



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Currie House

on 12/17/2013

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	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	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory:95.83%
Percent of indicators rated Limited:4.17%
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

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

Gina Dozier, COO, Capital City Youth Services

Lydia Breaux, Contract Manager, Florida Department of Juvenile Justice

Joel Booth, Program Administrator, Achorage Children's Home of Bay County



Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" 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 | 0 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 13 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 13 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 12 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 14 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 1 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> Telephone Logs | |

Surveys

- 3 Youth 3 Direct Care Staff 3 Other

Observations During Review

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

The Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency responsible for Prevention and Intervention Services that provide programming and services to reduce juvenile crime and increase public safety. According to Florida Chapter 984 the state must provide a continuum of services to prevent Status Offenders from entering the Juvenile Justice system. These services are typically referred to as for Children in Need of Services and Families in Need of Services (CINS/FINS). The Lead Agency for Children in Need of Services and Families in Need of Services (CINS/FINS) Services for the State of Florida is the Florida Network of Youth and Family Services (FNYFS).

Lutheran Services Northwest (LSF-NW) is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in the Northwest region of the Florida Panhandle. Each youth shelter operates 24 hours a day, 365 days a year and serves a range of six (6) youth up to a maximum of ten (10) CINS/FINS shelter beds in each program. At the time of this onsite Quality Improvement (QI) review, the Currie House residential program was caring for three (3) CINS/FINS youth.

The agency promotes its broad range of service offerings to those youth and families in need through Outreach efforts their immediate service region. The agency has several interagency agreements with local community stakeholders and partners. These local area stakeholders and partners include local schools, law enforcement, United Way, local area businesses, faith-based organizations, medical partners, homeless shelters, and various other community-based organizations.

Prior to the QI Team's on-site visit, the agency's personnel were notified of the monitoring visit and informed how to obtain all of the current monitoring tools that were to be utilized. Further a Document Request List was provided in advance, listing specific documents and files to be available during the onsite visit. All of the LSF-NW staff members were prepared for the onsite review and cooperative with the monitoring team which resulted in a productive and hospitable monitoring environment.

All LSF-NW staff were extremely professional and cooperative throughout the entire on site QI program review.

Strengths and Innovative Approaches

Rating Narrative

The agency provided the QI review team with an update on several program, staffing and operational issues. **Shelter** Both Currie House and HOPE House are hosting monthly cultural events for the clients. Each month a different country is highlighted and the clients get to try the cuisine from the country, learn about the culture, and in several cases have had the opportunity to learn a few words of the language of the country. Residential group care residents have the opportunity to participate once a month in a faith-based evening activity with motivational speakers and dinner. All residential clients had the opportunity to participate in a culinary school event at Pensacola State College and while there they also learned about a variety of educational opportunities available at the college.

Regarding the program shelter staff. All new hires are provided a 2-day mini course in the program's Behavior Management Motivational System. All shelter staff also required to attend this training one time per year as a refresher course. The Youth Care Specialists recently held their first annual retreat. The day was a combination of training, food, and fun. Key staff from Currie House and HOPE House have traded locations with each other several times to enhance communication, implement uniform service standards and perform their jobs in different work environment. This has been done as a cross-training event and in order to make certain that both shelters are performing tasks in the same manner. The agency has provided Deaf and Hard of Hearing training. This training has been delivered across the programs and a new manual has been completed for serving that population. The annual hurricane drill was held on site this year. HOPE House evacuated to Currie House and the drill was an exercise in sheltering in.

LSF-NW is in the process of its second re-accreditation with Council on Accreditation (COA). The agency has now implemented programming to be able to receive Domestic Violence Respite referrals in the program this year. Strategic Planning, starting with Sam Sipes, CEO and the Management Team has been implemented and is being conduct throughout all LSF-NW programs.

Local Judge Bilbrey became our newest Juvenile Judge in January 2013. He replaced one of the agency's biggest supporters, Judge Goodman. Soon after taking office, Judge Bilbrey and his assistant visited and took a tour of Currie House. During the tour, they met LSF-NW residential staff and non-residential counselors. The agency believes that fostering a relationship with the new has continued to be as strong as it was with the prior judge.

The agency provided a community programming update. A former client has reacquainted herself with several LSF-NW and she has volunteered to help LSF by being a speaker about the services she received and what LSF-NW did for her. Day of Caring – Armstrong and Home Depot provided materials and workers to complete several projects here. Ten (10) staff from LSF-NW also went to an elementary school to spend time and interact with youth. A local School Guidance Counselor was so impressed that he invited LSF-NW to return. From Blue to Better is a LSF-NW program that focuses on addressing the issue of child abuse. The local Juvenile Assessment Center (JAC) serving Escambia and Santa Rosa Counties has been closed since 2008 and will be reopening soon. The agency stated that their referrals dropped drastically when they closed and hope that the reopening of the JAC will provide an increase in referrals once it opens for services.

In addition to having the agency emergency plan reviewed annually, the agency has binders strategically placed through out the facility that contain pertinent emergency procedures that are readily accessible by staff and youth.

Standard 1: Management Accountability

Overview

Narrative

The Lutheran Services Florida Northwest Currie House youth shelter is located in Pensacola, Florida and provides CINS/FINS services in Escambia and Santa Rosa counties. Lutheran Services also operates a sister youth shelter called HOPE House that is located in Crestview, Florida located in Okaloosa County. The programs both continue to share the positions of Regional Director, Clinical director, Shelter Services Director, Outreach Manager and Human Resources Manager. The agency's Clinical Director oversees all counseling and mental health services provided to youth and families delivered at both service locations. The agency's Shelter Services Director is responsible for supervision program operations at both residential youth shelter locations. The agency also assigns the daily operation and direct responsibility of each shelter to a Youth Care Specialist that acts as the Residential Supervisor at each youth shelter.

