



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Currie House

on 10/20/2016

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 3: Shelter Care

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

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

Standard 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	Failed
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:0.00%
Percent of indicators rated Failed:20.00%

Percent of indicators rated Satisfactory:96.30%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:3.70%

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, FOREFRONT/FNYFS

Lea Herring, Regional Monitor, Department of Juvenile Justice

Joel Booth, Executive Director, Anchorage Children's Home of Bay County

Patrick Minzie, Shelter Manager, Capital City Youth Services

Teresa Clove, Executive Director, Thaise Educational and Exposure Tours

Persons Interviewed

- | | | |
|--|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input checked="" type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input checked="" type="checkbox"/> Program Manager |
| <input checked="" type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input checked="" type="checkbox"/> Direct-Care Part Time |
| <input checked="" type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 3 Case Managers | 1 Maintenance Personnel | 2 Clinical Staff |
| 2 Program Supervisors | 1 Food Service Personnel | 6 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" 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 checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 9 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 12 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 10 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 15 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 8 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

9 Youth 6 Direct Care Staff

Observations During Review

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

Strengths and Innovative Approaches

Rating Narrative

The agency has secured a Registered Nurse that was hired in the Summer of 2016. She works 6 to 10 AM, but beyond her duties as a nurse, she has also spearheaded an herb garden for the clients to enjoy.

The agency added a YCS III (YCS Supervisor) position this year. Additionally, the agency added male YCS staff members and a part-time non-res counselor now in Milton (Santa Rosa County). LSF-NW held a three (3) day supervisor training for the YCS II's and YCS III's at both shelters. The training's main focus was supervision relating to the behavior management program, but also covered how to be a supervisor in general.

The floors of the LSF-NW Currie House youth shelter building have all been replaced in the shelter and the kitchen has been completely renovated. This was done largely through donations from both suppliers and contractors. Additionally, LSF-NW purchased both a new van and a mini bus through a grant from Impact 100.

Non-residential school groups are growing and LSF-NW has added several schools to the program.

The United Way Day of Caring sent a team of workers to the shelter recently. This volunteer group painted baseboards and did some gardening while the team from LSF went out and painted at an elementary school.

A new surveillance camera system is being donated by Security Engineering and should be installed by the end of the calendar year. The new system is valued at \$7000.

The agency has a food donation portion of that program that continues to operate through the food program at HOPE House.

Both Currie House and HOPE House got together to hold the End of School Bash for the clients. This year's theme was a safari.

The agency also continues to hold an annual Cultural Celebrations event to promote diversity of its clients and workforce. The agency also continues to utilize its therapy dog, Dozer the Great Dane, to make his monthly visits to Currie House. Further, Currie House youth shelter clients visit the horse ranch two times a month as a therapeutic outing.

The agency celebrated 25 years of service with Beth Deck, LSF-NW Regional Director. A surprise luncheon was held with 50 local staff and 4 people from our Central Services office in Tampa, including the CEO and COO.

Standard 1: Management Accountability

Overview

Narrative

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. This youth shelter operates 24 hours a day, 365 days a year and serves a range of six (6) youth up to a maximum of twelve (12) 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 twelve (12) CINS/FINS youth. The agency promotes its broad range of service offerings to those youth and families in need through Outreach efforts in 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.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

All background screenings are required prior to an employee being hired to work as a mentor, volunteer, employee, or intern. All staff that reach to the five-year anniversary of their date of hire are required to have a five-year re-screening.

The program expectations are to follow the guidelines of FDJJ 1800, Background Screening Policy and Procedures.

The Annual Affidavit of Compliance was completed by the program and sent in to the Department of Juvenile Justice Background Screening unit by January 31st.

A total of twenty-one staff records were reviewed since the last annual review (from October 2015) to ensure compliance with background screenings. The Lutheran Services Florida Northwest has a policy in place that outlines the background screening process where all staff are to have a completed background screening prior to their hire date. Five year re-screenings are done for each active employee after the initial date of hire.

All nineteen (19) staff reviewed had completed background screenings prior to their hire dates. Two of the twenty-one staff were eligible for five-year re-screenings. All background screenings had been completed as required. One staff record showed a date of hire in February 2016, but a background screening was done September of 2015. The program explained that the staff member had been a volunteer previous to the date of hire. The program provided documentation of the Annual Affidavit of Compliance with Level 2 Screening Standards being completed on January 4, 2016. Ten staff training records were reviewed and all staff records reviewed had a signed copy of the Child Care Affidavit of Good Moral Character.

The program records reviewed were in compliance with the FDJJ 1800, Background Screening Policy and Procedures. None of the documents reviewed were out of compliance.

No exceptions were noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program provides an environment in which the youth, staff, and others feel safe, secure, and not

threatened by any form of abuse or harassment. It is the requirement of the program to abide by the policy and procedure of the Department of Juvenile Justice and Florida Statute as it relates to reporting of abuse, suspected abuse, a child abandoned by parent, caregiver, legal guardian, or persons responsible for the child welfare. The expectations of the program are to immediately act on any allegations of child abuse appropriately according to set policy and procedures of the Department and Florida Statutes. The program must have an accessible responsive grievance process in place to address complaints of the youth.

The program has a written policy in place that adheres to the code of conduct that prohibits any physical abuse, profanity, threats, or intimidation to youth. Youth at the program are not to be deprived of basic needs such as food, clothing, shelter, medical care, and security.

According to program policy, failure to report any incident of abuse leads to serious disciplinary actions of employment termination. The program has a policy to address grievances during the orientation process.

The program procedure outlines that all agency staff immediately report all allegations of child abuse or suspected child abuse to the Florida Abuse Hotline at 1-800-96-Abuse, The Department of Juvenile Justice Central Communications Center. Each case is logged in a client file and is accounted in an Abuse Registry Report.

