



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

Review of Arnette House

on 11/09/2016

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/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 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
3.08 Video Surveillance System	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

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

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

### Review Team

#### Members

**Keith Carr, Lead Reviewer, Forefront LLC / FNYFS**

**Mike Marino, Regional Monitor, DJJ Prevention**

**Brian Dye, Residential Services Manager, Stewart-Marchman Act Behavioral Healthcare**

**Nefretiri McGriff, Director of Program Operations, Children's Home Society**



## Quality Improvement Review

Arnette House - 11/09/2016

Lead Reviewer: Keith Carr

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**Sebastian Roth, Non-Residential Program Supervisor, Youth and Family Alternatives**

**Persons Interviewed**

- |   |  |   |
|---|--|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer            |
| <input checked="" type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director   | <input checked="" type="checkbox"/> Program Manager         |
| <input type="checkbox"/> Program Coordinator                | <input type="checkbox"/> Direct- Care Full time        | <input type="checkbox"/> Direct-Care Part Time              |
| <input type="checkbox"/> Direct-Care On- Call               | <input type="checkbox"/> Volunteer                     | <input type="checkbox"/> Intern                             |
| <input checked="" type="checkbox"/> Clinical Director       | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input type="checkbox"/> Case Manager                       | <input type="checkbox"/> Advocate                      | <input checked="" type="checkbox"/> Human Resources         |
| <input type="checkbox"/> Nurse                              |  |   |
| 1 Case Managers   | 1 Maintenance Personnel                                | 2 Clinical Staff  |
| 1 Program Supervisors                                       | 0 Food Service Personnel                               | 0 Other   |
| 0 Health Care Staff   |  |   |

**Documents Reviewed**

- |   |  |   |
|---|--|---|
| <input checked="" type="checkbox"/> Accreditation Reports             | <input type="checkbox"/> Fire Prevention Plan                        | <input 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 checked="" type="checkbox"/> Key Control Log                  | <input type="checkbox"/> Youth Handbook             |
| <input checked="" type="checkbox"/> Logbooks                          | <input checked="" type="checkbox"/> Fire Drill Log                   | 0 # Health Records                                  |
| <input type="checkbox"/> Continuity of Operation Plan                 | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 0 # MH/SA Records                                   |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input checked="" type="checkbox"/> Table of Organization            | 0 # Personnel Records                               |
| <input type="checkbox"/> Contract Scope of Services                   | <input type="checkbox"/> Precautionary Observation Logs              | 0 # Training Records                                |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 6 # Youth Records (Closed)                          |
| <input type="checkbox"/> Fire Inspection Report                       | <input type="checkbox"/> Telephone Logs                              | 3 # Youth Records (Open)                            |
| <input type="checkbox"/> Exposure Control Plan                        | <input type="checkbox"/> Supplemental Contracts                      | 1 # Other   |

**Surveys**

9 Youth                      6 Direct Care Staff

**Observations During Review**

- |  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/> Intake                         | <input checked="" type="checkbox"/> Posting of Abuse Hotline      | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities             | <input type="checkbox"/> Tool Inventory and Storage               | <input checked="" type="checkbox"/> Facility and Grounds       |
| <input checked="" type="checkbox"/> Recreation                     | <input type="checkbox"/> Toxic Item Inventory and Storage         | <input type="checkbox"/> First Aid Kit(s)                      |
| <input type="checkbox"/> Searches                                  | <input type="checkbox"/> Discharge                                | <input type="checkbox"/> Group                                 |
| <input type="checkbox"/> Security Video Tapes                      | <input type="checkbox"/> Treatment Team Meetings                  | <input type="checkbox"/> Meals                                 |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts                |  |
| <input 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

**Arnette House, Inc. is now using the Why Try program. Arnette House started providing WHY TRY groups in the classroom in January 2016. Training with staff started in August 2016. The agency obtained funding to purchase four (4) sets of WHY TRY materials and training in Resiliency for their Clinical Services Supervisor in October.**

**The agency made notable changes to the facility in 2016. Client-focused changes in décor of shelter were implemented in March. A new camera system with a total of twenty-four (24) cameras and forty-five (45) day back-up capability was installed in June. New commercial vinyl flooring in client's bedrooms in July. The agency received funding for new cushions in the day room in September 2016. The security installed locks in the shelter, education and administration buildings in October. Chalkboard paint was used on a specified wall area in each client room near each bed to allow for freedom of expression (added in November).**

**The agency instituted thirty (30) minute breaks for DCWs intended for them to spend time together to develop cohesive relationships for October.**

**The agency developed a partnership with the Woodside Baptist foster grandparent group. Groups with them are to take place at the shelter every other Thursday (started in October).**

**The agency is also waiting for a challenge grant award to purchase new beds for the Shelter.**

**The agency will have funds for Acoustic Tech Panels for the dayroom to reduce the noise level (scheduled for November 23, 2016).**

**Additionally, the agency has a ropes training course located onsite. The ropes course is designed to be a challenge, confidence and recreation course for residents and staff members.**

## Standard 1: Management Accountability

### Overview

#### Narrative

The Arnette House organization is a non-profit children and families service organization located in Ocala, Florida. The agency is currently engaged as a local service provider agency with the Florida Network of Youth and Family Services to provide Children In Need of Services and Families In Need of Services in the North Central area of Florida. The agency is led by Cheri Pettitt, Chief Executive Officer and a Chief Compliance Officer, Chief Financial Officer, Licensed Clinical Mental Health Counselors, and more than twenty (20) residential staff members. The residential shelter is licensed by the Department of Children and Families to serve twenty (20) residents at one time.

The program's senior management team includes the executive director, chief financial officer, human resource officer, clinical supervisor, shelter program manager, and assistant shelter manager. Management and committee meetings are conducted to address shelter operations, program planning, incidents, corrective action, personnel processes, and other information as needed. All-staff meetings are conducted to share information from the management and committee meetings with staff. The human resource officer is responsible background screening of new employees and re-screening of employees every five years. The human resource officer ensures new hires receive and acknowledge personnel and program expectations. The human resource officer also oversees staff training. The program has several interagency agreements with various community partners, to include law enforcement, education, healthcare, and service provider agencies. Representatives from the program regularly participate in meetings with multiple community entities.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

Policy requires background screening of all applicants, independent contractors, volunteers, and interns prior to beginning work or volunteer service at the facility. Policy also requires 5-year rescreening and completion of an Annual Affidavit of Compliance with Level 2 Screening Standards. The policy was last reviewed on March 10, 2016.