The agency continues to maintain uniform operating and performance protocols for both residential and non-residential service locations in the areas of screening, hiring, orientation and training. The agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency trainings combine staff members of both service locations to be trained on various core training topics. The agency also conducts outreach services through partnerships with local community stakeholders and various system partners. The agency has on-going initiatives with nearly twenty (20) partners including the Escambia Sheriff's Department, Escambia County School System, United Way and the Junior Achievement of Northwest Florida.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy on background screening was conducted and contains policy and language that meets the the general requirements of this indicator. Employee backgrounds screenings were completed in compliance with FDJJ-1800, Background Screening Policy and Procedures. A total of 14 files were reviewed. Of these files, twelve (12) were new hires and two (2) met the criteria for a 5 year re-screens. All screens were completed in compliance with FDJJ-1800, background screening policy and procedures. None of the employees required an exemption and the review was completed prior to the submission of the annual affidavit of compliance with level 2 screening standards.

No exceptions were noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy on the provision of an abuse free environment was conducted and contains policy and language that meets the the general requirements of this indicator. A written policy is in place. The shelter is free from any visual signs of graffiti. Client's rights and responsibilities were posted in plain view as well as hot line numbers. Grievance box is in the hallway of the shelter and easily accessible for client use. There is evidence of clients taking advantage of the grievance process as evident from youth filing a complaint against staff. While the resolution of the grievance did not concur with the youth's desired outcome the process adhered to the established policy and procedures.

No exceptions were noted for this indicator.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy on incident reporting was conducted and contains policy and language that meets the the general requirements of this indicator. There were a total of nine (9) recorded CCC incidents reported during this review period. Three (3) of the 9 incidents reported exceeded the 2 hour reporting timeframe. Incident report 1 has the caller gaining knowledge of the incident at 8 pm, but not reporting it until 11:40 pm. Incident report 2, the caller gained knowledge at 8:04 pm and the incident was reported at 10:52 pm. Incident report 3 has the caller gaining knowledge at 9:34 am, but the incident was not reported until 3:09 pm. Two of the reports were medical related incidents that resulted in clients not receiving medications as scheduled and the third was verbal altercation among clients.

There are exceptions to this standard as three (3) Department of Juvenile Justice (DJJ) Central Communications Center (CCC) incident reports exceeded the 2 hour reporting timeframe. Two (2) of the reports were medical errors in which youth did not receive medications as prescribed and 1 verbal altercation among youths.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy on training requirements was conducted and contains policy and language that meets the the general requirments of this indicator. The agency has a policy and procedure in place for this standard. A review of the 12 new employee files documents employees receiving 80 hours of the recommended and in most files exceeding the minimum required hours. In some instances training is combined with similar areas as opposed to individualized or separate training on each area.

No exceptions were noted for this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

A review of the agency's protocol and practice related to analyzing and reporting was conducted and contains policy and language that meets the the general requirments of this indicator. There is a policy and procedure in place that establishes four (4) teams from various program areas that consist of: Safety Risk Management/Incident/Accident/Grievance; Consumer Satisfaction; Outcome Data; and Case File Review. Each team is tasked with the responsibility of identifying strengths and or weaknesses, making recommendations for improvement and quarterly follow-up within the program areas. Reports are generated from the program area and discussed or reviewed as agenda items during staff meetings. While the process appears to differ from the written procedure the outcome meets the requirement of the policy.

No exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services Florida Northwest (LSF-NW) delivers a broad range of services including Centralized Intake services. The non-residential staff members include a Clinical Director, a Counselor III and seven (7) Counselor II positions. According to the agency's organizational chart, these services are delivered through non-residential staff members located at each respective site.

Non-residential services are provided to program participants and their families. These services are delivered through the agency's non-residential component. Services are provided twenty-four hours a day, seven days a week. The program participants receive program orientation materials upon their initial entry to the program. Program information provided to youth and parent/guardians includes confidentiality notices, release of information, service options and other orientation materials. In addition, participants are provided with information related to intake and grievance procedures.