There were postings of the Florida Abuse Hotline posted in the youth dorm and administrative reception area. Ten staff records reviewed revealed that staff are trained in reporting child abuse. Any abuse calls made on behalf of the youth at the time of admission are placed in the youth's case management records. Records of all abuse reports made while the youth receives services are tallied and kept in an administrator's office. In the case of any allegation made toward program staff, the shelter service manager and/or clinical director is immediately notified to determine the need for further action.

The program staff stated they have not had any internal abuse allegations or grievances made within the program in the last year. Grievance forms are kept in the dorm of the facility to ensure that they are accessible to youth. There was not a grievance box in the dorm, but interview with the staff supervisor reported that completed grievances in phase two would be turned into him for response. Internal investigations from all other non-abuse reports were reviewed to verify immediate action from management was conducted.

Nine out of nine youth stated they have never been stopped or delayed in making a call to the abuse hotline. Six of the nine youth stated they knew about the abuse hotline being available for youth to report abuse at the shelter. Youth surveys revealed all nine youth stated they feel safe at the program. Six staff surveys were conducted where all six staff stated they have never observed a co-worker telling a youth that they could not call the Abuse Hotline.

No exceptions were noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

In the event an incident happens, the program notifies the Department's Central Communication Center (CCC) within two (2) hours of an incident or becoming aware of an incident. The expectations is for the program to comply with the requirements of the Department and Florida Administrative Code as it relates to incident reporting.

The program has a policy in place for incident reporting.

The program policy clearly states all reportable incidents involving CINS/FINS clients are verbally reported to Department of Juvenile Justice, Office of Inspector General, and Central Communication Center (CCC)

within two (2) hours of knowledge of the incident. The policy outlines incidents that are labeled as reportable incidents—that includes definitions of each kind of incident.

The program provides training to all staff during the first forty hours of employment and receives additional training during the new hire orientation process and in-service trainings.

A review of incidents from the last six months (March 2016-October 2016) revealed a total of twenty-six (26) incidents reported to the Central Communication Center (CCC). Two of the ten incidents reviewed were reported late which was out of the required time-frame of two (2) hours of gaining knowledge of the incident. Both incidents were already reported in the CCC description as failure to report due to the report being outside the required time-frame. Of the twenty-six total CCC reports, two reports sited contraband, twenty-one reports were for medical error, one was for youth injury resulting from youth on youth altercation, and one was for disturbance as a result of law enforcement being called, which did not include any youth arrest.

No exceptions are noted for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

[Rating Narrative](#)

The agency has a written policy approved on 08/21/16 that addresses the requirements of the indicator.

All direct care CINS/FINS staff are required to have a minimum of 80 hours of training during the first year of employment and direct care staff in the shelter are required to have 40 hours of training after the first year. Specific topics are outlined as either required or recommended. The policy also explains the training and/or documentation necessary for non-licensed clinicians that work in the shelter and complete Assessments of Suicide Risk.

The program has a training plan that includes offering two key components, Orientation and Workplace Safety, each month on an alternating rotation. A training calendar for the current quarter was observed posted in the staff office in the shelter.

Each employee has a training file that is separate from their personnel file. Training files contain a record of the number of hours and topics that an employee has been trained in since their hire date. Supporting documents such as certificates and/or sign-in sheets are also included in many cases. This was verified by review of a total of 10 employee training files. The files reviewed included a cross section of files for employees that were currently within the first year of training (5 total), as well as some who had been employed 2 years or longer (5 total). They also included staff in various categories including direct youth care workers, counselors, and supervisors.

All of the files reviewed met the minimum number of required training hours for all those who had completed at least one year of employment. Five files were reviewed for staff that were still within the first year of employment. All files reviewed had orientation and most of, if not all, of the required topics were completed.

No exceptions are noted for this indicator.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

[Rating Narrative](#)

The program has a policy in place that collects and reviews several sources of information to identify patterns and trends, data from quarterly reviews of incidents, annual reviews, monthly medication management reviews, case records, grievances, and monthly data reports.

The program has information that is recorded on a monthly basis for any corrective actions implemented, trainings, program improvements, quality of services provided and facility issues that may need to be addressed.

A review of client satisfaction surveys of residential youth showed that 100% of youth stated that they felt safe in the program. Bi-Monthly meetings are held to review peer quality improvement. Trends are tracked through the minutes taken at these meetings and are maintained by the Quality Services Manager. Documentation from the NetMIS Extract on trend data indicated the numbers of year-to-date admissions was above the yearly average. Data revealed 97% of youth are living at home within 30 to 60 days and attending school within 60 days of receiving services.

Reports are run on the Pyxis med station daily. Reports ran reflect information such as med discrepancies, staff assigned to assist, user summaries, and cancelled transactions. These reports are reviewed by the Registered Nurse weekly, if not daily, and the RN is also able to pull or run data upon request. There were no grievances filed at Currie House for the past year.

No exceptions are noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program's Client Transportation policy was approved and dated for August 21, 2016 by the Regional Director. The policy provides guidelines regarding ratios for transportation of clients indicating that 1 staff member may transport 2-3 clients, 2 staff members may transport 4-6 clients with 1 staff member positioned between the genders, and transporting 7 or more clients requires 3 staff members. Note that the agency has a full-size/larger capacity van that can accommodate 12 people.

The policy and procedure outlines that clients may not sit in the front seat without requesting permission or approval from the shelter supervisor or the Shelter Manager. One or more staff must be seated in the passenger section of the van to supervise client behavior.

Two forms of logging client transports were reviewed. The facility logs regular transports of clients in the facility logbook and irregular transports of clients in a transportation logbook. These log entries include staff transporting, date and time, clients in transport, purpose of travel, supervisor's approval, and staff initials. However, transport log entries are inconsistent and often leave out one or more factors listed above.