The human resource officer is responsible for submitting the request for background screening or 5-year rescreening. The program also conducts a local law enforcement check and E-Verify check to verify an employee's employment eligibility status. The procedure also addresses post-hire arrests and reporting.

Five new hires were reviewed. Each new hire was background screened prior to hire and had an eligible rating. Three staff were applicable for a 5-year rescreening. A rescreening was completed prior to and within a year of each staff's anniversary of hire date. The program has not had any volunteers start with the program since the last review. The Annual Affidavit of Compliance with Level 2 Screening was submitted to the Department's Background Screening Unit (BSU) and logged as received on January 19, 2016.

There were no exceptions to this indicator.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

Policy states the program is to ensure a safe living environment for the youth, staff, and families served. There is a separate grievance policy which allows youth and family members to grieve, in writing, the actions of program staff or circumstances of care and treatment that is in violation of their rights. The policy was last reviewed on March 10, 2016.

Procedure states staff are to only use the least amount of force necessary to address youth behaviors or situations and that discipline measures cannot deny youth any basic rights. Prohibited forms of punishment are outlined in the procedure, as are appropriate staff interventions. The procedure emphasizes physical intervention should only be used as a last resort by trained staff. The grievance procedure addresses the requirements of the indicator. Written grievances are to be addressed within three business days, as are subsequent appeals. Youth are to sign grievance forms to acknowledge resolutions.

Program policy and procedure and the employee handbook address staff behavioral expectations. Upon hire, staff acknowledge the various procedures and expectations to include child abuse reporting, supervision and safety of youth, and confidentiality. All staff acknowledge receipt of the employee handbook, which includes personnel policies and staff expectations to reading all policies and procedures. All staff are trained in child abuse reporting. The program has made only one report to the Florida Abuse Hotline since their last review, which involved reporting abandonment for a youth from out of state.

Three grievances were filed by youth since the last review, all of which were completed on the same day and addressed the same issue. The issue was addressed with all three youth and the staff in question within 24 hours. All three youth signed the grievance form indicating they accepted the response and that the grievance had been resolved.

Nine youth were surveyed. All nine youth reported they knew how to report suspected child abuse and that they had never been stopped from reporting suspected abuse. All nine youth said staff were respectful to them and that they had not heard staff use profanity. The youth reported they felt safe at the shelter.

Six staff were surveyed. All six were able to explain child abuse reporting procedures. None of the staff reported seeing or hearing a co-worker use threats, intimidation, or profanity towards youth.

There were no exceptions to this indicator.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

Policy addresses reporting incidents concerning safety and liability issues. The policy was last reviewed on March 10, 2016.

The procedure requires reportable incidents be reported to the CCC within two hours. The procedure references the previous statewide procedures for reporting incidents rather than current Florida Administrative Code (most recently updated August 16, 2016).

A review of CCC reports found the program has reported four incidents to the CCC since the last review in March. Another three incident reports were automatically generated based on Department of Motor Vehicle Checks. Three of the incidents occurred at the program and were documented in the logbook. Each incident report is reviewed by administration. CCC incidents documented actions were taken as prescribed by the CCC.

An incident of suspected falsification was discovered during the review. The program immediately gathered necessary information and reported it to the CCC.

There were no exceptions to this indicator.

#### 1.04 Training Requirements

Satisfactory

Limited

Failed

##### Rating Narrative

The Orientation, Training and Staff Development policy was last revised in June of 2006 and was last reviewed in March of 2016. The policy addresses the first year training requirement to obtain a minimum of 80 hours of training and 40 hours each annual year thereafter. The Mandatory Training policy was last revised March of 2008 and was last reviewed in March of 2016. The policy focuses on all employees remaining compliant with completing mandatory training within the appropriate time frame.

Employees have an individualized training plan that maintains record of training requirements and the completion dates. Some of those courses listed on the plan are to be completed within the first 120 days of hire. Program orientation typically occurs within 60 days of an employee's hire date.

The documents reviewed were the Arnette House policies for Orientation, Training and Staff Development and Mandatory Training. All thirteen employee files that were reviewed contained a Mandatory Training Policy and a Statement of Expectations for Training hours signed by each employee. Found in the files were Individualized Training Plans with a current total number of hours for the anniversary year, copies of training attendance sheets, and certificates of course completion.

Seven DCW training files were reviewed for first year training requirements. Five out of seven files reflected more than 90 hours of training. The remaining two files reflected the employees' hire dates within the last two months. Four DCW training files were reviewed for the annual training requirements. Two employee files reflected more than 40 hours of training while the other two employees have ample time within their anniversary date to meet the requirement. Two shelter staff training files were reviewed. The files appropriately documented the Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk and the written confirmation by a licensed mental health professional.

##### Exceptions:

Seven out of seven DCW training files reviewed for first year training requirement files met the indicator's requirement of employees completing local provider orientation within the first 120 days of hire. However, the agency's policy specifies that orientation will occur within 60 days of hire. Six out of seven training files met the agency's expectation for program orientation.

##### For first year training requirements:

One training file reflects a total of 95.5 hours and reflects completed required training, however most of the courses were not completed within 120 days of hire or not completed at all. Seven out of twenty-one required courses were completed timely, eleven were completed outside of the 120 days, while three courses were not completed.

A second training file reflects a total of 91 hours and reflects some completed required training, however most of the courses were not completed within the 120-day time frame or not completed at all. Seven out of twenty-one required courses were completed on time, ten courses were completed outside of the required time frame, one was not applicable due to specific staff being trained to distribute medication, and three courses were not completed.

The third training file reviewed reflects 51 hours total. Out of twenty-one required trainings, five were completed but it should be noted that the employee's date of hire is September 27, 2016 and has until January 25, 2017 to complete the remaining sixteen courses.

The fourth training file reviewed reflects a total number of 113 hours completed with ten of twenty-one



required courses documented as complete within the 120-day time frame while six were completed after the time frame. There was no documentation found for the completion of five courses.

A fifth file reviewed reflects 117 hours of training with documentation verifying the completion of eleven required courses, six courses being completed outside of the time frame, and four courses not being completed at all.

The sixth file reviewed reflects a total of 115.5 hours with eleven courses being in compliance with the 120-day time frame. Seven courses were completed outside of the required time, while three courses were not documented as being completed.

The seventh file reviewed has a total number of 65.5 hours which the employee has a hire date of October 13, 2016 and has until February 10, 2017 to meet the requirement. The training file reflects seven out of twenty-one required courses being completed.

