



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House

on 03/16/2016

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	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory: 83.33%
 Percent of indicators rated Limited: 16.67%
 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: 96.00%
 Percent of indicators rated Limited: 4.00%
 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

Jennifer Schad, Regional Monitor, Department of Juvenile Justice

Joel Booth, Executive Director, Anchorage Children's Home



Quality Improvement Review

Arnette House - 03/16/2016

Lead Reviewer: Ashley Davies

Jason Ishley, Clinical Director Non-Residential Services, Capital City Youth Services

Cindy Starling, Regional Coordinator, CDS Family & Behavioral

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 1 Case Managers | 1 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 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 | 14 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 8 Youth Records (Open) |
| <input 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

- | | | |
|---------|---------------------|---------|
| 8 Youth | 9 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|---|--|--|
| <input 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 checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input type="checkbox"/> Meals |
| <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

The agency is a member of the DJJ and DCF Crossover Implementation Team in Marion County.

The "Why Try Now" curriculum has been implemented in the classroom.

A teacher is repainting the Education Building.

The Shelter Program Manager has completed the Youth Care Worker certification training and is going to be training staff across the state.

The shelter has been updated since the last review. A brick wall has been put up in the entrance and staff are going to paint positive graffiti on it.

The agency is a member of the Circuit 5 Advisory Board and Review Team.

The Maintenance Technician is rebuilding beds for all the youth rooms.

The agency is using Florida Network money to re-paint the shelter, replace blinds, and to update some technology.

Therapy dogs come to the shelter once each week.

Two local schools in the area came to the shelter asking for help with behavioral problems so the counselors started going to the schools and doing groups. They hope to start training with the teachers soon.

The agency applied for a United Way Grant for two new counselors.

The camera system went down the week prior to the review and was replaced five days prior to the review. As a result video coverage was only available for five days prior to the review up until the present.

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 Residential Care Manager, four Team Leaders, six full-time Direct Care Workers (DCW), and six part-time DCW staff, an Education Specialist, a Food Service Coordinator, an Intake Coordinator, a Nurse, a Community Outreach/Development Coordinator, a Residential Counselor, and a Maintenance Technician. In addition, the Non-Residential staff includes two Family Counselors. At the time of the Quality Improvement Review, the program had one CINS Case Manager position vacant and one Family Counselor position vacant.

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 program services and establishes relationships with local area system partners and community organizations.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

There were thirteen staff members and one intern/volunteer that were hired or started since the last annual compliance review. Each required a background screening with the Department's Background Screening Unit (BSU). Each received an eligible rating from the BSU prior to their hire/start date. One staff required the five year rescreen. The rescreen was completed prior to the staff's anniversary date of hire. The Annual Affidavit of Compliance with Level 2 Screening Standards was received by the BSU January 13, 2016.

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure to ensure a safe living environment for the youth, staff, and families serviced through behavioral interventions. The policy notes prohibited types of punishment and the promotion of natural consequences when dealing with youth. The policy also notes that physical intervention should only be used as a last resort when a child's behavior presents an immediate danger to himself or others and only by trained staff. The policy is reviewed annually by the Chief Executive Officer (CEO).

The Florida Abuse Hotline number is posted throughout the facility. New employees sign an acknowledgement for receiving an employee handbook. The handbook includes ethical communications and expectations that include appropriate professional behavior. The program's client handbook includes an explanation on the grievance policy and how the youth can file a grievance. The program has a grievance form available for youth to use. There have not been any grievances filed since the last annual compliance review. Since the last annual compliance review, there have not been any incidents requiring management response regarding staff using profanity, intimidation, or excessive physical force.

Eight youth were surveyed. All eight youth stated they knew the number to the abuse hotline and have never been stopped or delayed from making a call. All eight youth stated they have never heard adults being disrespectful

when talking to youth or heard an adult threaten a youth. Seven youth stated they had never heard an adult using profanity when speaking to a youth. One youth stated he had heard a direct care worker use profanity. All eight youth stated they feel safe in the shelter. Seven youth stated they knew about the grievance procedure. One rated the grievance process as very good, four rated it as good, one youth rated it as fair, and one youth rated it as poor. Nine staff were surveyed. All nine stated they had never heard staff using profanity, threats, or intimidation when speaking with a youth. All nine staff stated they had never heard staff deny a youth an abuse hotline call.