The vehicle mileage log was also provided and reviewed and this vehicle documentation includes date and time, driver name, trip reason, number of clients, and mileage. It does not include time of trip, names of youth on transport, and no information regarding supervisor's approval is provided. Therefore, between both documents, the program is providing all the transport information required by the 1.06 indicator, but this information is not readily found in one document location. In addition, the indicator 1.06, discusses detailed instructions regarding what steps are needed in a single driver transport and the program's policy does not discuss any additional information beyond a single driver being acceptable for one to three clients.

Interview of staff revealed that the program requires that all staff on-site have a valid driver's license upon hiring. Review of five personnel records revealed the dietary specialist driver's license expired three months after the date of hire.

No exceptions are noted for this indicator.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency does have a policy that addresses outreach services.

Outreach Coordinator serves as Secretary for the Circuit DJJ Council.

Minutes from these meetings for the past 6 months were readily accessible.

There were also interagency agreements with 9 other local agencies indicating good collaboration with partners. These include entities such as law enforcement, schools, a substance abuse treatment provider, Lakeview and Catholic Charities.

The program covers Escambia and Santa Rosa Counties. Santa Rosa County has no DJJ council, but has the Northwest Florida Prevention Coalition which meets monthly and consists of partners similar to a DJJ council. The Outreach Coordinator attends these meetings as well as the Escambia County Juvenile Justice meetings. Outreach coordinator attends circuit meetings quarterly and the other meetings monthly. Most recently outreach was done with one of the local high schools. Volunteers from the shelter helped paint around the campus and the school has shown an interest in having non-residential counselors facilitate school groups.

No exceptions are noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The LSF-NW agency provides residential and non-residential services to youth ages 6 - 17. The Youth Shelter residential facility is located in Crestview. The Non-Residential program is under the direct supervision of a Licensed Mental Health Counselor (LMHC). The agency LMHC supervises an all Master's Level counseling team of Counselors that service clients in both Pensacola, Florida service areas. The Non-Residential program services client needs across several counties. Several of these counties are in rural and outlying areas.

The agency provides several services. The referrals for services are received from parents, school, counselors, the court system, the youth themselves and other sources. The services provided by LSF-NW include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home/community. Youth also receive referrals for substance abuse and mental health services.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services Florida NW has a written policy for the Screening and Intake Indicator. It contains all elements that are needed and is being implemented in the facility. The Policies and Procedures Manual was updated and signed by the Quality Services Manager on 8/21/16, Clinical Director on 10/17/16 and Regional Director on 9/7/16.

The youth and parents are receiving

- a) available service options
- b) rights and responsibility
- c) grievance procedures and
- d) possible action taking during the time in service.

Lutheran Services Florida NW has procedures and practices in place to ensure 24 hour access to services. Screenings are completed during the day at the main office and at the shelter and after hours at the shelter only. An on call counselor or Clinical Director is available by phone to respond to service delivery emergencies or to resolve questions or issues.

Eight (8) cases were reviewed-- four (4) Residential (2 open and 2 closed), and four (4) Non-Residential (2 open and 2 closed). All screenings were completed within 7 calendar days of referral. In fact, all screenings were completed the same day for both Residential and Non-Residential Services.

No exceptions are noted for this indicator.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services Florida NW has a written policy for the Needs Assessment Indicator. It contains all elements that are needed and is being implemented in the facility. The Policies and Procedures Manual was updated and signed by the Quality Services Manager on 8/21/16, Clinical Director on 10/17/16 and Regional Director on 9/7/16.

The procedures are being followed consistently. The bachelor level counselor, master's level counselor, and residential staff or on call staff conducts clinical intakes within 24 hours of a youth admission to the shelter or Non-Residential program and the needs assessments are completed within 72 hours of the intake/admission.

Eight (8) cases were reviewed-- four (4) Residential (2 open and 2 closed) and four (4) Non-Residential (2 open and 2 closed). All of the Needs Assessments for the four (4) Non-Residential Program were completed on the same date as the intake. Three (3) of the Needs Assessment for Residential Program were completed on the day after the intake and one (1) was completed the same day of the intake. All were within the standard. All the Needs Assessment were completed by a master's level counselor and signed by a clinical supervisor.

No youth were identified with suicidal tendencies. One youth had a past history of suicidal tendencies but denied present tendencies. She came in from Baptist Medical Center and was placed on sight and sound at the shelter but it was not due to suicidal tendencies but for threatening her mother. Automatically when a youth comes in from Baptist Medical Center they are immediately placed on sight and sound until further evaluated.

No exceptions are noted for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services Florida NW has a written policy for the Case/Service Plan Indicator. It contains all elements that are needed and is being implemented in the facility. The Policies and Procedures Manual was updated and signed by the Quality Services Manager on 8/21/16, Clinical Director on 10/17/16 and Regional Director on 9/7/16.

A Case Plan is developed within 7 days following the completion of the Needs Assessment and addresses the following:

- a) identified needs and goals
- b) type, frequency, and location
- c) person responsible
- d) targeted date for completion
- e) actual date of completion
- f) signatures (youth, parent, counselor and supervisor)
- g) date and time initiated.

The procedure is for the case plan to be initiated during the intake and completed within 7 working days following the completion of the clinical intake for Residential and Non-Residential Services. The case Plan is reviewed by the counselor, parent (if available) every 30, 60 and 90 days for progress/achievement or making any necessary revisions.