For annual training requirements:

One training file documents the employee having 15.5 hours completed but not having an initial Prison Rape Elimination Act training completed.

The second and third training files reflect 56.5 hours completed and 193.5 hours completed but no documentation could be found regarding the 2-year requirement of Managing Aggressive Behavior course completion.

The fourth training file reflects 9 hours of training and is still within time to complete 40 hours, however there is no documentation of the completion for Managing Aggressive Behavior or Prison Rape Elimination Act.

#### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

##### Rating Narrative

Program policies address data analysis, incident reporting, and case records. The program also has a Performance and Quality Improvement Plan that addresses reviews of incidents and corrective action.

Program procedures and the Performance and Quality Improvement Plan outlines steps to be taken for the requirements of analyzing and reporting information.

Documentation showed individual case records for both residential and non-residential youth were completed more frequently than quarterly. Summaries of outcome measures for each counselor were documented monthly.

Residential Quality Measures meetings were conducted in March, April, and August; these meetings address incidents and grievances. Client satisfactory surveys were printed and reviewed. Documentation showed the program met all Florida Network outcomes for fiscal year 15-16. Documentation also showed monthly review of NetMIS data.

The program conducts Programming & Quality Improvement (PQI) meetings. These meetings address the program's quality improvement plan, corrective action plans, external audits, contract monitoring, polices, and client grievances. The program also has a Safety, Health, & Risk Management Committee (which conduct monthly meetings). All-staff meetings were documented in April, July, and August. The all-staff meetings documented administration shared important information related to shelter operation, personnel procedures, and other general information. The documentation also showed staff are able to provide input.

Board of Director meetings were documented monthly with the exception of June and July. Information regarding shelter operations and incidents were shared with the Board of Directors.

There were no exceptions to this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

#### Rating Narrative

The program has two policies for transportation, which addresses safe use and responsible maintenance of vehicles.

Procedure states drivers must be approved by administration and legally able to drive. The procedure addresses single youth transports by one staff requires supervisor approval, but does not specify that the supervisor considers the client's history, evaluation, and recent behavior for such transports.

Driver license checks are done for all staff upon hire and periodically thereafter. A review of personnel files found driver license checks had been completed in 2016 for the staff reviewed.

The program had developed a log form to record all transports. The logs reflect the date, beginning and ending times, the driver, beginning and ending odometer readings, and destination. The log also includes three columns to record supervisor approval and time of the supervisor approval when one staff transports a single youth. A review of the logs found some were copied without the column for the date, resulting in the date sometimes not being logged.

Thirty-six instances of a single youth being transported by one staff were reviewed. Thirty-two of these instances were appropriately documented on the vehicle logs, reflecting the dates and times of the transport and supervisory approval along with identifying the supervisor who gave the approval. Two instances did not list the date of the transport (the form was copied without the date). Two instances had the time of the supervisor approval listed, but not the supervisor who gave the approval (one supervisor approval was in the logbook).

#### Exceptions:

Four instances of one staff transporting one youth did not have all required information. Two of the instances missed the date of the transport and two did not identify the supervisor who gave the approval (date and time of approval was documented and the logbook reflected who the supervisor was for one).

Some of the logs did not have the column for the date, resulting in the date of the transport not always being reflected.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

#### Rating Narrative

There is no Arnette House specific policy for this indicator. However, staff did furnish the Florida Network policy for outreach services as a guide to how they establish outreach services.

There is no Arnette House specific procedure for this indicator. However, staff did furnish the Florida Network policy for outreach services as a guide to how they establish outreach services.

The program had documentation indicating attendance at the August 2016 DJJ Circuit Advisory Board

meeting and cancellation of two other meetings that would have taken place since the last review in March. The program also had documentation of attendance at the Marion County Juvenile Justice Council in August. A representative from the program also serves on the Circuit 5 Local Review Team and had documentation of participating in meetings. The program also has a representative on the Marion County Juvenile Detention Center Community Advisory Board.

The program documented meetings with various community agencies and attendance at activities or functions related to youth services. The agencies included but were not limited to the Marion County Children's Alliance, Kids Central, Non-Profit Business Council, the United Way, education agencies, and service providers. Activities included a Family Faith Fun Day and a Community Fair to promote Safe Place. The program has developed a pamphlet and cards that include contact information and a description of services provided. The pamphlets and cards are available in the community. The program is a member of the National Safe Place Network.

The program had interagency agreements or memorandum of understandings with several community service agencies, police agencies, medical providers, education services, and mental health and substance abuse providers. Documentation reviewed found the agreements are updated annually. The recent agreements or updated agreements include the following agencies:

Marion County Homeless Council (updated 8/4/16)

Ocala Housing Authority (updated 8/8/16)

Lake County Sheriff's Office (updated 8/18/16)

Marion County Sheriff's Office (updated 8/29/16)

Ocala Police Department (updated 8/12/16)

Interfaith Emergency Services (7/19/16)

United Way of Marion County (updated 7/25/16)

Express Care of Ocala (updated 7/25/16)

Premier Pediatrics (updated 8/17/16)

Marion County Health Department (9/15/16)

Heart of Florida Health Center (updated 8/2/16)

Munroe Regional Medical Center (updated 8/5/16)

Citrus Levy Marion Regional Workforce Development Board (7/19/16)

Citrus Hearing Impaired Program Services (updated 7/26/16)

Marion County Public Schools (updated 6/14/16)

Kimberly's Center for Child Protection (8/10/16)

The Centers (7/6/15)

Children's Home Society (7/8/16)

Silver River Mentoring and Instruction (updated 7/27/16)

Boys and Girls Club of Marion County (updated 7/25/16)

**Exception:**

There is no Arnette House specific policy or procedure for outreach services.



**Quality Improvement Review**

Arnette House - 11/09/2016

Lead Reviewer:Keith Carr

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## Standard 2: Intervention and Case Management

### Overview

Rating Narrative

Arnette House is a contracted CINS/FINS provider for both residential and non-residential services for youth and families in Marion and Lake Counties. Centralized intakes and screenings are available twenty-four hours per day, seven days a week. Referrals for services come from a variety of sources including the school system, law enforcement, parents, and the Case Staffing Committee.

Non-Residential services cover Marion and Lake Counties and include individual, family, and group counseling. Counseling services are provided in the school and in the office. Services are provided to youth in the school setting, and the remainder is in the local office. Arnette House works closely with the school systems in Marion and Lake counties to ensure sound delivery of services to the youth.