There were no exceptions to this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure for incident reporting. The policy provides staff with the type of circumstances requiring an incident report and the process for completing the incident report which includes notification and documentation. The policy provides direction for the completion of an incident report upon having immediate or thorough knowledge of an incident. The policy states the incident reports are to be completed thoroughly, detailed, and include documentation of any notifications made. The policy is reviewed annually by the Chief Executive Officer (CEO).

The Central Communications Center (CCC) database was reviewed and two incidents within the last year were found. Both incidents occurred over six months ago. One incident was reported within two hours with the other incident being reported over the two hours but less than four hours after the incident. The second incident was not called in until law enforcement had responded to the accident. Both incidents were found in the program's logbook. Both incidents were reviewed and signed by program supervisory staff.

Exception:

One incident was reported outside the two-hour time frame.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

Two staff training files were reviewed for first year training requirements. For the eighty hours of mandatory training required in the first year, one staff exceeded the requirement while one staff was twenty-one hours short. One staff, with 109.50 hours of training, did not have documentation of having CINS/FINS Core Training, Title IV-E Procedures, behavior management, or professional ethics & red flag behavior in the workplace. One staff, with fifty-nine hours of training, did not have documentation of having program orientation, in-service component, Title IV-E Procedures, behavior management, or professional ethics & red flag behavior in the workplace. This staff also did not have any documentation of job shadowing activities.

Five staff training files were reviewed for annual training. For the forty hours of mandatory training required annually, only two staff met the requirement. Staff training files reviewed found staff had 14, 19.50, 28, 40.75, and 49.50 hours of training. Two staff still have time remaining on their annual training year, one with eighteen days and one with forty-five days. None of the five staff training files had documentation of completing all five annually required training topics. One staff was missing one topic and four staff were missing two topics each. All five staff were missing crisis intervention skills for their annual training. Two staff were missing fire safety and two staff were missing suicide prevention for their annual training.

All seven staff training files reviewed did have documentation of cardiopulmonary resuscitation (CPR) and first aid training.

Exceptions:

One staff did not receive the required eighty hours of training during the first year of employment.

Both staff training files reviewed were missing required first year trainings.

One of the five in-service training files reviewed did not receive the required forty hours of annual training.

Two of the five in-service training files reviewed had very limited time left in their training cycle to receive more than twenty hours of training each.

All five training files reviewed were missing required in-service trainings.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program collects and reviews several sources of information to identify patterns and trends. The program conducts case record reviews monthly, exceeding the quarterly requirement. The program reviews incidents and grievances monthly, exceeding the quarterly requirement. The quality measures form does not include a review of the number of accidents. Additional reports reviewed include an annual review of client satisfaction, annual review of outcome data, quarterly review of medication management practice through the Knowledge Portal for Pyxis Med-Station Reports, and monthly review of NetMIS data reports. The program has a Performance Quality Improvement (PQI) Council/Committee meeting monthly. A standing agenda for the PQI meeting includes a review of sub-committed reports, corrective action plans, developed and revised policies, client grievances with corrective actions, and monthly benchmarks.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

Policy and Procedure regarding transportation was reviewed and is written in accordance to the indicator. The program has a "Vehicle Transportation, Safety, and Security" policy, as well as, a "Transport" (Non-Medical) policy. The procedure does state that a "Staff shall not transport a client unless accompanied by another client or staff, unless exception is approved by the Shelter Program Manager".

The Human Resources (HR) Officer screens employees for a valid Driver's License at hire and annually. The HR

Officer also maintains a current list of insurance coverage on all eligible drivers. The vehicle log does contain the date, time, name of driver, number of passengers, mileage, and destination.