Eight (8) cases were reviewed-- four (4) Residential (2 open and 2 closed) and four (4) Non-Residential (2 open and 2 closed). All four (4) Non-Residential Case Plans were opened on the day of admission and one (1) of the Residential Case Plan was opened on the same day as admission and the other three (3) were opened the next day. All were opened according to the standard. All the case files addressed the individual youth needs, had the type, frequency and location listed, and had the name of the person responsible for providing the services. All the case files had the targeted and actual dates of completion listed. Two (2) of the closed Non-Residential and two (2) of the Residential Case Plans target and actual dates were completed. Two (2) of the open Non-Residential and Two (2) of the open Residential Case Plans

actual dates were yet to be completed. The youth were still open and working toward their goals.

One (1) closed Residential case file was missing a parent signature on the Case Plan. This parent did not make themselves available to the shelter staff after repeated attempts and did not participate in the services provided for his child. All files had the date and time the Case Plan was initiated.

No exceptions are noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

Lutheran Services Florida NW has a written policy for the Case Management and Service Delivery Indicator. It contains all elements that are needed and is being implemented in the facility. The Policies and Procedures Manual was updated and signed by the Quality Services Manager on 8/21/16, Clinical Director on 10/17/16 and Regional Director on 9/7/16.

Eight (8) cases were reviewed-- four (4) Residential (2 open and 2 closed) and four (4) Non-Residential (2 open and 2 closed).

Each youth was assigned a counselor/case manager throughout the delivery of service. The counselors monitored the youth and families progress and addressed it in the progress notes. No referrals were made in the 8 cases reviewed. Each of the two (2) closed Non-Residential and 2 closed Residential cases files were terminated with a summary. One (1) of the Non-Residential and one (1) of the Residential case file had a 30 Day Follow-up completed. The other two (2) closed cases were not due for a follow-up.

No exceptions are noted for this indicator.

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

Lutheran Services Florida NW has a written policy for the Counseling Services Indicator. It contains all elements that are needed and is being implemented in the facility. The Policies and Procedures Manual was updated and signed by the Quality Services Manager on 8/21/16, Clinical Director on 10/17/16 and Regional Director on 9/7/16.

Eight (8) cases were reviewed-- four (4) Residential (2 open and 2 closed), and four (4) Non-Residential (2 open and 2 closed). The Non-Residential counselors provided individual and family counseling to the youth and their family. The Residential counselors provided individual, family and daily group counseling. All presenting problems for the youth were addressed in their Needs Assessment, Case Plan, and Case Plan Reviews. On the 8 cases reviewed, the counselors maintained case notes and reported their progress.

Exceptions:

On all 4 of the Non-Residential case files, the supervisor failed to do on-going clinical reviews on a regular basis.

For the Residential cases two (2) of the closed cases were missing supervisory reviews.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

Lutheran Services Florida NW has a written policy for the Adjudication/Petition Process Indicator. It contains all elements that are needed and is being implemented in the facility. The Policies and Procedures Manual was updated and signed by the Quality Services Manager on 8/21/16, Clinical Director on 10/17/16 and Regional Director on 9/7/16.

Eight (8) cases were reviewed-- four (4) Residential (2 open and 2 closed) and four (4) Non-Residential (2 open and 2 closed). No youth were staffed for Case Staffings. One (1) Shelter youth was court ordered into the shelter for 45 days. The youth was admitted 10/15/16 and has had some counseling within the 5 days at the shelter but no court reviews or staffings.

No exceptions are noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services Florida NW has a written policy for the Youth Records Indicator. It contains all elements that are needed for this indicator. The Policies and Procedures Manual was updated and signed by the Quality Services Manager on 8/21/16, Clinical Director on 10/17/16 and Regional Director on 9/7/16.

Eight (8) cases were reviewed-- four (4) Residential (2 open and 2 closed) and four (4) Non-Residential (2 open and 2 closed). All files were marked confidential and were neat and in an orderly manner. The files were locked in a secure room with a "Confidentiality" label on the door of the room.

Exceptions:

Although the room door was marked "Confidential", the file cabinets were not marked confidential as the indicator requires.

Lutheran Services Florida NW has two (2) opaque containers with a digital lock to transport files as needed but did not have "confidentiality" marked on the container as required.

Standard 3: Shelter Care

Overview

Rating Narrative

The Currie House Shelter is licensed by the Department of Children and Families (DCF) as a Child Caring Agency. The Currie House youth shelter provides temporary respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program, as well as for youth from the Department of Children and Families DCF. The shelter program management team is comprised of a YCS III Residential Shelter Manager. Each shift also has a YCS that is the designated team leader.

The Currie House youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services and other special populations. Specifically, this shelter is designated by the Florida Network to provide staff secure services, Domestic Violence (DV) respite, Probation Respite, and Domestic Minor Sex Trafficking.

The youth shelter building includes a large day room, individual girls' and boys' sleeping rooms, individual bathrooms, kitchen, laundry, residential and counseling staff offices. The building also has a separate medication and camera room and the exterior of the office includes a large back yard with a small basketball court and recreation area. During the Quality Improvement review, the shelter was found to have brand new flooring. The building was found to be in clean and good condition. At the time of this review, the furnishings are in adequate condition and the rooms and common areas were clean. The bathroom floors are tiled and the plumbing appeared functional. The sleeping rooms houses two (2) youth each. The resident sleeping rooms is equipped with individual beds, bed coverings, pillows and a locker. The windows are equipped for privacy for the youth.

The program has policies and procedures in place for its Shelter Care programming. The Direct Care workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the staff.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated on 8/12/2016 and was signed by the Regional Director.