The non-residential program is also responsible for coordinating the Case Staffing Committee (CSC) which is a mandated process within the Florida statutes. Its purpose is to provide services to youth who may be habitually truant, ungovernable, and/or persistent runaways. The CSC is initiated at the request of the parent/guardian or when other less restrictive options have been exhausted. The CSC may recommend the filing of a Child in Need of Services (CINS) petition with the court. The CINS case manager tracks each youth through the CSC, assists with implementation of recommendations made, and follows the youth (and family) through the course of the judicial process.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place that outlines how families are made aware of and receive information regarding available service options, rights and responsibilities of youth and parents/guardians, possible actions through CINS/FINS services, and grievance procedures. Initial screenings for eligibility must occur within seven calendar days of referral.

A total of eight files were pulled at random from the past six months for this standard. Five non-residential files that were closed within the past six months and three non-residential files that are currently open were reviewed.

All eight files displayed evidence of youth and parent receipt of this information via signatures on the forms including: information regarding available service options, rights and responsibilities of youth and parents/guardians, possible actions through CINS/FINS services, and grievance procedures. Written screenings were found in all files as well.

### Exception:

Two files had completed screenings but were missing the dates that the screening was completed and who completed the screening. FLJ is present on screening. It was clarified by staff that non-residential screenings are completed the same day as intake.

### 2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place regarding initiation of the Needs Assessment within 72 hours of admission to residential, or completion within 2-3 face-to-face contacts if receiving non-residential

services. The Needs Assessment must be conducted by Bachelor's or Master level staff. The Needs Assessment should include a supervisor review signature upon completion. Also if the youth is identified with an elevated risk of suicide as a result of the needs assessment, that youth is referred for a suicide assessment by or under supervision of a licensed mental health professional.

A total of eight files were pulled at random from the past six months for this standard. Five non-residential files that were closed within the past six months and three non-residential files that are currently open were reviewed.

The agency completes the Needs Assessment during the first face-to-face meeting with youth. All of the Needs Assessments reviewed were completed thoroughly by a Bachelor's or Master's level clinician and signed by a supervisor. One file was found with evidence of elevated suicide risk and a suicide assessment was completed by staff and reviewed by a licensed clinical supervisor.

There were no exceptions to this indicator.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

#### Rating Narrative

A written policy is in place regarding development, implementation, and review of case plans. All the plans reviewed were developed within contractual time frames and were based on information gathered during initial screening, intake, and assessment. Reviews were conducted to track progress with goals throughout the delivery of services. The agency's case plans included identified needs and goals, type, frequency, and location of services, person(s) responsible, target date(s) for completion, actual completion date(s), signature lines for all parties involved, and date the plan was initiated.

A total of eight files were pulled at random from the past six months for this standard. Five non-residential files that were closed within the past six months and three non-residential files that are currently open were reviewed.

The agency completed all case plans the same day as the assessment. All case plan goals were reflective of the psychosocial assessment. All case plans were reviewed every 30 days for the first three months by staff and/or clients. Case plan types, frequency, and location of services, person(s) responsible, target date(s) for completion were all present in the case plans.

#### Exceptions:

One file reviewed did not have the youth signature in the case plan but all other signatures were present.

Three files did not have completion dates filled in on the case plan after discharge.

### 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy in place regarding delivery of counseling services for their residential and non-residential programs. The policy includes: establishing referral needs and coordinating referrals to services based on the ongoing assessment of youth/family needs, coordinating service plan case

termination with follow implementation, monitoring progress of youth/family, providing support for families, monitoring out of home placement if necessary, referrals to case staffing committee as needed, recommending and pursuing judicial intervention in selected cases, accompanying youth and parent/guardian to court hearings and related appointments, referrals to additional services if needed, continued case monitoring and review of court orders, and case termination with follow up.

A total of eight files were pulled at random from the past six months for this standard. Five non-residential files that were closed within the past six months and three non-residential files that are currently open were reviewed.

All eight files showed the counselor and/or case manager had been assigned. All files displayed evidence of establishment of needs, coordination of service plan implementation, monitoring of progress in services, support to families, referrals to additional services (when applicable), and monitoring of out-of-home placements (when needed). One file reviewed had a referral to the case staffing committee, the file displayed recommendations for pursuing judicial interventions, accompanying youth and parent to court hearings, and continued monitoring and review of court orders.

Exceptions:

Two 30 day follow-up calls could not be found.

One youth was discharged 9/28/16 and the other 9/21/2016 but no follow-up call appeared to be made.

## 2.05 Counseling Services

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a policy in place regarding delivery of counseling services that is aligned with the youth's service plan which addresses needs identified during the assessment process (screening, intake, needs assessment). The residential and nonresidential programs provide individual, family, and group counseling on a consistent basis. The programs that offer counseling services reflect all case files for coordination between presenting problems, psychosocial assessments, case/service plan, case/service plan review, case management, and follow-up. All individual case files must adhere to all laws regarding confidentiality, maintain chronological notes on youth's progress, and maintain an ongoing internal process that ensures clinical review of case records, youth management, and staff performance regarding CINS/FINS services.

A total of eight files were pulled at random from the past six months for this standard. Five non-residential files that were closed within the past six months and three non-residential files that are currently open were reviewed.

Counseling services provided reflect coordination between presenting problems, screening, intake, needs assessment, case plan (and reviews), and case management. Chronological case notes are maintained that track the youth's progress. In addition, the chronological notes were detailed. There is also evidence of an ongoing internal process ensuring review of the file by a licensed clinical supervisor.

There were no exceptions to this indicator.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a written policy for the case staffing committee (CSC) and adjudication/petition process. A case staffing is scheduled to review a case that the program determines is in need of services if youth /family is not in agreement with services or treatment, if youth and family will not participate in services, or if program receives a written request from parent/guardian or members of case staffing committee.

Of the eight files reviewed for the other indicators, one displayed evidence for this indicator so an additional file was pulled for review.

In both files, the recommendation to begin the CSC was made by the case manager. Since the request did not come from the parent/guardian, the CSC was not held within the seven-day timeframe (but it did occur in a timely manner). In both files, the members of the CSC were notified of its occurrence no less than five working days prior to the staffing. As a result of the CSC, the families were provided with a new or revised plan for services. (One family was not issued a new or revised plan due to the original plan being created seven days prior to the case staffing.)

Members of the CSC included the family, CINS case manager, school representative, and DJJ representative. Both families participated in the CSC via conference call. In both cases, the CINS case manager completed a review summary prior to the hearing. In both cases, the program worked with the circuit court for judicial intervention for the youth/family.