Lutheran Services Northwest- Currie House provides an array of intervention and case management services to Okaloosa and Santa Rosa counties. These services include screening, Centralized intake, assessment, service plan development and oversight, as well as short term residential (shelter) care and nonresidential counseling. The agency currently has one Clinical Director, one Counselor III (supervisor), three Counselor II and one Counselor I positions to provide these services. Each counselor is designated primarily as either a residential or nonresidential counselor. The agency is also equipped to provide adjudication services through the Case Staffing Committee and CINS petition process for cases, as needed and appropriate, pursuant to Florida Statute 984.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The program has a policy that reflects the requirements of the screening and intake standard. Access to services is available twenty-four hours, seven day per week. In practice, information about available services as well as rights and responsibilities are addressed on the *Client Informed Consent and Introduction to Services* form, which is signed by the youth and parent/guardian at intake. The form includes a check box for the family to acknowledge receipt of the *Guide to CINS/FINS Services for Parents brochure* which outlines possible actions occurring through involvement with CINS/FINS services. The check box is inapplicable to residential clients and documentation of parents' receipt of information is achieved by way of Title IV-E paperwork or medication consent forms. Four (4) residential and three (3) nonresidential files were observed for this indicator. Six (6) of the seven (7) files had the Client Informed Consent and Introduction to Services signed by the parent.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy on psycho-social assessments was conducted and contains policy and language that meets the the general requirements of this indicator. The program's psychosocial assessment form contains the elements required by the Florida Network's Policy and Procedure Manual. Seven (7) out of 7 files reviewed contained psychosocial assessments which were both initiated and completed within the specified time frames, and in three of seven cases, the psychosocial was actually completed the date of intake. All assessments were completed by a Master's level counselor and reviewed, signed and dated by the clinical supervisor. None of the completed assessments in the reviewed files indicated identification of an elevated risk of suicide that warranted an Assessment of Suicide Risk conducted under the supervision of a licensed mental health professional. There were no exceptions noted.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy on case/service planning was conducted and contains policy and language that meets the the general requirements of this indicator. Six (6) of the seven (7) files reviewed contained Case/Service Plans that were developed the same day that the psychosocial assessment was completed. One case was completed 6 days following the completion of the assessment. Thus, all were done within the required time frame. The psychosocial assessments forms contained all elements required by the indicator. The agency file protocol did not have an explicit space or notation of the date the plan was initiated, but an interview with the Counselor III confirmed that the date the plan is signed ;is considered the date of initiation. Four (4) of the files reviewed were recently opened / shelter files that did not yet require a 30 day review of the Service Plan. One file had documented reviews of the service plan by the counselor, youth, and parent at 30, 60, and 90 days as required for cases that remain open that length of time. Two (2) files had documented 30 day reviews appropriate to the length of services in place.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency's written policy and procedure and interviews with staff indicate that counselors work with the family to ensure that the goals of the service plan are implemented. In all of the files reviewed the assigned counselor or case manager was evident by signatures on various forms as well as case progress notes. Three (3) youth were surveyed and all indicated that they had a counselor and all three gave a response to what goals they were working on. Progress is documented both on service plan reviews as well as in case notes. During the review of client files, one was noted to have referrals for a Baker Act assessment and for possible abuse. These referrals appeared to be the result of on-going assessment of the family's situation. In another file, the service plan identified the need for referral for additional services for a gender transitioning youth. There was no documentation of the implementation or outcome of such a referral. The counselor was interviewed about the case documentation and she explained that there was difficulty finding a service provider for the specified services. There were no noted referrals to the case staffing committee. There was one case with noted information sharing on case progress for Truancy Court. There was also one file noted to have a 180 day follow up completed from a previous service provision. The other files did not appear to have those follow ups completed as they had been closed more recently.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

A review of the agency's policy on counseling services was conducted and contains policy and language that meets the the general requirements of this indicator. The program employs two counselors in the shelter, and four non- residential counselors to provide counseling services for residents of Escambia and Okaloosa Counties. All of the files reviewed indicated that individual, group, or family counseling was offered based on the needs identified during the assessment and prescribed on the Service Plan. The provision of group counseling in shelter five days per week was evidenced by progress notes in the files, interview with the Counselor III, and a sample of the group log. Group counseling was also observed to be included on the youth activity schedule that is posted in the shelter. All case files observed contained up-to-date progress notes utilizing the S.O.A.P (Subjective, Objective, Assessment, Plan) format to detail sessions. The program ensures clinical oversight of cases by having a supervisor review and sign the assessments, service plans, etc. Staffing of cases with a supervisor is noted in the files on the contact sheet and/ or on a staffing form. Not all files contained the staffing form. The residential counselor and supervisor were interviewed and both indicated that counselors have weekly individual supervision meetings with the supervisor (Counselor III) as well as weekly group staffing. The counselors as well as the supervisor have bi-weekly supervision with the Clinical Director who is a Licensed Mental Health Counselor.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

Although the program has a policy and procedure that outlines the Case Staffing Committee and Adjudication / Petition process, there was no evidence to be reviewed as the staff reported that they had had no requests for or meeting of the Case Staffing committee during the past year. The Counselor III was interviewed and she explained that there is a very active Truancy Court process, which is different from and prevents many cases from being referred for CINS petitions. She reported that program staff is active with the truancy court system, attending staffings and truancy court every other week as well as participating at the Truancy Committee meeting quarterly. According to staff interviewed, the regular members/attendees of the Case Staffing Committee are LSF staff, the school guidance counselor, a law enforcement representative, a DCF representative and sometimes a representative of Lakeview (mental health service provider).

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

A review of the agency's policy on youth records was conducted and contains policy and language that meets the the general requirements of this indicator. All client files viewed were uniformly organized with sections outlined and tabbed. All client files were stamped confidential as well as having the service type (residential or nonresidential) stamped on the outside of the file. The reviewer observed staff enter the file room which was locked, organized, and contained locking file cabinets. The door to file room is self- locking upon door closure. A residential counselor and a counselor /supervisor were interviewed and they explained that both open and closed clinical/ counseling files (residential and nonresidential) are all maintained in the file room. The keys to the file room cabinets are kept on a master key ring that is kept in the front administrative office. For youth in shelter, a separate file containing forms and information specific to shelter service provision is kept in a locked file cabinet in a locked office within the shelter portion of the building. Upon a youth's discharge, the clinical and shelter files are combined and kept secured in the file room.