The program's policy ensures that all of the key indicators are thoroughly addressed:

1. Health and fire safety inspections were both current (fire inspection was completed in 8/2016 and the health inspection was completed on 10/2016). There were no major violations requiring corrective actions.
2. Furnishings were in very good repair. The facility has recently had major renovations on the floors throughout the shelter. The kitchen had new cabinets as part of the recent upgrades. The shelter was very clean, well maintained, and in good repair.
3. The facility was free of insect infestation.
4. The grounds were very well maintained.
5. The bathrooms and showers were clean and appeared to be in good working order.
6. The facility was free of graffiti. The facility was clean and provided a very welcoming environment.
7. The bedrooms were observed to be very clean and each youth had his/her own bed with mattress covers, pillows, linen and blankets.

8. Lighting was adequate throughout the facility.
9. A safe is provided in the intake office for youth that have personal items that they desire to be secured. Additionally, there is a closet that locked at all times that is utilized to secure belongings as well.
10. There is a posted schedule in the living area with designated times for education, recreation, etc... seven days a week during awake hours. The youth are engaged in activities and idle time is avoided.
11. The posted schedule identified an hour of recreational time/physical activity is provided daily.
12. Faith based activities are identified on the weekly schedule (specifically on Sunday). An interview with YCS1 Katherine Lewis confirmed that youth are afforded frequent opportunities to participate in faith-based activities and alternate, non-punitive activities are provided for youth that do not desire to engage in any faith-based programs.
13. The daily schedule identifies study/homework time and quiet time.

The daily schedule is publicly posted on the bulletin board in the living area.

Observations were conducted by completing a walk-through on numerous occasions and conducting staff interviews with staff (YCS 3 Anthony Kyle and YCS1 Katherine Lewis). The facility has recently undertaken a huge renovation project of replacing the wooden floors throughout the shelter and upgrading the cabinets in the kitchen. The facility should be commended for this initiative. This is a tremendous improvement to the shelter environment and it is obvious that the staff and administration take great pride in this upgrade. The overall environment of the shelter is very welcoming and promotes a very therapeutic atmosphere.

No exceptions are noted for this indicator.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the CQI indicator. The policy manual was last updated on 8/12/2016 and was signed by the Regional Director.

The program's policy ensures that all of the key indicators are thoroughly addressed. Specifically, the program orientation reviewed the program's expectations, rules, and the behavior management system strategies. Evidence of the following elements were found in all client files reviewed:

- List of items considered to be contraband,
- The program's disciplinary rules,
- The program's dress code,
- Access to medical and mental health services,
- Procedures for visitation,
- Grievance procedure,
- Disaster preparedness instructions,
- Physical layout of the facility,
- Sleeping room assignment and introductions,
- Suicide prevention.

A total of six (6) residential files were reviewed for this indicator; two (2) closed files and four (4) open files.

All files consistently contained documentation verifying that the youth received orientation within 24 hours of admission. The youth signs a client intake checklist indicating that they have been provided a handbook that explains, in detail, all required items in this indicator. Additionally, files contained client rights and responsibilities, grievance, and other specific policies with individual signatures from the client indicating that this information had been discussed and explained to them. The orientation process appeared to be very thorough and was well documented in all six (6) files that were reviewed.

No exceptions are noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the Youth Assignment indicator. The policy manual was last updated on 8/12/2016 and was signed by the Regional Director.

A process is in place that includes an initial classification of the youth for purposes of room or living area assignment with consideration given to potential safety and security concerns that include, but are not limited to the following:

- Review of available information about the youth's history, status and exposure to trauma,
- Initial collateral,
- Initial interactions with and observations of the youth,
- Separation of younger youth from older youth,
- Separation of violent youth from non-violent youth,
- Identification of youth susceptible to victimization,
- Presence of medical, mental or physical disabilities,
- Suicide risk,
- Sexual aggression and predatory behavior.

The program does implement an alert system that assesses all youth who enter the shelter for potential harm to self at the point of intake. Mental health, substance abuse, potential harm to others, physical health and security risk factors are also assessed during the intake. The client's information is recorded in the Shift Pass Down Log to communicate to staff any mental health or other alerts. A colored dot system is utilized to provide a "quick reference" to staff when identifying potential risks with youth (dots are placed on shelter files which are housed in the intake office).

A review of six (6) residential files; two (2) closed and four (4) open confirmed that a consistent practice of room assignment is implemented in the program. Youth are thoroughly screened upon intake and room assignments are given after due consideration of the youth's history in all screening areas and his/her current presenting demeanor.

Exception:

One (1) of the six (6) residential files reviewed indicated that a youth came in and was screened for suicide. The youth was placed on constant sight and sight and sound, which was indicated by bed checks entered into the log book. However, there wasn't an entry in the logbook informing the staff that the youth had been placed on constant sight and sound. While the practice of sight sound checks was documented, the protocol to inform staff was deficient.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the Log books indicator. The policy manual was last updated on 8/12/2016 and was signed by the Regional Director.

A review of the log books, covering a six month period, indicated that the following key elements were consistently being met:

1. All log book entries that related to security and safety were highlighted according to the established color code system. This practice was consistently implemented throughout the log book.
2. All entries are brief and legibly written in ink and include:
 - Date and time of incident, event or activity
 - Names of youth and staff involved
 - A brief statement providing pertinent information
 - The name and signature of the person making the entry.
3. All recording errors were struck through with a single line and were initialed and dated by the staff making the correction.
4. The program director completed very detailed reviews and they were well documented in the log book. YCS3 Anthony Kyle also completed reviews and this was documented in the log book.
5. Oncoming supervisors made consistent entries into the log book documenting reviews of the previous two shifts. These entries were signed and dated.
6. Direct care staff consistently documented reviews of the previous two shifts in the log book and were signed and dated.

The agency log book is utilized very effectively to pass down all critical information to staff. Entries were legible and very few errors were observed. In addition to the log book, the program utilizes a pass down log that captures critical information on each youth in residence. The pass down log provides an overlap of information to help ensure that all critical information is received by all staff on each shift.