There were no single client transports of CINS youth. The agency reported they do not transport CINS youth. The youth attend school on-site and the parent/guardian are required to transport the youth to any off-site appointments. During an emergency situation emergency services would be called. All single client transports observed during the review were DCF youth and not CINS youth. The agency does have a procedure in place in the event they do need to transport a CINS youth off-site.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency maintains an Outreach Notebook which contains numerous outreach events hosted by the agency as well as many community meetings that are attended by agency staff. The agency attends the local Juvenile Justice Council meetings and has recently been attending the quarterly Juvenile Justice Circuit 5 Advisory Board meeting. The agendas for these meetings are contained in the outreach notebook. The agency staff also attend numerous events/meetings including: Marion County Children's Alliance, Marion Juvenile Detention Advisory Board Meeting, Marion County Homeless Council, Human Trafficking Forum, and the Community Council Against Substance Abuse.

The agency also maintains an Interagency Agreement notebook with numerous partners. Some of the agreements that are currently in place include: Marion County Sheriff's Office, Lake County S.O., Ocala Police Department, Marion County Homeless Council, Express Care, Premier Pediatrics, Citrus Hearing Impaired, Marion County Schools, The Centers, Silver River Mentoring and Instruction, and the Boys and Girls Club of Marion County.

The agency has program pamphlets and outreach materials located throughout the buildings and readily available to families and participants.

There were no exceptions for this indicator.

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.

Residential services are based in Marion County and include individual, family, and group services. Services are provided to CINS/FINS, Domestic Violence Respite, Probation Respite, and youth in the care of the Department of Children and Families. Youth in residential services receive at least one individual counseling session per week, and attempts are made to engage parents/guardians in a family session. Groups occur on a daily basis for all youth. Educational services are also provided on-site. Youth are enrolled in residential services for a period of 7-14 days, and stays may be extended up to 30 days depending on presenting issues.

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. At this time roughly 80% of services are provided to youth in the school setting, and the remainder is in local office. Staff also provide group counseling in the schools and topics include social skills, anger management, anti-bullying, and grief/loss. 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

A total of eight files were reviewed for this standard: four residential and four non-residential. 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. All eight files displayed evidence of youth and parent receipt of this information via signatures and/or initials on the forms. One residential consent form was missing a counselor signature, but did have other required signatures. All eight files had eligibility screenings completed within twenty-four hours of the referral.

There were no exceptions to this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

A total of eight files were reviewed for this standard: four residential and four non-residential. The agency has a written policy in place regarding initiation of the Needs Assessment (NA) within 72 hours of admission to residential services, or completion within 2-3 face-to-face contacts if receiving non-residential services. The agency's policy

indicates the NA is initiated during the initial screening and the files reviewed show this is their standard practice. It should be noted the agency strives to complete the NA during the first face-to-face meeting with the youth. All of the NA's reviewed were completed thoroughly by a Bachelor's or Master's level clinician and signed by a supervisor. There was some inconsistency with clinician completing the NA with their credentials after their signature. In these files it was initially difficult to determine if this clinician had, at minimum, a Bachelor's or Master's degree. In files with evidence of elevated suicide risk there were observation logs and risk assessments reviewed by a licensed clinical supervisor.

Exception:

Staff completing Needs Assessments were not consistently adding their credentials after their signature.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

A total of eight files were reviewed for this indicator: four residential and four non-residential. 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. One file reviewed did not have the youth and parent date their signature, and was also missing the counselor's signature. A second file did not have evidence of youth and parent consent to the plan, and the 30-day review was five days late.

Exceptions:

One file reviewed was missing the counselor's signature on the case plan.

Another file reviewed did not document the youth and parent consent to the case plan and the thirty day review was five days late.

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. A total of eight files were reviewed for this standard: four residential and four non-residential. 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). None of the eight files reviewed had referrals to the case staffing committee, recommendations for pursuing judicial interventions, or continued monitoring and review of court orders.

There were no exceptions to this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

A total of eight files were reviewed for this indicator: four residential and four non-residential. The agency has a policy in place regarding delivery of counseling services that is aligned with the youth's service plan that addresses needs identified during the assessment process (screening, intake, needs assessment). The residential and non-residential programs provide individual, family, and group counseling on a consistent basis. Evidence of group counseling in the residential program is tracked with a "Group Log" for each day group is provided. It was noted that some youth did not sign their name on certain days, and there is evidence lacking as the reason they were not in group (or did not sign).