Standard 3: Shelter Care

Overview

Rating Narrative

The LSF-NW Currie House residential program services up to a total of ten (10) residents. According to the agency's organizational chart the Currie House youth shelter staff consists of a Shelter Services Manager, a Youth Care Specialist (YCS) III, a Dietary Specialist, over two (2) YCS II, and more than twenty (20) YCS I staff members. At the time of this QI program review, there are a total of three (3) youth in the youth shelter. The residential shelter is co-located with the agency's administrative offices. The administrative offices are connected to the main structure of the youth shelter so that all staff members have easy access to the residential facility to provide counseling, supervision and other support services. The program has two (2) sets of therapists, one to serve the shelter and one for the non-residential clients and their families.

The Currie House youth shelter serves two (2) different residential group care populations. The LSF-NW has on-going contract with the Florida Network of Youth and Family Services to provide CINS/FINS services. This contract serves youth that are considered status offenders. These services include entry level of intervention and treatment for youth and families that are at risk for legal complications such as chronic runaway, lockout from the home or repeated school truancy. The agency also has a contract with the Family First Network (FFN), which is a division of the Lakeview Center. The Lakeview Center is a provider under the Department of Children and Families (DCF) network. Under the terms of this contract, LSF-NW is required to provide reunification and or placement care for youth that are in the Foster Cares. Both the CIN/FINS and FFN residents receive similar service offerings interventions and treatment.

The overall shelter environment is very positive and well maintained. The agency has an established program orientation for all new residents that enter the shelter that is conducted at the time of intake. This orientation encompasses all the required elements established in standard 3 and is well documented in the client files. Room assignments are completed by the Youth Care Staff at time of intake and are thoroughly reviewed, ensuring that any youth placed in a room with another resident is not a threat to the safety of him/herself, another resident, and the staff in the program.

Log books met all of the established requirements: All entries were legible and written in ink. Errors found were struck through with a single line and the staff had initialed and dated the correction. Consistent supervisor reviews and Program Director reviews were found and consistently met the established timeline criteria. Staff coming on shift documented review of the previous two shifts.

The agency had a very well established behavior management system that was consistently implemented to influence the youth to make positive choices and increase his/her personal accountability and social responsibility. The system use the Boystown Model and encourages staff to interact with the youth and implement corrective teaching to help modify ill adapted behavior. The use of manual restraints is allowed by policy but highly discouraged and only used as a last resort. There were no incidents of manual restraint to review over the past year.

All staffing requirements were met by the program with the exception of having a male and female staff on each shift. The program provided an organizational chart that indicated Youth Care Staff vacancies that was impeding the agency's ability to meet this requirement consistently. Additionally, the Shelter Manager reported that numerous applicants for these positions were failing background checks.

The agency does participate in the Domestic Violence Respite program but does not have assigned beds. All files reviewed confirmed that the agency was conducting appropriate screenings of these cases and obtaining authorization from the Florida Network to place youth in these beds. Thorough documentation was kept in each file reviewed confirming that the youth had qualifying charges for admittance into the DV Respite program; each youth in the program was discharged within 14 days and transitioned into a CINS/FINS bed when appropriate.

Through consistent implementation of the above practices, the agency demonstrates satisfactory compliance of Standard 3: Shelter Care.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

A review of the agency's protocol regarding the shelter environment was conducted and contains policy and language that meets the the general requirements of this indicator. The shelter environment is well maintained. All health and fire inspections are current and all furnishings are in good repair. The grounds are well maintained. The bathrooms and shower areas are clean and functional and appeared to be in good repair. No graffiti was visible in any areas of the facility. There were two beds in each room that provided adequate individual sleeping space for the population indicated on the DCF license. The facility had adequate lighting throughout and numerous windows that provided additional natural light and added to a very comfortable environment. All youth are provided the opportunity to lock personal belonging in the closet if they so desire. A very detailed daily schedule is posted in the living area that confirms that structured activities such as education, one hour of recreation, counseling, life skills, faith based activities, etc...and are kept well occupied with minimal down time. The daily schedule also documents designated quiet time as well.

This practice was validated by participating in a shelter tour with Jamie Cochran, Outreach Service Coordinator and conducting personal walk through of the facility and inspecting the resident rooms, bathrooms, and living area.

Shelter Safety/Security

The agency's annual disaster plan was reviewed and met all required components and received its annual review on October 31, 2013. The facility provided fire safety and health inspections that were completed on in July of 2013. Fire drills were conducted once a month per shift and the evacuation of staff and clients was conducted in less than two minutes. Additionally, an agency wide major hurricane drill was conducted on June 19, 2013 which incorporated both shelters.

All fire safety equipment was current and valid (fire extinguishers were inspected in October 2013 and maintenance personnel documents monthly checks). An inspection by the health department was conducted on July 16, 2013 with no major findings. A copy of the DCF Child Care License was posted in the All menus were posted and certified by a Licensed Dietician annually (certificate expires on May 31, 2013). Egress plans were prominently posted throughout the facility. The abuse hotline and DJJ Incident Reporting Number were posted in the living area. Surveillance cameras were operational and could be viewed in the intake office via a large screen TV. Shelter Manager, Patricia Rock, indicated that recorded material is maintained approximately 30 days, but could be longer or shorter depending on the amount of activity recorded and the system's ability to store the data.

Agency vehicles were locked and equipped with all required safety equipment. A copy of the valid insurance certificate was located in the file housed in the vehicle. All chemicals were listed, approved for use, inventoried monthly (per agency policy), stored securely and had Material Safety Data Sheets maintained on each appropriate item. The laundry room was well maintained and all lint collectors were clean. A new soap dispensing system had just been installed in the laundry room as well.