Exception:

While reviews by the program director and YCS3 were conducted periodically, there were not consistent weekly reviews documented in the log book. It is obvious that reviews are completed, but consistent weekly reviews were not found to be documented in the log books.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of this indicator. The policy manual was last updated on 8/12/2016 and was signed by the Regional Director.

The agency's behavior management system is designed to influence the youth to make positive choices and increase their personal accountability and social responsibility. Upon detailed review of the policy, observation of the system's point cards, and receiving an overview of the system from YCS1 Katherine Lewis, there was confirmation of the following key elements of the system:

1. A detailed written description of the behavioral management system strategies was found in the youth

handbook. Completed point cards indicated that youth are positively rewarded for positive choices and applied expeditiously and appropriately.

2. Consequences were reasonable and met the severity of the infraction.
3. A variety of awards and incentives are built into the system such as free time, tv time, off-site outings, point store, and other incentives as they become available.
4. Training records confirmed that all staff are trained in the behavior management system and the importance of providing positive feedback for both positive and negative behaviors.
5. YCS3 Anthony Kyle has recently participated in training on how to effectively use the current behavior management system. Mr. Kyle is a relatively new supervisor, so the supervisor feedback has been deficient in the recent past. However, the program is positioning itself to provide effective feedback to staff as it moves forward with stabilizing the supervisory positions.

Behavioral interventions utilize the least amount of force necessary to address the situation and basic rights of the youth are respected.

1. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention.
2. When staff are required to physically engage youth, only nationally recognized techniques approved by the Florida Network of Youth and Family Services and the DJJ are used. Lutheran Services Florida – Northwest trains staff in the use of Crisis Prevention Institute’s Non-Violent Crisis Intervention which is one of the approved techniques.
3. Only staff is allowed to discipline youth.
4. Group discipline is not imposed at this facility.
5. Room restriction is used only as part of a system that ensures the least restrictive means possible and is utilized to maintain the safety and security of the youth and others in the program. Room restriction is not used for youth who are physically and/or emotionally out of control.
6. Disciplinary measures do not deny youth any of the following: regular meals and snacks, clothing, sleep, physical health services or mental health services, educational services, exercise, correspondence privileges or contact with parents or guardians, attorney of record, juvenile probation officer or clergy.

The behavior management system is well implemented and appears to promote positive behavior among the youth in the program. Card conferences are held every evening to discuss the positive and negative behaviors of the youth for that day. Youth are encouraged to proactively identify negative behaviors that can be improved upon for the next day. Youth can earn the achievement level which allows them the opportunity to not carry a point card and, at the end of the day, help staff determine how many points they earned for that day. This is a good incentive for youth to work towards and affords them greater autonomy as their stay in shelter becomes extended.

Exception:

The agency has recently undergone significant personnel changes and the supervisory capacity has been impacted by this. The current supervisor has completed supervisory training on the behavior management system and how to provide effective supervisory feedback to the direct care staff as they implement the system. Moving forward, the agency will be better positioned to give this critical feedback to staff.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy in place that meets general ratio requirements.

Program maintains a staffing pattern of one staff to six youth during awake hours and community activities. The overnight ratio for the program is one staff to every twelve youth during the sleep period. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. Overnight work shifts maintain a minimum of two staff, one of the same gender as youth residing at the program.

The program has the staff schedule posted in the day room of the dorm. There is no current formalized process for holdover or overtime rotation roster. Policy 3.06 (#4). Staff reported that the informal practice when the need arises is the responsibility of the YCS or supervisor/on-call. The shift times for staff to report to work are staggered to prevent lack of coverage should a staff member not show up for work.

There is also a phone list of staff numbers kept in the staff office on the dorm in case a request for coverage is needed. Credible proof of effort to meet the requirement is not clearly documented and no examples could be provided of a case where efforts were made because the program did not meet the same gender guidelines.

The program provided a shift change document which is utilized by staff in cases where a staff is not available to work their assigned shift and changes shift with another staff of the same gender.

Review of logbook supported policy requiring staff to complete ten-minute checks while youth are sleeping—either during the sleep period or at other times, such as during illness or room restriction. Cameras were observed throughout the program. Cameras were all in working condition at the time of walk-through. Cameras provided clear sight of the areas being monitored.

No exceptions are noted for this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The program has Staff Secure policies and procedures in place that were approved on 8/12/16. Program does have a policy outlining the requirements for a staff secure placement that includes orientation and admission, assessment and service planning, enhanced supervision, parental involvement and collaborative aftercare. Staff was able to discuss steps/requirements needed if a Staff Secure placement was necessary.

Program does have applicable Domestic Violence Respite policies and procedures in place that were approved on 8/12/16.

Agency has policy and procedures for Probation Respite that was approved on 8/12/16.

Agency has Domestic Minor Sex Trafficking policy and procedures that were approved on 8/12/16.

The agency has not had any staff secure cases in the last 6 months or since the last onsite QI review was conducted. Therefore, reviewer is unable to observe practice of policy with regards to bed assignments and assigned staff supervision to one staff secure youth at any given time.

At the time of the review, the program had no clients placed in shelter under DV respite. During the past six months the program had 13 clients placed under DV respite. Of these 13 clients, (5) client files were reviewed. All 5 files had clear and adequate documentation and a clear case plan.

The program reports that they have not had any youth placed under the criteria. No noted Probation Respite in the last 6 months or since the previous QI review was conducted.

At the time of this review and since the previous QI review there had not been any Sex Trafficking youth admitted to the program.

No exceptions are noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency does a policy that addresses the video surveillance system.