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. There is also evidence of an ongoing internal process ensuring review of the file by a licensed clinical supervisor.

Exception:

It was noted that some youth did not sign their name, on certain days, in the Group Log, and there is no evidence as to the reason they were not in group (or did not sign).

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

None of the eight files reviewed for the other standards displayed evidence for this standard, so two additional files were pulled for review. The agency has a written policy for the case staffing committee (CSC) and adjudication/petition process that matches this standard. In the first file, the recommendation to begin the CSC was made by the case manager. In the second file, the recommendation to begin the CSC was made by a school social worker. 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. Members of the CSC included the family, CINS case manager, school representative, and DJJ attorney. In another CSC all previously mentioned people were present in addition to social workers from the local school system. In one case, the CINS case manager completed a review summary prior to the hearing, and the other case had not yet gone to judicial intervention.

There were no exceptions to this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place regarding maintenance, transportation, access, and review of confidential youth records. All eight files reviewed displayed a confidential stamp on the front. Some of the stamps were difficult to see and these files may need to be re-stamped. The agency has a file room that is locked and access is limited to staff that need the files. The room contains filing cabinets for open and closed files that are arranged alphabetically. Open non-residential files are arranged by assigned counselor.

There were no exceptions to this indicator.

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 eight youth in the shelter. 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. Each hallway can house up to fifteen 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.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

A shelter tour was conducted. The facility is in very good condition. It is located on a very beautiful wooded lot which provides for a comfortable and welcoming environment. The bathroom and shower areas were in good working condition; the agency received a CDGB/SHIPP grant and was able to renovate their bathrooms (flooring, sinks, and showers). The facility was clean and free of graffiti; insect infestation, and all the furnishing were in good repair.

Youth have individual lockers for personal hygiene products and other items which are kept behind locked doors. Each youth had his/her own bed with homemade quilts that were donated by a local organization. A daily schedule is posted in the day room. Additionally, a white board is used daily to give current schedules and upcoming activities for the day (was written by staff to give a real time look at what is happening that day). The daily schedule is publicly posted and includes an hour of free time and outside activities. Quiet time is allowed during the free time period. Youth are engaged frequently with staff by playing board games, doing puzzles, playing outside and other activities. There is an on-site educational building in which youth attend school when not currently attending public school. The facility also has its own low ropes course which they utilize frequently.

Fire drills are documented to occur monthly, one time per shift. All times indicated that evacuations were completed in less than two minutes. A quarterly episodic drill was also consistently completed (one per month). These typically involved real life occurrences in the shelter and are used as training opportunities and documented in the log book.

Knife for life and wire cutters were present in the Direct Care Office along with fully stocked first aid kits. A first aid kit is also located in the kitchen. Camera system was viewed and was operational. Management reported that the system had been down for a week and was brought back up on 3/11/16. Writer observed the system which appeared to be working properly and reviewed two separate dates (3/11 & 3/14) confirming that bed checks were completed on time and documented appropriately.

There were no exceptions to this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

Program orientation is consistently implemented. The youth receive orientation during the intake process and sign an acknowledgement form stating that they received the handbook which covers all of the required elements.

A review of three open files and two closed files was completed for this indicator. All files reviewed consistently had acknowledgement pages signed by the parent/guardian which outlined the grievance procedure. Additionally, each file contained an orientation checklist with signatures stating that they received a handbook that outlined the following items:

- Identification of key staff and their roles
- Review of emergency evacuation procedures
- Tour of program
- Room assignment
- Review of contraband policy
- Review of daily schedule
- Review of rights and the grievance procedure
- Review of how to contact the abuse hotline
- Review of program services
- Review of how to access medical health care (sick call)
- Review of how to access mental health care
- Review of the visitation schedule
- Review of telephone procedures
- Review of program rules regarding youth conduct
- Review of consequences when rules are broken
- Review of dress code
- Review of hygiene practices