Arnette House has an established case staffing committee and has regular communication with committee members and has an internal procedure for the case staffing process, including a schedule for committee meetings. This is evident by policy and procedure in place and by emails that were provided to reviewer.

There were no exceptions to this indicator.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

Case Records policy was reviewed and it coincides with the indicator. The policy was last reviewed by the program in March of 2016.

Case files are to be stamped as confidential, locked in a secure area and maintained in a neat and orderly fashion.

Files are housed in the staff office in a secure area. Files were observed being transported in secured, opaque rolling briefcases with combination locks. Files were observed as being stamped with a confidentiality statement and visible alerts. Ten files were reviewed to be in compliance with agency and CINS/FINS policy.

There were no exceptions to this indicator.



## Standard 3: Shelter Care

### Overview

#### Rating Narrative

The shelter is well maintained and is very attractive. The shelter is comprised of a large central building that has two separate hallways on opposite sides of the building, to house female youth on one hallway, and male youth on the other. 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 supervision of the youth is maintained by the Direct Care staff with support from administration. The Direct Care Worker staff are also 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.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The Arnette House uses an extended family model which will provide a safe and secure environment.

The Clients are provided with rules and guidelines that are found in a home setting. The clients are expected to keep their area neat and clean by doing chores that are rotated on a daily basis. Staff may conduct searches of clients' rooms or their belongings if there is suspicion of contraband. There is an alarm system in place on exit doors and windows. There is also a camera system with vision and auditory capabilities.

A tour of the program was given and the grounds were very well maintained. In the shelter there was no evidence of any insects. The health and fire safety inspections were reviewed and are current and up-to-date. The bathrooms were clean and have been recently renovated. In the bedrooms, all beds were made up and was neat and presentable. The shelter had recently changed the mattress and pillows to sealed Bob Barker items to help eliminate any changes of bug infestation. Some dressers were missing the fronts and staff explained that they are in the process of buying new beds and dressers.

Lighting was good for the clients to do assigned tasks. There was some graffiti in the boys wing but the shelter recently painted some walls in the bedrooms with chalk board paint to help eliminate this problem. The clients can request for personal items to be locked up and the shelter provides lockers for them to do so. In the dayroom there are some ripped cushions and the shelter is in talks to get them recovered.

There are schedules posted in the dayroom and in both the boys and girls hallways. The schedules show many activities through out the day that consist of school, groups, recreation and quiet time. Staff explained that every morning there is a PowerPoint that they show the clients of the days events on first shift. Second shift uses a dry erase board to show what is going on for the evening. The schedule days show 1 hour of physical activity daily. Staff explained that on Tuesdays and Thursdays they have a bible study. Clients not choosing to participate have quiet time. There is also time for the clients to do homework and those that do not have homework can read. Clients are also allowed to read during quiet time.

Exception:

Fire extinguisher in one of the vans' inspection was from 2015. It was expired, but was corrected on-site during the review.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has a policy in place to show the importance of clients being knowledgeable about the program rules and procedures.

During the orientation process, staff reviews the handbook with clients. The things that are discussed are identification of key staff and their roles, emergency evacuation procedures, room assignment, policies on contraband, daily program schedule, dress code & hygiene, grievance procedures, how to contact abuse hotline, program services, access to medical & mental health services, visitation & phone procedures and behavior expectations which include consequences if rules are violated.

Seven files were reviewed for this indicator. All 7 had the Orientation form checked that the client was explained: identification of staff, emergency evacuation procedures, room assignment, tour of shelter, contraband policy, daily schedule, rights and grievances procedure, how to contact abuse hotline, program services, access to medical and mental health services, visitation and phone procedures, rules regarding conduct, consequences if rules are broken, dress code & hygiene practices and was given a client handbook. All 7 forms were signed and dated by the client, the parent and staff.

There were no exceptions noted for this indicator.

### 3.03 Youth Room Assignment

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has a policy in place that facilitates client manageability and security. During the admission process it is determined, by many factors, what is the best room assignment for the client to ensure that they are protected from threat of harm or violence.

At intake, the staff determines what is the best room assignment for the client by using the CINS/FINS Intake form. Considerations that make the determination are: Physical stature (which includes - age, gender, height, weight and build), History of criminal offense, History of assault or aggressive behavior, Chronic runner or previous client, History of/or current gang affiliation, History of sexual assault or misconduct and History of mental health or substance use issues.

Seven client files were reviewed for this indicator. The 7 files that were reviewed showed the CINS/FINS Intake form was utilized in assigning a room for the client. It was observed that the clients were placed in appropriate rooms. The proper steps were also taken when it showed the client was at risk. Three files showed that the clients were at risk for self harm. The 3 had a needs assessment. All the forms were signed and dated by staff. All 7 files were signed and dated by a supervisor that it was reviewed.

A recommendation given was on the CINS/FINS form, if nothing is checked in the Client room assignment it could be perceived that the questions were not asked. There should be an indication that shows the questions were asked but the client did not meet those criteria.

There are no exceptions noted for this indicator.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has a policy in place that ensures they are maintaining a logbook that is a record of the life of the program. The logs should be bound with sequential pages. Entries must be made with ink with no erasures or use of white-out as the documentation could be used in legal proceedings.

The log books document routine daily activities, events or incidents in the program. They are reviewed by team leaders and staff to ensure that information is shared with everybody. The logbook entries must be highlighted if entry is a security or safety issues. All entries are brief and legibly written in ink. All errors are struck through with a single line and initialed and dated. The program director or designee reviews the log book weekly and makes an entry reflecting that it was reviewed and oncoming shift supervisors review previous 2 shifts and relays pertinent information to direct care staff.

Logbooks were reviewed from June 2016 to present. The log books were documented with any safety and security issues and were brief and legibly written in ink. However, some were missing the staff initials for writer of the entry. All errors had a single line through them but some were missing either staff initials and date or both. There was no evidence of erasures or white-out usage. The log books were highlighted to reflect the legend in front of each log book. The log books showed client count and staff on duty for each shift. The logbook showed any visitations, appointments and outings. The log books were reviewed by shift leader coming on shift and weekly reviews by supervisor.

#### Exceptions:

Some entries were missing the staff initials for writer of the entry.

All errors had a single line through them but some were missing either staff initials and date or both.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter has a policy for a Behavior Management System that utilizes a point system. By using this system it allows the client to make choices and to accept the natural consequences that goes along with their choices. The point system provides rewards, privileges and consequences. The RAP (R-recognize, A-admit contribution to the problem, P-problem solve & S-solution) problem solving is used to determine the consequences of actions, rather than staff administering punitive consequences.