The above practices were validated by conducting inspections of the facility which was accommodated by Howard Jordan, Maintenance Mechanic. Additional validation was received by interviewing Youth Care Staff, Lawanda Springer and Youth Care Staff II, Peter Estepa and Patricia Henderson, Dietary Spec.

The practice of quarterly emergency drills was conducted by a prior staff member who is no longer with the agency. Documentation was provided which showed drills were conducted in May and June of 2013. Jamie Cochran, Outreach Service Coordinator, reported that the practice of quarterly emergency drills is consistently implemented, however, with the departure of the staff member that previously conducted these drills, documentation was unaccounted for. Additionally, an agency wide major hurricane drill was conducted on June 19, 2013 which incorporated both shelters.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

A positive orientation process is established and implemented at time of intake by the Youth Care Staff conducting the initial intake. A client handbook is given to the youth at time of intake which covers the following areas:

- Contraband items;
- Discipline policy; ;
- Dress code;
- Access to medical and mental health services;
- Visitation, mail, and telephone;
- Grievance procedure;
- Disaster preparedness; and
- Sleeping room assignments and introductions

A tour of the facility is given at time of intake as well. In addition to the client handbook, during the initial intake, the Youth Care Staff completes a client contract that reiterates the above information that is covered in the client handbook and requires a signature from the client committing to adhering to these policies. Additionally, during the intake process, a complete suicide evaluation is completed and staff note in the log book and shift pass down log if a youth is placed on sight and sound observation or has other alerts that they should be aware of. All youth coming in to the shelter sign a Safety Contract as well. The pass down log is the first document that oncoming staff look at when coming on shift to ensure that they are aware of pertinent information. Documentation of the youth receiving this information is kept in the client file and the Youth Care Staff conducting the intake signs all documents as well to verify that the youth received the information.

These practices were validated by reviewing a client file which contained all of the above listed information. Additional validation was received by interviewing Youth Care Staff, Lawanda Springer who provided verbal verification that supported the documentation found in the client file.

No exceptions were noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The program has a well established system to ensure the most appropriate sleeping room assignment is given at time of intake. The Youth Care Staff completing the initial intake form completes a room assignment section that addresses potential safety and security concerns such as:

- Review of available information about youth's history;

- Initial collateral contacts;

- Initial observations regarding interactions and observations of the youth;

- Separation of younger youth from older youth;

- Separation of violent youth from non-violent;

- Identification of youth susceptible to victimization;

- Medical, mental or physical disabilities;

- Suicide risk; and

- Sexual aggression and predatory behavior

An alert system is implemented using two main processes. First, an alert dot system has been implemented to give the staff a quick reference to see any alerts that a particular youth may have. The dots are placed on the clients file for quick access and reference. Red dots indicate a youth is court ordered or have aggressive behavior, green dots indicate a youth is on medication, and an orange dot indicates a youth is on sight and sound observation. Additionally, a shift pass down log is used to document any pertinent alerts for staff to be aware of. The pass down log is the first document that staff coming on shift will read to give them a quick understanding of the status of each youth in shelter. Both systems are redundant to ensure information relating to alerts is disseminated quickly.

This practice was validated by reviewing a client file that contained a completed room assignment section at time of intake with the youth. Three client files were reviewed which contained dots on the file indicating various alerts listed above. An interview was conducted with Youth Care Staff, Lawanda Springer, which validated the above stated practices.

No were exceptions noted for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

A review of the agency's policy on logbooks was conducted and contains policy and language that meets the the general requirments of this indicator. A daily log book is maintained and is reviewed by direct care staff and supervisory staff at the beginning of each shift. All entries reviewed were entered in ink and were legible. Entries did include the date and time of incident, event or activity and included the youth and staff involved. All entries captured the information in a brief but professional manner and gave pertinent information to the specific incident. All recording errors were struck through with a single line the staff's initial and dated. The evidence of the Program Director reviewing the logbook every week was observed which included feedback to staff concerning corrections and recommendations and was appropriately signed and dated. Supervisory reviews were observed as well. Direct care staff consistently documented reviews of the previous two shifts and made entries in the logbook recording this review and signed and dated the entry.

This practice was validated by reviewing the current logbook which covered a period of approximately two months.

No exceptions were noted for this indicator.

Rating Narrative

The program has an established behavior management system in place help the youth achieve the program rules and make positive choices and increase personal accountability and social responsibility. The program has a policy that provides a detailed description of their Behavior Management System (Behavior Management Strategies/Behavioral Intervention Policy # 3.05). The plan implements a variety of positive incentive and encourages staff to interact with the youth to provide corrective teaching to help the youth understand the natural consequences of their actions in a timely and appropriate manner. All staff are trained on the Behavior Management system at time of new employee orientation (40 hour training) and then receive an annual refresher training that is approximately four hours. The established policy and the youth handbook document that the program does not allow youth to discipline other youth and group discipline is not allowed. Room restriction is only used to encourage a youth to deescalate his/her behavior and is never used as punishment. The Behavior Management System does not deny the youth of regular meals and snacks, clothing, sleep, physical health services or mental health services, educational services, exercise, correspondence privileges, and contact with parent/guardians. The program has an active grievance process in place that allows for the youth to provide feedback and address complaints with staff, program directors, and management.