The program has a video surveillance system that is instituted and in operation 24 hours a day, 7 days a week. The purpose for the operation of the system is to guarantee personnel accountability while capturing the agency happenings to ensure the safety of all youth, staff, and visitors. The program had signs posted outside the entrance of both the shelter and the administrative offices notifying visitors of camera surveillance. Cameras are monitor the interior and exterior locations of the shelter. No cameras are located in bathrooms or sleeping quarters. The camera records date, time, and location. Video is kept on file for over a month before being deleted.

The program has a backup system to keep video records in case of a power outage. The program manager, Regional Director, and administrative personnel are the designated staff to review videos. Supervisory reviews of the video footage are conducted regularly.

There are no exceptions for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

LSF-NW operates both the Currie House and Hope House Shelter. Their residential and non-residential CINS/FINS Programs are located in Escambia, Santa Rosa, Okaloosa County, Florida and is also the designated CINS/FINS provider for both Escambia and Santa Rosa Counties. The program has a management team that is comprised of the following positions: North Region Director; Clinical Director that is a licensed Mental Health Counselor; Residential and Non-Residential Counselors; a Youth Care Specialist III-Residential Services Manager; Residential Direct Care Staff, Outreach Coordinator; Administrative and Maintenance staff. At the time of the onsite QI visit, the agency reports that staff turnover has been an issue this year, both in YCS shelter staff across all shifts and with the clinical staff.

The Regional Director and Shelter Manager oversee the operations and duties at two (2) shelters in Pensacola and Crestview, providing oversight and supervision of the direct care workers that are responsible for the CINS/FINS residential and non-residential programs as well as other programs operated by the provider in the Northwest Region.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a detailed policy on Healthcare Admission Screening. A review of the agency's current policy was conducted on site and the current policy was found to have met general requirements for the agency's staff to conduct healthcare screenings on 100% of all clients admitted to their programs. The Lutheran Services Florida policy specifically lists examples of major medical conditions to include diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries which occurred during the previous two (2) weeks, acute allergies, chronic bronchitis or other chronic disorders.

The agency practice for the health screening process is initiated during the healthcare screening process. The CINS/FINS Intake Form screens each youth for a broad range of health and medical conditions. The CINS/FINS Intake Form is one of the primary tools utilized by the program to screen for the current status of acute health conditions. Further, the screening form asks about the past, recent or current status of medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings. The agency's health screening form addresses all elements of the indicator.

A review of nine (9) open residential client files reviewed contained documentation of the CINS/FINS Intake form that was completed by direct care residential and screening staff. A review of each of the 9 health screening documents revealed that the agency is capturing health screening findings according to the requirements of this indicator. The agency has a separate form that documents the observation of scars, marks or tattoos. All 9 files reviewed contained the required forms. The agency has an active medical or injury referral process and follow-up medical care on an as needed basis when applicable.

No exceptions are documented for this indicator.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a detailed policy and procedure for the Suicide Prevention screening, assessment and

supervision practice for the Currie House Youth Shelter. A review of policy was conducted on site and the policy meets the general requirements of the indicator. Specifically, the agency's policy requires that all of the program's residential and non-residential clients eligible to receive CINS/FINS services be screened for suicide risk as part of the initial intake and screening process.

If a youth indicates positive for suicide risks, a licensed professional or a non-licensed professional under the supervision of a licensed clinician shall assess the youth within 24 hours. The agency uses an Evaluation of Imminent Danger of Suicide (EIDS) tool to determine the level of risk. The policy states that the youth awaiting assessment by a licensed professional are placed on constant sight-and-sound supervision. If a youth exhibits or engages in suicide or self-harm gestures, the youth is placed on one-to-one supervision and referred to law enforcement and/or constant sight-and-sound. Following the assessment of suicide risk, the youth supervision status can stay the same or only be removed from the status by the licensed clinician. All staff assigned to monitor and supervise must maintain one-to-one supervision or constant supervision. They are required to document their observations at a 30 minute or less interval on observation log sheets.

The current practice for screening for suicide requires that the agency use the CINS/FINS Intake form and the Evaluation of Imminent Danger Survey (EIDS) to determine the past and present risk for suicide. The agency uses the CINS Intake form at Intake. The CINS intake form screens each program participant for suicidal risk by asking each of the six (6) suicide risk questions on the CINS/FINS Intake form. The EIDS is also used during intake and a resident that meets a score of 5 or more is placed on suicide risk observation status. The agency has two (2) levels of suicide risk supervision that include Sight and Sound and Elevated Supervision. At the time of this review, the agency's current plan for addressing suicide risk addresses all general elements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

A total of nine (9) residential client files reviewed on site contained evidence that each was screened for suicide risk by the using the six (6) suicide risk screening questions on the CINS/FINS Intake form. All 9 client files also had documentation that an EIDS was executed on each admission. The EIDS rating warranted that each resident be placed on suicide risk observation. The documentation of each resident resulted in a positive rating for the presence of suicide risk. In all 9 case files reviewed, the program immediately contacted the Residential Counselor or Licensed Clinician to verify the placement of the youth on sight and sound status. Each client file reviewed in this sample had documentation of observation check logs and official assessments completed by non-licensed staff being overseen by 2 licensed clinicians. A review of observation logs indicate that observation checks are being documented.

Documentation of clients being placed on sight and sound status; observation checks; and taking youth off sight and sound status are documented as required in 6 out of 9 clients files reviewed.

The agency has 1 residential counselor working towards the completion of a minimum of 5 assessments. This is verified by documentation of the Non-Licensed mental Health Clinical Staff Person's Training in completing a total of 5 Suicide Risk Assessments reviewed by a clinician.