Upon admission to shelter the client is assigned a peer leader to go over the point system. The client is provided a specific set of rules at the intake orientation process. This will provide the client with a positive admission to the program. The client is also given a client handbook that explains the process.

Thirteen staff files were reviewed to verify Behavior Management training. Eleven of the files showed that staff had the training while two files showed the staff are in their first year of hire and still have time to complete the training.

One youth was interviewed about the Behavior Management system. The client knew the system well and explained how they earn points throughout the day. The client explained that they go over their point totals daily. The client then proceeded to explain how they earn rewards and privileges. The client expressed that they can buy items from the closet with their points. The closet was seen during the tour at the beginning of the program review. It was supplied with a lot of items (appealing to both males and females). The client explained that points are not taken away, they are just not earned if they don't do what they are supposed to. The client enthusiastically talked about the system and its rewards. The client said "she would stay here forever if she could because staff really cares about us".

There were no exceptions noted for this indicator.

**3.06 Staffing and Youth Supervision**

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy in place to provide adequate staffing to ensure the safety and security of the program, staff and clients so the program's mission, goals and outcomes can be achieved.

Program procedures note that shelter will have a minimum of at least 1 male and 1 female on duty at all times. The shelter will have 24 hour awake supervision at all times. The ratio will be 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleeping hours. The schedule showing the staffing is posted in the staff office. There is also a folder with all staff names and telephone numbers to contact if coverage is needed. Staff are to do room checks at least every 15 minutes if the clients are in their rooms either during sleeping hours or for illness purposes.

The shelter's video camera system was reviewed by two witnesses. Days and times that were reviewed were:

	Documented in log book and bed check form	Visual on video
11/4/16 Boys	0100 am	0101 am
	0230 am	0229 am
	0430 am	0431 am
11/4/16 Girls	0100 am	0101 am
	0230 am	0231 am
	0430 am	0430 am
10/25/16 Boys	1100 pm	1100 pm

	0230 am	0230 am
	0515 am	0520 am
10/25/16 Girls	1100 pm	1101 pm
	0230 am	0232 am
	0515 am	0519 am
10/1/16 Boys	1200 am	1205 am
	0215 am	*
	0400 am	*
10/1/16 Girls	**	**

\*Camera's was not working due to a lightning strike so reviewer could not verify checks.

\*\*When video was reviewed a check was done at 1205. Tried to determine if it was for 1200 or 1215.

Started visual review of video 1200 am - checks were done at 1205 am, 1235 am, 0110 am and 0145 but checks were documented in logbook and on bed check form that they were done on 12 am, 1215 am, 1230 am, 1245 am, 0100 am and 0130 am. It clearly shows that checks were not done as documented. Two witnesses went back and reviewed two more days. The days and times were:

	Documented in log book and bed check form	Video check
10/22/16 Boys	1200 am	1200 am
	1215 am	1214 am
	1230 am	1229 am

<b>10/22/16 Girls</b>	<b>1200 am</b>	<b>1203 am</b>
	<b>1215 am</b>	<b>1219 am</b>
	<b>1230 am</b>	<b>1229 am</b>
<b>10/13/16 Boys</b>	<b>1200 am</b>	<b>1201 am</b>
	<b>1215 am</b>	<b>1216 am</b>
	<b>1230 am</b>	<b>1231 am</b>
<b>10/13/16 Girls</b>	<b>1200 am</b>	<b>1204 am</b>
	<b>1215 am</b>	<b>1217 am</b>
	<b>1230 am</b>	<b>1231 am</b>

The shelter has a practice in place that the video is reviewed bi-weekly by CCM, ASPM or Designee. The Video Surveillance Log was reviewed and was done according to standard and appears that any event could be captured if it happened when video is reviewed.

It was recommended to use real time when logging the room check times. There were inconsistencies in room checks with what was being documented and what was observed when reviewing the video. There was evidence of falsified documentation. (Shelter called in a report to the CCC and it was accepted.) The staff member responsible for falsifying the information was discharged the same day of discovery (during the QI review.)

**3.07 Special Populations**

Satisfactory                       Limited                       Failed

Rating Narrative

The agency has a Special Population policy that addresses youth referred for charges of a sexual nature, domestic violence respite, and probation respite. The policy was last revised in March of 2015 and last reviewed March of 2016. The policy correlates with the CINS/FINS indicator.

The agency provides services for youth who are in need of domestic violence respite and probation respite. Domestic violence respite youth are screened into the shelter by a referring DJJ officer. Youth who are in need of probation respite will be referred to the agency with adjudication withheld. The agency collaborates with DJJ to determine youth eligibility. The agency does not provide staff secure supervision and did not have any youth who were identified as Domestic Minor Sex Trafficking.

Four files were reviewed for Domestic Violence Respite. Length of stay did not exceed 21 days and documentation existed in each file of transition to CINS/FINS placement. Each of the case plans appropriately reflected goals that reflect on aggression management, or other interventions designed to reduce reoccurred violence. The files show documentation of each youth being provided the same services provided to all other youth.

Three files were reviewed for Probation Respite. The files documented that the youth were on probation. Two youth were on probation with adjudication withheld and one was court ordered. Due to miscommunication between the Florida Network and the agency, it was difficult to determine if approval prior from FNYFS was required. Each file documented the length of stay within the appropriate time of 14 to 30 days. Case plans were noted as sufficient in addressing appropriate counseling needs and the youth received all services provided to other clients.

There were no exceptions to this indicator.

### 3.08 Video Surveillance System

Satisfactory

Limited

Failed

#### Rating Narrative

The policy reviewed was the Video Surveillance System which indicates an effective date of August 31, 2016. The policy follows the guidelines referred to in the CINS/FINS indicator.

Procedures not that the video surveillance system is to be set to capture a minimum of 30 days and record date, time and location; and facial recognition. The cameras are to be placed in interior and exterior common areas, excluding bathrooms and sleeping quarters. The system is accessible to designated staff and a list of those staff are maintained by the agency.

A written notice could be seen notifying all residents, staff, and visitors that all activities are subject to recording. Visible cameras were observed in the common areas, entrance and exit doors, and hallways excluding private areas such as bathrooms and bedrooms. The system shows a clear image of facial recognition and records dates, time, location, and video for 30 days. The agency has a diesel generator as a back-up for power outages. There have been some cameras that have been out due to lightning but was notated in the agency's video surveillance log which shows documentation of a supervisory review every 14 days. The log shows comments on each review date indicating the need for improvement or accolades of following protocol. A list was reviewed which indicated designated personnel who can access the system on site and on their mobile devices. There is also a process for third party review of video recording should it be needed.