The behavior management system encourages positive behavior and minimizes crisis by the use of verbal intervention and manual restraints are seldom used. Manual restraints are used as a last resort and implemented using approved CPI techniques. Only program staff who receive CPI training are authorized to use manual restraints. If a manual restraint is used the Shelter Manager debriefs the event and discusses the incident with the youth and parent/guardian within 24 hours of the event. A second debrief occurs within 72 hours with all staff involved in the incident to look at the incident and determine if other alternative measures could have been implemented. There have been no incidents of manual restraint in the program over the last year that could be reviewed.

Staff receives feedback ongoing feedback from their supervisors on the appropriate implementation of the behavior management system. Additionally, this area of expertise is critiqued at the employee's annual performance evaluation with the supervisor. Supervisors receive training on the appropriate implementation of the behavior management system by Cynthia Freshour, Quality Services Supervisor. There has been a recent turnover in staff and there are new supervisors that will be scheduled for training in the appropriate implementation of the behavior management system. Ongoing on the job training is conducted with the supervisors by the Shelter Manager and the Quality Services Supervisor.

This practice was validated by reviewing the agency's behavior management policy and reviewing the student handbook which has an overview of the established behavior management system. The youth signs the handbook acknowledging that the system was reviewed at time of intake. Four (4) training files were reviewed which documented new employee training on the behavior management system (40 hours) and refresher training a year later (typically this training was 4-5 hours). Additionally, an interview was conducted with a resident youth that provided his point card and gave detailed descriptions of how the point system worked, including the implementation of positive and negative points, the attainment of privileges, corrective teaching and the ability to earn back points by participating in the corrective teaching process, and what privileges were available when he earned enough points on a daily basis to be eligible privileges.

No exceptions were noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

Adequate staffing is provided to ensure the safety and security of youth and staff. The program has a written policy (Staffing and Youth Supervision 3.06) which meets all general staffing requirements. A one (1) staff to six (6) youth during awake hours and 1 staff to twelve (12) youth during sleep hours is met at all times. All overnight shifts consistently maintain a minimum of two staff on shift. The staff schedule is posted on the bulletin board in the Intake office; this location is visible to all staff and has easy access. An overtime roster is maintained which includes contact numbers of all staff when additional coverage is needed.

Surveillance cameras are used on site and appear to be well positioned and provide excellent coverage of the property. Video footage is retained as long as possible (generally 30 days); this is dependent on the amount of recording that is required for a particular time period and amount of storage space available. Bed checks are conducted every 10 minutes (exceeding the 15 minute requirement).

This practice was validated by viewing the posted staff schedule, reviewing the shelter logbook to confirm staffing patterns and documented bed checks. Interviews were conducted with Shelter Manager, Patricia Rock and Quality Services Supervisor, Cynthia Freshour. Both interviews confirmed the documented practices and solidified the agency's struggle to maintain appropriate gender representation on each shift.

The staff schedule reflected that some shifts did not have both sexes scheduled. The current org chart reflects two Youth Care Staff vacancies. Interviews with the Shelter Manager, Patricia Rock and Cynthia Freshour, Quality Services Supervisor, confirmed that turnover in these positions has made meeting this standard challenging. Additionally, the current application pool has had several applicants that had criminal backgrounds that made them ineligible for hire.

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

At the time of this on site Quality Improvement review, the LSF-NW Currie House program is not designated as a staff secure program.

At the time of this on site Quality Improvement review, the FNYFS is no longer receiving referrals for the Probation Respite program. agency is not designated as a staff secure program.

The agency does serve domestic violence respite youth; however they have recently suspended that practice due to it having a negative impact on their CINS/FINS care days. They are monitoring this and will reimplement the practice when the utilization rate of their Care Days increases.

The agency has an applicable policy and procedure in place for Domestic Violence Respite beds and has had cases in the last six months. Files reviewed confirmed that:

1. Due to the fact that the agency does not have assigned DV beds, approval was received from the Florida Network for DV placement. Emails to Megan Smith at the Florida Network were contained in the two client files reviewed which included approvals from Mrs. Smith and a completed DV referral form.;
2. The two files reviewed contained JJIS face sheets that verified that the referred youth had a pending DV charge and would not be detained by the detention.;
3. The two files reviewed had documentation that confirmed that youth were discharged from the DV Respite beds within 14 days of admission (one file had an entrance/exit of 7/25/13 – 8/8/13 and second file of 7/21/13 - 8/3/13).;
4. Both files reviewed showed that youths transitioned from DV placements to CINS/FINS placement and adequate documentation was available to verify this transition.;
5. Both case plans in the file addressed the referring charge of violence and focused on treatment to help each youth identify triggers and implement deescalation techniques.;
6. All other services identified in both files reviewed were consistent with the general CINS/FINS requirements.

This practice was validated by reviewing two DV Respite files and interviewing Jaime Aughtman, Counselor. No exceptions were noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

A review of the agency's protocol regarding the shelter environment was conducted and contains policy and language that meets the the general requirements of this indicator. The LSF-NW agency provides screening, counseling and mental health assessment services. To execute these services, the agency utilizes seven (7) counselors, a Residential Supervisor, a Shelter Services Manager and a Licensed Mental Health Clinician.