Additionally, all five files reviewed had an Arnette House Life Contract which each youth signs stating that they will immediately notify an Arnette House counselor or House staff if they are having thoughts of harming themselves or others.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has an established practice for evaluating all youth entering the shelter to determine the appropriate room assignment for each individual youth. The agency utilizes the CINS/FINS Intake Assessment form to screen youth entering the shelter which does a thorough job of assessing each youth for risk. Specifically, the screening form assesses for the following risks:

- Youth's trauma history
- Staff's initial observations of the youth
- Need to separate rooms due to age variances
- Need to separate rooms due to violent behavior or past history of violence
- Potential for victimization
- Medical, mental and physical history and/or concerns
- Risk of self-harm/suicide
- Sexual predatory behavior

The program uses the shelter log book to note when a youth is placed on sight and sound. Additionally, a pass down log is implemented which captures every youth that is currently in shelter and identifies all special alerts relating to each child. This log is kept separate from the agency log book. A review of the log book and pass down log confirmed that this practice is consistently implemented.

A consistent practice is established which thoroughly assesses youth as they enter the shelter to determine the appropriate room assignment. A review of three open files and two closed files validated the consistent implementation of the use of the CINS/FINS Assessment Forms in all files reviewed. Each youth was assigned a room with a number and description of which bed they were in (window/door). If a youth was placed on sight and sound and placed on a cot then it was noted on the assessment form and in the log book and pass down log. Review of the shelter log book and the pass down log confirmed that pertinent alerts were consistently documented and passed down from shift to shift.

There were no exceptions to this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency maintains a current log book to capture routine daily activities and events in the shelter. The log book is secured in the Direct Care Office. The agency has a log book policy to ensure that all contractual requirements are met; the policy was reviewed and signed by the CEO on 3/10/16. A review of the current log book and archived log books showed consistent documentation. Counts of youth and staff occurred at the beginning and end of shifts. Entries were brief and included the date and times, and staff involved. When errors occurred, they were lined through and initialed by staff. The oncoming supervisor notates in the logbook that the past shift has been reviewed and information was passed down to Direct Care Workers. However, each Direct Care Worker does not individually review and initial the log book. The program designee, a Direct Care Supervisor, reviews the facility log book weekly. However, these reviews did not appear to be completed on a consistent basis.

The agency uses a highlighted color code system: yellow indicates incidents and standard important information, red indicates medical information, injuries, constant sight and sound/mental health information, green indicates offsite activities and trips, blue indicates groups and volunteers, orange indicates screenings, intakes and discharges, and purple indicates fire drills and emergency preparedness drills. The staff provides signatures and initials in the front of each log book.

Exceptions:

The oncoming supervisor notates in logbook that past shift has been reviewed and information was passed down to Direct Care Workers. However, each Direct Care Worker does not individually review and initial the log book.

Weekly reviews by the Program Manager's designee were found to be inconsistently documented. A review of the current log book and three archived log books confirmed that this practice was not consistently implemented.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a Behavior Management System policy in place that was reviewed by the CEO on 3/10/16. The shelter uses a point system which encourages residents to make choices in how they will perform daily tasks and accept consequences when poor decisions are made. Peer Leaders are chosen and assigned to a group of 4 – 5 of their peers to help these youth make good choices. The point system provides rewards, privileges, and consequences. The RAPS (Recognize the problem, admit contribution to the problem, problem solve, and solution)

process is employed with youth as they process their behavior. With the point system, residents have the ability to earn a total of eighteen points per day; if they make their full points in each category they are eligible to receive an additional 25 points per category which brings their possible weekly total to 301 points. Youth are able to use their points at the end of the week to purchase items from the point store. Once points are earned they cannot be taken away. Observation of the point store confirmed that numerous items were available for purchase.

Staff is observed by the Shelter Manager, Team Leaders, and Direct Care Worker Supervisor on the effective implementation of the Behavior Management System. An interview with the Compliance Manager, confirmed that monthly staff meetings are held and discussions about the proper implementation of the Behavior Management System is discussed. Additionally, Team Leaders give direct feedback to staff when on shift if needed. Youth receive a copy of the handbook at orientation which details the shelter's Behavior Management System. The Behavior Management Policy specifically states that the facility uses a system of praise and encouragement to promote self-control and desirable behaviors. Isolation methods are not permitted as an acceptable method of discipline and no youth or group of youth are permitted to discipline other youth. The policy additionally states that the staff shall not use:

1. Physical punishment, inflicted in any manner on the body.
2. Ridicule, intimidation or verbal abuse of children.
3. Employ cruel or humiliating treatment or other emotionally abusive behavior.
4. Assign excessive exercise or work duties which are inappropriate to the child's age or development.
5. Deny food, clothing, shelter, medical care or prescribed therapeutic activities, or contact with family, counselors, and/or legal representatives as a form of punishment.