There were no exceptions noted for this indicator.

## 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 of 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 using the Pyxis Med-Station. 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.

#### 4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a detailed policy on Healthcare Admission Screening and the agency's practice in this area. The name of the policy is Health Admission Screening. This policy has an effective date of March 30, 1998. The current Health Screening on Admission was last reviewed, approved and signed by the agency Chief Executive Officer on March 3, 2014. A review of the policy indicates that it includes provisions for screening all past and current evidence of health issues, injury, mental health and substance abuse status and signs/markings.

This health screening process is initiated during the healthcare screening process and also during the intake/admission process. Specifically, the procedure involves the use of a Medical and Mental Health Alert Form, Dental History, Injury/Limitation Documentation, Central Intake Referral/Screening/Assessment Form, CINS/FINS Intake Form. The aforementioned forms are required to be completed on each resident admitted to the Arnette House shelter.

The agency uses the CINS/FINS Intake Form as the primary method to screen each youth for a broad range of health and medical conditions. The agency's health screening form addresses all elements of the indicator. The screen form asks about the past, recent or current status of 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. The written practice also addresses the referral process and follow-up medical care.

A total of seven (7) active client case files were reviewed to determine the organization's adherence to the requirement of the health admission screening indicator. A review of the said client case files was conducted onsite. The review found that all 7 files had evidence of completing Medical and Mental Health Alert Form, Dental History, Injury/Limitation Documentation, Central Intake Referral/Screening/Assessment Form, CINS/FINS Intake Form. Of the 7 client file cases, 3 were currently on medications. A total of 2 out of 3 with allergies documented during the health screening process had evidence of allergies documented



on a colored sticker on the outside of the client files. A review of 7 open residential client files reviewed contained documentation of the CINS/FINS Intake form that was completed by direct care residential staff. The agency documents health screening findings on this form to meet the requirements of this indicator in 7 out of 7 cases reviewed on site. The agency has a separate form that documents the observation of scars, marks or tattoos. One (1) out of the 7 cases had evidence of a scar/markings.

No exceptions were noted for this indicator.

#### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a detailed policy on Suicide Prevention and the agency's practice in this area. The name of the policy is Suicide Protocol. This policy has an effective date of March 30, 1998. The current Suicide Protocol was last reviewed, approved and signed by the agency Chief Executive Officer on March 30, 2016. A review of the policy indicates that it includes provisions for screening for past and current evidence of risks related to suicide or other mental health issues.

The agency's practice is to screen all clients admitted to the Arnette House shelter for risk of active suicide risks. Staff are trained to recognize, notify and screen for any potential risk of harm, threat or attempted suicide. The agency uses forms including the initial screening, CINS/FINS Intake Form, Assessment of Suicide Risk, and Follow Up Suicide Assessment of Risk. The agency has primary supervision levels called Constant Sound and Sound Supervision.

The current practice for screening for suicide requires that the agency use the CINS/FINS Intake form and the Assessment of Suicide Risk and Follow Up Suicide Assessment to determine the past and present risk for suicide. The CINS intake form screens each program participant for suicidal risks by asking each of the six (6) suicide risk questions on the CINS/FINS Intake form. The agency trains all direct care staff members to use the CINS Intake form at Intake to determine the presence of any suicide risks. Arnette House Shift Team Leaders have primary responsibility of administering and completing the suicide screening forms.

A total of six (6) residential client files reviewed on site contained evidence that each was screened for suicidal risk by using the six (6) suicide risk questions on the CINS/FINS Intake form. Five files also had documentation that each section of the CINS/FINS Intake was used as required in all 6 cases. Each client had a minimum of 1 Suicide risk indicator identified and confirmed by the screener. The agency then places each student on a constant Sight and Sound status that requires that an assessment be completed by a Master's Level Counselor. The EIDS rating warranted each resident be placed on suicide risk observation. In all 6 case files reviewed, the agency immediately contacted the Residential Counselor to notify them of the placement of each resident constant sight and sound status.

All client files contained the correct client observation logs and included documentation of observation check logs with counts completed every 15 minutes or less. All 6 client files contain official Suicide Assessments completed by non-licensed staff being overseen by a licensed clinician on staff. At the time of this onsite review, all residential counseling staff possess Master Level degrees. All completed assessments contain observation logs that indicate that observation checks are being documented.

Documentation of clients being placed on sight and sound status; bed checks conducted across all shifts including the overnight shift; and removing/stepping down youth from constant sight and sound status are documented as required in 6 out of 6 cases identified with suicide risks.

At time of this onsite review, each counselor has documentation of form verifying working towards the completion of a minimum of 5 assessments. This is verified by documentation of the Non-Licensed mental Health Clinical Staff Person's Training in completing Assessment of Suicide Risk.

Exception: One (1) out of six (6) clients being placed on sight and sound status revealed a clear finding.

One (1) out of 6 cases reviewed by a licensed clinician is missing documentation of the time that the assessment was reviewed and cleared by the clinician. Documentation was found in five (5) remaining client files.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a policy on medication in place. The current policy is called Medication Distribution For Non-Health Care Staff. This policy was made effective in 2013 and was last reviewed and signed by the Arnette Chief Executive Officer on August 31, 2016. The policy addresses all general medication policy requirements including secure storage, access, inventory, disposal, and administration/distribution of medications. The policy also addresses program measures related to medications such as operation of the Pyxis MedStation 4000 Cabinet. The policy also included language to address the Registered Nurse (RN).

The agency is required by the terms of their contract to provide prescribed, over-the-counter and controlled medication to all residents required to receive medication during their shelter stay. The agency requires the Registered Nurse to be the primary trainer of all non-licensed staff that will be distributing medication to shelter residents.

The agency does have a Registered Nurse (RN) that started on November 10, 2015. The RN works on site twenty (20) hours a week. The RN is in the process of adjusting her schedule to be on duty during periods when medication pass is at its highest. The agency provided a current list of staff that are trained and designated as being able to assist in the delivery of prescription and controlled medication. The agency has that are Super Users including the Registered Nurse. Super Users are primarily assigned to the staff work schedule on the first and second work shifts.

