. All three cases included case plan goals targeted at reducing the re-occurrence of violence in the home. All three cases are consistent with all other general CINS/FINS program requirements. Of the three cases, only one indicated a specific referral for additional aftercare services.

Two cases of Probation Respite were reviewed. Both cases indicated that referrals came from DJJ probation, adjudication was withheld, Florida Network was contacted for approval, and criteria was met for appropriateness for placement with placement agreements signed and in the files. Both admissions were less than 30 days, so no additional approval was required from JPO, CPO, or Florida Network. Case management & counseling needs were considered and addressed and services were consistent with all other CINS/FINS requirements.

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 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 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.

The agency's CEO is a LMHC, as well as, the Clinical Supervisor. There are two Family Counselors, One Residential Counselor, and one Cins Case Manager working under the Clinical Supervisor.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy for Health Screening on Admission last reviewed and updated on January 27, 2015. Upon admission to the shelter, staff will use the CINS/FINS Intake Assessment Form to screen youth for medical, mental health, and substance abuse concerns. There were five youth files reviewed for Healthcare Admission Screening. In all five files the CINS/FINS Intake Assessment Form was completed at admission. None of the youth documented any chronic conditions requiring follow-up; however, there are procedures in place for follow-up care when a youth is admitted with a chronic condition. Four of the five youth were on medications and they were listed as well as the reasons for the medications.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

Arnette House provided a policy on Suicide Protocol revised last on 3/13/2014. This policy provided a written plan that details the program's suicide prevention and response procedures. The plan provides specific details on staff responsibilities, involvement of licensed professionals, documentation protocols, notification procedures, and referral systems in connection with suicide prevention and response. The program policy identifies the process for determining level of suicide risk (none noted or reported, moderate risk, high risk, active high risk, and attempted suicide) and has a corresponding procedure for each level of risk.

There were three cases of clients placed on Constant Supervision reviewed. In the first case, client was placed on constant supervision for answering "yes" to questions on the intake screening. Client received an assessment of suicide risk within 24 hours, completed by a master's level counselor & reviewed by licensed clinician and then a follow-up assessment was conducted by a licensed clinician in accordance with the program's policy. The constant observation log was consistent with the intake time and maintained until the time notification was provided by a counselor to discontinue constant observation.

In the second case, client was placed on constant supervision due to writing statements about self-harm in a writing assignment during the Life Skills class. Progress note in the file indicated that counselor placed client on constant sight & sound supervision due to these statements. Client received a suicide assessment completed by a master's level counselor and reviewed by a licensed clinician and a follow-up assessment was conducted by a licensed clinician in accordance with the program's policy. The constant observation log was consistent with date and time the counselor determined Constant Sight & Sound was necessary and maintained until the time notification was provided by the licensed clinician to discontinue constant observation.

In the third case, client answered "no" to all questions on the intake risk screening, but was placed on Constant Sight and Sound observation due to mother reporting client was recently Baker Acted due to homicidal and suicidal threats. Client received an assessment of suicide risk within 24 hours, completed by licensed clinician and it was noted that client would be removed from constant supervision and placed on standard supervision. The constant observation log was consistent with the intake time and maintained until the time notification was provided by the licensed clinician to discontinue constant observation.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medication Distribution that was last reviewed and updated on January 27, 2015. The policy addresses requirements outlined in the DJJ Health Services Rule. The shelter provided documentation of all staff who are trained to help youth in self-administering medication.

Observations of medication storage revealed medications are stored in a locked cabinet, inside a locked box, in the staff office. Each medication is stored in individual zip lock bags with the youths name on the bag. A separate box is used for all topical medications so they are stored separately from oral medications. There is a small refrigerator located in the staff office for any medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration. The shelter does not provide over-the-counter medications, unless the youth comes in with it and has a doctor's order, so they did not have a stock of over-the-counter medications.

The policy also requires that staff members must follow measures/steps to ensure that all medication entering the shelter originate from a licensed pharmacy. The policy addresses that all medications that enter the facility with a youth admitted to the program must be accompanied by a doctor's prescription. Of the cases reviewed onsite, all cases had evidence that the medication entering the facility included documentation that the agency verification process was completed by a staff member. The Verification section on the Medication Distribution Log (MDL) included the actual date that the verification was conducted, the person verifying the medication at the pharmacy, and the staff member that completed the process.

There were two closed files and three open files reviewed for verification of the medication administration process. The shelter maintains a binder for all youth currently in the shelter that contains all the MDL's, shift-to-shift inventories and a cover sheet documenting the youths name, date of birth, allergies, a picture of the youth, and the full printed name and signature of each staff member. None of the files reviewed documented the full printed name and signature of the youth on the MDL or cover sheet and only documented the full signature of one staff member. An individual MDL is maintained for each medication the youth is on that documents the medication the youth is taking, the dosage, and side effects. All MDLs documented medications were given at the time specified or within the one hour time frame before or after the time specified. Two files documented a few instances when either the staff member or the youth did not initial the MDL when the youth self-administered a medication. A perpetual inventory with running balances is maintained on a separate sheet located behind the MDL, that is completed each shift, with the exception of third shift. All non-controlled medications were inventoried daily on first and second shift. Controlled medications were not being inventoried on the third shift, only on the first and second shift. Staff reported there is currently no one on third shift who is qualified to handle the medications and since there are no medications dispensed on that shift, the medication box is locked up and not opened during that time frame. It was recommended that staff inventory controlled medications each shift, including third shift, as required by the DJJ Health Services Rule and Florida Network requirements.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

All youth alerts are entered into a computer system, printed out each shift and placed in a binder for all staff to review. The form is updated each shift as needed and is color coded. All youth files reviewed documented all applicable alerts on the outside of the file coincided with alerts documented on the alert form located in the binder for staff to review. All alerts are also documented in the shelter logbook. All dietary alerts were also documented in the kitchen.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

Arnette House has a policy regarding Episodic/Emergency Care. Staff are made aware of the policy. The policy provides direction and guidance for staff if/when an incident should occur.

Arnette House maintains an Episodic Emergency Care log to keep record of incidents that occur each month. This log is well-organized and the incident reporting form is clear and captures information in a concise manner. The log book was reviewed and 3 incidents of episodic/emergency care were documented. All three cases indicate the type of incident, the care required, and contact to the guardian. All incidents were in compliance with Arnette House's policy and met the Florida Network standard.