This practice was validated by reviewing three open and two closed residential files. In all files, documentation was found verifying that a program orientation had been conducted within 24 hours of admission in which the Behavior Management System was thoroughly explained. The youth signed an acknowledgment page stating that they had received the handbook detailing the system. Additional interviews were held with the Compliance Manager, Direct Care Supervisor, and Team Leader to verify that the Behavior Management System is consistently implemented. Copies of the point sheets were reviewed on site as well.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

There is policy and procedure in place that meets staffing ratio requirements entitled "Staffing Requirements/On-Call". There is also policy entitled "Supervision (Client) and Staff Conduct". It should be noted, in this policy under 2(C) it states that "Bed checks will be conducted at least every 15 minutes until staff is confident that clients are asleep, then within every thirty (30) minutes between bedtime and wake-up, and recorded in the Bed Check Log". During the review another policy was provided entitled "Bed Checks" which was revised on 9/22/2010 and reviewed on 3/10/16, which indicates that bed-checks are to be completed every fifteen minutes.

A review of the log books, bed-check log, and cameras reveal that bed-checks are indeed conducted every fifteen minutes.

The staff shift schedules are completed three weeks in advance and are posted on a bulletin board in the direct care office. The schedules are visible to all shelter staff. Review of the schedules indicate that the overnight work shifts consistently maintains both male and female staff on each work schedule. There is a roster located in the direct care office that includes staff contact phone numbers for backup when additional coverage is needed.

A review of the camera system revealed adequate coverage of the program. In fact, the agency has two camera systems that provide coverage of several outside areas, driveway, obstacle course, several lobby views, boy's and girl's hallways, two views of day room, kitchen, residential counseling office, computer room and classroom.

There were no exceptions to this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Written policy and procedures are in place for special population clients. The procedures are specific to Domestic Violence, Domestic Minor Sex Trafficking, and Probation Respite.

Since the 2015 Quality Improvement Review in March 2015, there have been no Staff Secure, or identified victims of domestic sex trafficking. Therefore, no files could be reviewed for those types of youth. There were three files reviewed for Domestic Violence Respite cases and two files reviewed for Probation Respite cases.

All of the three Domestic Violence Respite files reviewed were in compliance with guidelines for DV populations. In all three files, the DV charge was noted, no stay exceeded the 21-day DV limit, and case plans included plan to work on anger management, coping skill, and family conflict resolution.

The two Probation Respite files reviewed were in compliance with the guidelines for Probation Respite populations. Upon review of both probation respite files, the referrals did come from DJJ and neither youth had been adjudicated delinquent. The length of stay was determined at placement. Each youth had a stay of less than fourteen days and case management/counseling needs were evaluated and in process of being addressed.

There were no exceptions to 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.

The agency's CEO is a LMHC, as well as, the Clinical Supervisor. There are two Family Counselors working under the Clinical Supervisor.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medical, Mental Health, and Substance Abuse Screening and Alert that was last reviewed September 16, 2015.

There were three open youth files reviewed for Healthcare Admission Screening. All three files documented that the CINS/FINS Intake Assessment was completed at intake. Two of the three youth were on medications and they were listed on the Intake Assessment. Two of the three youth also had mental health conditions. One of the files documented on the Intake Assessment what the actual mental health condition was but the other file did not. However, this youth's mental health condition was listed on the shelter's computer generated alert form.

In addition to the CINS/FINS Intake Assessment completed at intake, the Nurse also completes a thorough Facility Entry Physical Health Screening on all youth after they have been admitted to the shelter. This screening is more in-depth and includes a body chart, a Tuberculosis Symptoms Screening, General Physical Health Screening, current medications, drug/alcohol screening, allergies, and an overall Physical Health determination made by the Nurse. All three files reviewed had this screening completed by the Nurse, usually within one to two days after intake.