Observations conducted onsite during the onsite program review, confirm that all medications for all clients are being stored in the Pyxis MedStation 4000 automated medication cabinet. At the time of this program review, the epi-pen is not being stored in the Pyxis MedStation. The agency reports that Epi-pens are stored in a locked 2 drawer cabinet in the Youth Care Work Station. All oral medications are stored separately from injectable and topical medications. Specifically, all medications are kept in a plastic cube or plastic boxed compartment in the Pyxis MedStation. The agency does have a medication-specific refrigerator for prescribed medications. The refrigerator is stored in a secure room with the Pyxis MedStation. At the time of this onsite QI program review, there are no medications housed in the refrigerator. The room is locked and inaccessible to youth. The temperature inside the refrigerator was observed on site and was 39 degrees Fahrenheit.

The agency policy requires that all controlled medications be counted on each shift with a witness. There was documented evidence of shift-to-shift counts for each client's medications. Syringes and sharps are secured in the locked youth care staff office room in a locked metal 2 drawer cabinet. The sharps are counted on a weekly basis and when used. Sharps maintained on site include razors only. A review of the last 6 months of Sharps inventory binder over the last 6 months was conducted. All counts of scissors and razors are completed and counts are accurate from May 10, 2016 to November 10, 2016.

The agency maintains a standardized paper Medication Distribution Log (MDL) document. The MDL captures client information that included the client photograph, prescription medication order/dosage instructions, side effective, times for distribution, verification results and spaces for the client and staff to sign their initials. At the time of this onsite review, there were active CINS/FINS residents receiving prescription medications on a daily basis. A review of medication information of CINS/FINS clients was conducted onsite. Each file included all required medication distribution and logging documents. A review of five (5) additional medication client files were also reviewed for accuracy and completeness.

These files had evidence of meeting all documentation and medication counts. This sample of client files had evidence of no interruptions or missing medication sessions.

The agency has a process for notification of low medication supplies to reduce running out of medications. There is a 5-7 day advance notification process to the parent/guardian as a preventative measure. The agency has a medication disposal process that requires 2 staff members to complete the process.

The Registered Nurse is currently being trained to run reports on the Pyxis MedStation Knowledge Portal. The RN is generating reports to be used at staff meetings. In general, the medication distribution process used by the agency is consistent with the Florida Network of Youth and Family Services medication management policy.

**Exceptions:**

The agency has reported one (1) incident related to a medication error in the last 6 months. This incident was reported to the DJJ CCC on April 10, 2016. The incident was reported as a Complaint Against staff that resulted in a resident not receiving their required medication at the designated time. The staff person that was responsible for providing the resident with their medication was identified, received a written reprimand and was required to receive re-training on Medication Issuance Procedure on April 21, 2016.

The agency has contracted with a Registered Nurse. One of the Nurses duties involve reviews of medication management practice via the CareFusion Knowledge Portal. At the time of this onsite QI review, the agency did not have consistent evidence of monthly reviews of medication practice logged in the CareFusion Knowledge Portal or Pyxis Med-Station Reports.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy on Medical, Mental Health, and Substance Abuse Screening and Alert and the agency's practice in this area. The name of the policy is Medical/Mental Health Alert Process. This policy has an effective date of March 30, 1998. The current Medical, Mental Health, and Substance Abuse Screening and Alert Screening on Admission was last reviewed, approved and signed by the agency Chief Executive Officer on September 16, 2015. A review of the policy indicates that it includes provisions for screening of Medical/Mental Health and Alert policy. The reviewer found that the current policy meets the general requirements of this indicator.

The agency's procedure requires that all clients admitted to the Arnette House shelter are screened for potential Medical and Mental health risk. Staff are trained to recognize, notify and screen for any potential risk of harm, threat or attempted suicide. The agency uses forms that include the initial screening, CINS/FINS Intake Form, Assessment of Suicide Risk, and Follow Up Suicide Assessment Risk.

Practice observed on site involves the agency having set procedures for when there is an actual medical, mental health emergency including accidents, injury, illness, suicidal attempts, active hallucinations, etc.

The agency is also required to have a process to transport all clients to a local Emergency Room. In cases of non-emergency medical or mental health or dental treatment, the clients are to be taken to the local health department for treatment after obtaining parent approval. The agency is required to notify the appropriate shelter Program Manager and/or Team Leader accordingly. All events should be documented with official incident report completed by the staff member with the most knowledge of the situation.

The agency has a general alert system that identifies residents with medical, mental health and/or dental issues. The agency uses a system of alerts for residents with specific conditions that staff members are required to be aware of. A review of a sample of six (6) client files with various alerts was conducted to verify if the agency has an active system that correctly identifies and labels the appropriate alert affixed to the client's file. The reviewer of this indicator verified and confirmed that the 6 files were labeled correctly and found to be consistent with the agency's general alert system.

No exceptions are noted for this indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

The agency has a written policy called Episodic/Emergency Care. The policy was last reviewed on March 10, 2016. The agency's Episodic/Emergency Care policy includes measures to ensure the provision of emergency medical and dental care. The policy includes a specific focus on collecting off-site emergency services; parental notification regarding emergencies; incident reporting to the DJJ CCC and FNYFS; daily logging of events/activities; and returns to the shelter, verification of medical clearances, discharge instructions and follow-up care. In addition, the policy addresses the provision of emergency equipment.

The procedure requires that agency staff utilize safety measures obtained via all trainings. The agency is also equipped with first aid kits, knife for life, breathing barriers and blood borne pathogen kits. The agency has a total of 3 vans with fully stocked first aid kits, seat belt cutter, window punch/glass breaker and fire extinguishers.

A review of on-site emergency events was conducted. A review of all incidents in the last 6 months was conducted from May 7, 2016 to November 10, 2016. There were a total of two (2) actual incidents that resulted in hospitalization on July 13, 2016 (rash and breathing) and November 10, 2016 (lethargic and shortness of breath). All agency emergency events were documented as incidents in the DJJ CCC Log accordingly.

Evidence of comprehensive documentation is found for the parent/guardian notification requirement for both cases of emergency incident that involved the residents obtaining off-site emergency services (i.e. EMS).

The agency provides a broad array of emergency and safety training to all staff members. The agency provides CPR/First Aid, Suicide Prevention, Fire Safety, Blood Borne Pathogens, Disaster Preparedness, Emergency Evacuation, Mock Emergency and Fire Drills. These said trainings are provided to each staff member upon hire and on an annual basis as needed. A training sample of thirteen (13) staff members training files indicated a total of 11 out of the 13 had evidence of completing CPR and First Aid certification.

There were no exceptions noted for this indicator.



## Quality Improvement Review

Arnette House - 11/09/2016

Lead Reviewer: Keith Carr

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