Additionally, the agency has comprehensive policies that address program requirements related to health screening, behavior management, mental health and suicide assessments. The agency's current suicide assessment practices and policies have been reviewed and approved by the Florida Network of Youth and Family Services. The agency also has an active health screening process that detects for the existence of acute health issues of all residents screened and admitted into the CINS/FINS residential program.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The program has a policy called LSF-NW Healthcare Admission Screening Number 4.01. The policy contains and addresses the general requirements of this indicator. The program conducts a preliminary physical health screening for each individual youth at the time of admission. Non-health care staff are permitted to perform this duty upon each resident's admission to the program. The preliminary healthcare screening includes, but is not limited to the following: Current Medication; Existing medical conditions; Allergies; Recent injuries or illnesses; Presence of pain or other physical distress; Observation for evidence of illness, injury, physical distress, difficulty moving, etc.; and Observation for presence of scars, tattoos, or other skin markings. The screening also includes a mechanism to make referrals and a method of follow-up medical care as required of needed. The program requires parental notification and coordination and documents all medical referrals on a daily log.

A total of five (5) Currie House client files were reviewed to assess the agency's adherence to the requirements of this indicator. Of the files reviewed, two (2) were open/active cases and three (3) were closed. All files reviewed have evidence of documentation that verify that an individual health screening had been conducted on each child. The client files reviewed include documented information of the current status of each youth's health condition and any acute medical issues. A review of these 5 indicated that the agency is documenting existing (acute and chronic) medical conditions. The agency client files also documents that youth conditions that include residents currently on medications. The agency client files include documentation of past and recent illnesses, injuries, allergies, observation of pain/physical distress and evidence of any scars, tattoos or skin markings. The agency also documents the presence of chronic medical conditions that include diabetes, pregnancy, seizure disorder, cardiac disorder, asthma, tuberculosis, hemophilia and head injuries. In addition, the agency has a practice of documenting medical referrals and necessary follow-up medical care for youth admitted with chronic medical conditions. Of the files reviewed, none of the files included evidence that youth served by the program required a referral that included necessary follow up by the agency.

Four (4) out of five (5) client files did not include initially include evidence that the agency is screening for observation of presence of scars, tattoos, or other skin markings. The agency does use a consolidated form that addresses markings and scars.

There were exceptions noted for this indicator. Five (5) out of six (6) client files did not include initially include evidence that the agency is screening for observation of presence of scars, tattoos, or other skin markings. The agency does use a consolidated form that addresses markings and scars. At the time of this on site program review, not all agency client files were included the Shelter Intake Assessment screening form.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive written policy that details the program's suicide prevention and response procedures. The policy includes roles of each staff, procedures for after-hours suicide assessment/screenings, guidelines for how youth are stepped down from constant sight and sound, and timeframes for completion of the suicide assessment. Upon intake each youth accepted for admission into the residential or non-residential program are screened for suicide risk by a direct care staff person using the Evaluation of Imminent Danger for Suicide (EIDS). If the youth indicates a positive by stating yes on 1 of the 6 suicide risk question, they are then placed on youth supervision status. The youth's level of supervision can consist of one-to-one or constant sight-and-sound and it determined by their assessment results. If the youth is then placed on constant sight and sound supervision until a suicide assessment is administered by a counselor.

The agency's Director and Clinical Supervisor both have clinical licenses. The agency conducts a suicide assessment on suicide risk clients. This assessment is executed by the clinician or non-licensed counselors under the supervision of the licensed mental health professional. In addition, the agency has documentation verifying parent or legal guardians had been notified.

The agency executes close watch supervision process according to their one-to-one or constant supervision status. In these cases, the agency documents the youth's supervision status in the shelter's daily log. The agency assigns a staff person to monitor the youth on each shift. The monitoring process calls for the agency to observe and document the youth's behavior/status every 30 minutes or less. Of the 5 files reviewed, all cases contained evidence of the agency documenting supervision counts in the log as required. All 5 suicide cases contain evidence of the agency on initial suicide screen being conducted by the agency; evidence of results being reviewed and signed by supervisor; documentation of youth meeting being placed on sight and sound supervisor until assessed by licensed staff or assessment is reviewed by licensed staff; proof that youth are being placed on the correct level of supervision based on the assessment; and if applicable the supervision level of youth were not changed or reduced until reviewed by a licensed staff person. Interviews with staff indicate that the programs practice is to designate and document sight and sound counts in the daily log.

The agency's suicide assessment policy was been approved by the Florida Network in 2012 and has not had any substantive changes. In addition, all files reviewed on site had evidence that bachelor and master level staff have had their suicide risk assessment results reviewed and signed by the agency licensed clinician.

There was a documentation observation made regarding the review of this indicator. Documentation of youth staff on supervision is not always legible and difficult to locate at times. Agency should make certain that youth designated as being placed on sight and sound supervision status must be legible for all staff to recognize and follow any changes accordingly.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy on Medications. The agency's current policy is called the Medications Policy and was approved by the Agency Director on October 31, 2013. The agency's policy contains written content that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. On site observations found that all medications in the shelter are stored in a separate medication room. This room is secure with a two-way lock that requires key access in and out of the room. This room is inaccessible to residents. All medication in the room is stored in a four (4) drawer cabinet with a total of 4 pad locks affixed to the metal cabinet. Oral medications are also stored in this 4 drawer cabinet. Each drawer requires a key to access the content located inside. The oral and topical medications are stored in a separate container or in the pill jar or box used to originally house the medication.

The agency maintains a Medication Distribution Binder. The binder includes the medication log, picture of the youth, over the counter record, side effects notice, dosage, reason for medication, date received, method of administration, controlled substance inventory, non-controlled weekly inventory, staff names, Verification of Medication and staff and youth initials on the MAR when medication is disbursed and received. A review of five (5) client medication records were conducted onsite (3 open and 2 closed). At the time of this onsite review, three (3) CINS/FINS active clients were on medication. Additionally, the review included two (2) findings were closed files. All files reviewed contained the general documentation requirements.