None of the youth reviewed were admitted with any type of chronic condition requiring further care or evaluation by an outside professional. However, there are procedures in place for follow-up medical care if needed. The agency also maintains interagency agreements with local providers for easy access to medical, mental health, and substance abuse services for youth in need of such services.

There were no exceptions to this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for suicide precautions that was reviewed and updated on September 16, 2015. The policy indicates each youth admitted to the shelter will be screened for suicidal risk by the six suicide risk questions on the CINS/FINS Intake form. If the youth answer "yes" to any of the six questions they are placed on suicide precautions until an assessment can be completed by a qualified professional. Once the assessment is completed four different outcomes are possible: Emergency Transport – Baker Act, Continue the Youth on Constant Sight and Sound and reassess in 24 hours, Discontinue Sight and Sound – and Remain on Cot for close supervision, or Discontinue Constant Sight and Sound and return to normal supervision.

The shelter employs a Residential Care Manager who is a Licensed Mental Health Counselor (LMHC). This LMHC completes all suicide risk assessments. The shelter also employs a Clinical Supervisor who is also a LMHC. The Residential Care Manager reports to the Clinical Supervisor. The Clinical Supervisor reviews and signs-off on documents completed by the Residential Care Manager, including Suicide Risk Assessments.

There were five youth files available for review for youth who had been placed on suicide precautions. Four of the five files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. The fifth youth was placed on suicide precautions after admission due to making comments of self-harm. All five youth remained on sight and sound supervision until assessed by a qualified professional. All youth were seen and assessed by a LMHC, using a suicide risk assessment, within twenty-four hours. All the youth were placed on normal supervision levels upon completion of the assessment. There was documentation the youth slept on a cot in the hallway if they were on suicide precautions during the overnight hours. All five youth had ten minute observations documented the entire time they were on suicide precautions. All changes in supervision levels were documented in the logbook.

There were no exceptions to this indicator.

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 November 14, 2015. The shelter provided a list of staff who are trained to supervise the self-administration of medications. The shelter is using the Pyxis Med-Station for all medication. At the time of the on-site review the shelter had been using the Med-Station for approximately one year. There were also three super-users identified, two team leaders and the Registered Nurse (RN).

The shelter has an RN on-site two days each week. The days on-site vary each week; however, the RN is on-site for ten hours each of the days. While on-site the RN completes Healthcare Admission Screenings on new youth, dispenses medications if needed, provides trainings for staff, and does health education groups with the youth.

The RN was not on-site during the two-day on-site Quality Improvement Review. A Team Leader, who is also a Super User, was interviewed about the medication process and use of the Pyxis Med-Station. The Team Leader reported there have been no major discrepancies and no medication errors in the last six months. The staff have had minor discrepancies that were easily fixed. A review of the discrepancies revealed a majority of them were staff inputting the wrong counts.

The shelter completes inventories of all medications during first shift and second; however, no inventories of the medications are completed on the third shift. The Compliance Manager reported this is because third shift staff are not trained on the Pyxis Med-Station because they do not give out medications on that shift. Procedures were put into place while on-site to ensure inventories of the medications are also completed on the third shift.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that

required refrigeration during the time of review. The shelter maintains a supply of three different over-the-counter medications: Tylenol, Advil, and Pepto-Tablets. These medications are stored in the Pyxis Med-Station and are inventoried two times per day with the other prescription medications. At the time of the on-site review the shelter did not have any sharps requiring an inventory.

There were six youth currently in shelter who were taking prescription medications. All six files were reviewed. The youth's Medication Distribution Log (MDL) is maintained in a binder in the staff office near the Pyxis Med-Station. The binder contains all the MDL's, shift-to-shift inventories, and a cover sheet for all youth in the shelter on medication. The cover sheet documents: the youth's name, date of birth, allergies, a picture of the youth, medical/mental health information, all medications, 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. An individual MDL is maintained for each medication the youth is on that documents: the medication the youth is taking, the dosage, the reason, the time to be given, method, prescribing doctor, side effects, and also a picture of the youth. All MDL's documented medications were given at the time specified.

There are procedures in place to obtain refills of the youth's medication when it is getting low. There was documentation observed in the logbooks of staff calling parents to notify them of the low count and requesting them to bring in a refill.

The shelter has had no CCC reports relating to medication errors in the last six months.

Exception:

There were no shift-to-shift inventories completed on the overnight shift of controlled medications.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for the Medical, Mental Health, and Substance Abuse Screening and Alert system. The policy was last reviewed September 16, 2015. If any medical, mental health, or substance abuse issues are identified during the initial screening process or at any other time the youth is in the shelter, an alert is generated. An alert form is placed in the youth's file and also documented on the front of the file, and documented in a computer system. The alert form in the computer system is printed out and reviewed with staff each shift. Updates are made to the form as needed. After the form is reviewed it is placed in a binder. Any dietary alerts are also documented in the kitchen. Any suicide precaution alerts are also documented in the logbook.

There were five open residential files reviewed to verify the alert process. Two youth documented mental health conditions and medication and in both files an alert form was completed documenting this information. Another file also documented the youth was on medications for a mental health condition and the alert form in this file did not have the mental health concern documented but did have the medication alert documented. The fourth file documented the youth had a mental health condition on the CINS/FINS Intake Assessment but did not explain any further or document what the condition was. This youth was also on medication. The alert form in this file did document that the youth was on medications but did not document the mental health condition. However, a review of the computer generated alert form in the staff office revealed this youth's mental health condition was documented on that alert form. The fifth file documented the youth had asthma, was on medications, and had allergies. The CIN/FINS Intake Assessment had allergies checked off but when asked to explain, did not. The alert form in this file did document the actual allergy, which was seasonal allergies. The alert form also documented an alert for asthma and medications.

The computer generated alert form, reviewed by all staff each shift, was reviewed for the two open files and all applicable alerts were appropriately documented on that form. The shelter maintains all the alert forms in a binder so older forms were able to be reviewed for the closed files, although alerts were missing on the alert form in the youth's file or on the CINS/FINS Intake Assessment, they were all appropriately documented on the computer generated form, which is the main source of documentation used by staff when reviewing alerts.

Exceptions:

One file documented the youth was on medications for a mental health condition and the alert form in this file did not have the mental health concern documented but did have the medication alert documented.

Another file documented the youth had a mental health condition on the CINS/FINS Intake Assessment but did not explain any further or document what the condition was. This youth was also on medication. The alert form in this file did document that the youth was on medications but did not document the mental health condition.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

Policy and Procedures are in place to address Episodic and Emergency Care. The Policy is to ensure every client served receives the highest level of care available. The policy also states that an Episodic/Emergency Care Log is kept to track every incident that happens at Arnette House that requires any outside medical attention or Law Enforcement involvement. The procedure includes obtaining off-site emergency services as needed, parental notification requirements, incident reporting, and an Episodic/Emergency Care Report to ensure that all follow-ups and phone calls have been made or scheduled.

During interview with the Compliance Manager, it was reported that there is no current episodic/emergency care daily log in place due to having had no emergency care episodes this year. However upon review of the agency's incident reports, one incident report dated 2/3/16 cited an incident wherein a client who had injured his hand at the shelter was transported to the hospital by his mother. The youth was returned to the shelter with no special instructions.

First Aid kits are located throughout the facility in the staff kitchen, school building, nurse's office, direct care office, and agency vans. The agency has two vans and one mini-van which all contain fire extinguishers, first aid kits, and window punch tool. The direct care office also contained the knife for life and wire cutter in a secure box. All first aid kits were well stocked and items with expiration dates were current.

A review of two first year and five annual training records reveal that all direct care staff were currently trained in CPR and first aid. The agency also completes mock emergency drills to better prepare staff for actual medical emergencies. The following medical related drills were conducted: On 12/20/15 DCF youth with temperature of 103 degrees was transported to the hospital and on 2/10/16 youth was treated on-site due to having been elbowed in the head while playing basketball.

There were no exceptions to this indicator.