The shelter has a system in place for the refrigeration of medication. At the time of this on site review, there were no medications requiring medication on site.

All controlled medications are locked in a cabinet behind two (2) locks. All Controlled medications are stored and placed in a locked metal box inside the aforementioned 4 drawer cabinet. At the time of this review, there were 3 CINS/FINS youth that were on controlled medication. The agency does provide over-the counter medication. The agency distributes Triple Antibiotic Ointment, Pepto Bismol, Acetaminophen 500 mg, Acetaminophen Jr. (Tylenol), Ibuprofen 200 mg (Motrin), Antacids (Pepto Bismol, Milk of Magnesia). The agency maintains a weekly sharps form for each over the counter (OTC) medication.

Sharps are also kept in the bottom drawer of the 4 drawer cabinet. The sharps maintained in the shelter included a scissors box that also contains a finger nail cutter. Inventories on sharps are conducted one time per week on the third shift. The agency provided the previous six (6) month of sharps inventories dating back to May 2013 to present have limited documentation of sharps and over the counter medication counts.

The agency had a total of four (4) documented DJJ CCC incidents that involved medical errors. These incidents were self-reported as required. The reviewer requested all evidence of documented follow up performed by the agency's management in response to these documented incidents. The agency provided evidence of follow up on all cases to demonstrate supervisory review, assessment and managerial action steps taken to address each medication incident error.

There were exceptions noted for this indicator. The agency had a total of four (4) documented DJJ CCC incidents related to medication errors.

One (1) closed client medication log possessed numerous missing counts and missing documented initials of the staff distributing medications. Additional closed files included several documented errors on the medication log where either medication counts or initials were not documented on a consistent manner across several medication distribution sessions taken by residents.

Review of the agency policy revealed that the policy does not currently contain language to address and require Verification of all medication accompany any admission to the residential facility. The agency must review its current policy to incorporate the agency's ability to verify all medications entering the residential youth shelter. It is recommended that the agency update and its current practice in the area to be able to meet this requirement.

Sharps counts for all of the aforementioned sharps on a weekly basis are not consistent. Routine weekly sharps counts are consistent for some weeks during some months and limited evidence of counts were observed in other months. There should be an average of four (4) weekly counts being conducted on each month for each OTC medication.

Over the counter counts for all of the aforementioned OTCs on a weekly basis are not consistent. Routine weekly counts are consistent for some weeks during the six (6) months period while there is no evidence of consistent counts observed in other months. There should be an average of 4 weekly counts being conducted on each month for each OTC medication.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive written policy that addresses the requirements of this indicator. The policy is called the Medical/Mental Health Process. The agency is required to address any information pertaining to the youth that identifies the youth's medical condition, physical activity restrictions, allergies, common side effects, of prescribed medications, foods, and medication contraindication, and other pertinent treatment information to ensure that it is effectively communicated to all staff through an alert system.

The agency utilizes a colored alert system that includes a blue folder or section divider sheet for CINS/FINS clients. A green dot is placed on the client's name if they are on medication or has a medical condition. An orange dot indicates that a client is on Sight and Sound. A red folder indicates that the youth is a CINS/FINS Staff Secure or Court-Ordered client. A red dot indicates that the client is high risk (aggressive behavior, gang affiliation, sexual assault or misconduct, chronic runner, history of mental health or substance use issues, etc.).

The agency utilizes a pro log to also document alerts that are documented in the logbook. Yellow indicates an important documented event. Pink indicates important events. Blue indicates discharges. Green indicates parent, legal guardian, and Case Worker notification. Orange indicates staff sign-in or sign-out. Red ink indicates incident, accidents or injuries. Green ink indicates medication distribution or special medical conditions. Black ink indicates any pro log entry. No Blue ink is allowed in the pro log.

A total of six (6) files were randomly selected to verify the agency's adherence to the requirements of this indicator. Of these files reviewed. Three (3) were open cases and 3 were closed. All cases were appropriate marked for the corresponding documented alerts. The logbook verifies the condition of all 3 open cases.

Upon a file being closed, the colored alert dots are removed from the client's file. Because of this, it was difficult to determine with certainty if the youth was correctly assigned to the alert system while they were in shelter. However, of the closed files reviewed there was evidence in the pro log that the youth had been properly assigned alerts. In addition, each file reviewed had corresponding alerts.

There were no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses Episodic and Emergency care with regard to obtaining off-site emergency services, parental notification requirements, and the use of a daily log. The agency's policy was last updated in October 31, 2013. During the past six (6) months the agency's records indicate that there were twelve (12) incidences that were reviewed that required first aide and or emergency care visits, medical, dental and mental health related issues. Four (4) out of 12 instances involved youth that required outside medical care. In each of these cases, parents were notified and the pro log maintained the details of each incident.

The agency conducts annual emergency and episodic trainings with both LSF-NW Currie and Hope House staff members on an annual basis. The agency has certified safety training specialists on staff to provide trainings to staff in CPR and First aid. In addition, the agency requires that all staff receive CPR and First Aid training, as well as other safety and security training.

The agency has two (2) knives for life, multiple fire extinguishers and multiple first aid kits in the residential shelter. The agency also has first aid kits in each transportation van.

There were not exceptions noted for this indicator.