Exception:

A review of observation logs indicate that observation checks are being documented. In general, the documentation of clients being placed on sight and sound status and observation checks are being conducted. However, documentation found in the Observation Checks on the status of behavior (missing behavior codes) and signature of a designated Lead or Supervisor at the end of each work shift is inconsistent in 3 of the 9 cases reviewed.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy on medication. The current policy is called Medications 4.03. This policy was last reviewed and signed as being in effect by LSF-NW Regional Director on September 7, 2016. The policy

addresses all general medication process requirements including secure storage, access, inventory, disposal, and administration/distribution of medications. The policy also addresses program measures related to medications such as operation of the Pyxis MedStation 4000 Cabinet. The policy also included language to address the Registered Nurse (RN).

Medications of all residents admitted to the program are required to be verified by a designated staff person. All medication records files are required to be maintained on medication specific forms and kept in a binder. The medication record files are maintained in same area as medications. Additional procedures require the Registered Nurse to train all staff persons. The agency does have a list of all staff that are authorized to distribute medications. The staff are executing distribution of all medications via the use of the CareFusion Pyxis MedStation 4000.

The agency hired a Registered Nurse (RN) on November 10, 2015 to work on site for twenty (20) hours a week. The agency provided a current list of staff that are trained and designated to have access to secured medications and limited access to controlled substances. The current list consists of a total of eleven (11) YCS staff members. The agency has a total of four (4) Super Users including the Registered Nurse. Super Users are primarily assigned to the staff work schedule on the first and second work shifts.

Observations conducted onsite by the reviewer confirm that all medications for all clients are being stored in the Pyxis MedStation 4000 automated medication cabinet. All oral medications are stored separately from injectable and topical medications. Each medication is being kept separately in its own cube or plastic boxed compartment. The agency does maintain a medication-specific refrigerator. At the time of this onsite QI program review, there are no medications housed in the refrigerator. Additionally, there were no injectable medications on site, or identified as needed for any youth during the time of the review. The refrigerator is housed in a secure room with the Pyxis MedStation. The room is locked and inaccessible to youth. The temperature was observed on site and meets the minimum 36-46 degrees Fahrenheit requirement.

All narcotics and controlled substances are required to be stored in the Pyxis MedStation cabinet. At the time of this onsite QI program review, there are no Narcotics stored in the cabinet. The agency policy requires that all controlled medications be counted on each shift with a witness. There were no current shift-to-shift counts, due to no controlled substance being house on site. Syringes and sharps are secured in the locked room in a locked metal file cabinet. The sharps are counted on a weekly basis and when used. Sharps maintained on site include razors and scissors. A review of the last 6 months of Sharps inventory binder was conducted. All counts of scissors and razors are generally conducted and documented as required since April 19, 2016 to October 16, 2016. There are 2 weeks in June 2016 that sharps were not counted as required. The only documented weeks that sharps were counted was on June 7 and June 29, 2016.

The agency maintains standardized Medication Distribution Log (MDL). The MDL includes client photograph, warning label, parent/guardian identification card, prescription medication consistent addendum form, over the counter medications approval form, doctor's diagnosis and prescriptions, prescription medication log counts and OTC log counts. At the time of this on site review, there was only 1 active CINS/FINS youth receiving prescription medications. This file included all required medication distribution and logging documents. A review of 4 other recently closed files were also reviewed for accuracy and completeness. These files include all required documentation and medication counts. At this time, medication distribution log documentation does not indicate interruptions, delays or missing medication sessions.

The Registered Nurse is capable of running reports on the Pyxis MedStation cart and the Knowledge Portal. In addition, the RN is clearing discrepancies. The RN is primarily on duty on the early part of the first work shift. The RN reports that she is generating reports to be used at staff meetings. The agency verifies medication by documenting medication type, medication pharmacy and date medication was last filled. In general, the on-site medication documentation process in the medication logs used by the agency meets the requirements of the Florida Network of Youth and Family Services medication management policy.

Exceptions:

A review of all incidents reported by the program in the last 6 months was conducted from April 19, 2016 to October 19, 2016. A total of 16 incidents were documented in the DJJ CCC system for medication related errors. A review of the errors found that 4 occurred on the AM work shift and 12 were documented as occurring on the PM work shift. Medication errors related to missed medication distributions are on-going over the duration of the said period. The types of medication errors involve staff missing the distribution of medication (and includes staff failing to give medications at the required time or 1 hour before or afterwards). Other failings to give medications include failing to distribute medications to residents on temporary home visits/outings and lapses in medication dosage/supplies.

This series of missed medication episodes indicate a failure to identify the root cause attributed youth not receiving prescribed medications as required. Further, the agency was not able to produce consistent evidence of the identification, analysis and implementation of corrective actions by management to address this issue. This series of missed distributions over multiple weeks requires the attention of supervisors and management to address medication distribution sessions.

All counts of scissors and razors are generally conducted and documented as required since April 19, 2016 to October 16, 2015. There are 2 weeks in June 2016 that sharps are inconsistent and not counted as required.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy called Medical/Mental Health Alert Process. This policy was last reviewed and signed by the LSF-NW Regional Director on September 7, 2016. The agency policy includes measures to ensure the provision of emergency medical and dental care. The policy addresses youth condition, physical activity restrictions, allergies, common side effects of prescribed medications, foods and medication contraindication, and other pertinent treatment information is communicated to all staff through a designated alert system. The content in this policy meets the general requirements of this indicator.

The agency procedure requires all YCS, counselors and supervisors to complete a medical and mental health screening and notify the counselor if there are mental health issues. Youth Care Specialist staff also inform nurses of clients with medical issues that need further assessment. Staff must ensure effective communication of medical issues through the health screening, professional log, case progress notes and other forms of program communication. The agency requires that Critical care information be communicated to all staff by utilizing a dry erase board on which general client information is listed. The agency requires that residential staff use a code protect client confidentiality. The agency utilizes files to designate the specific type of client that includes a yellow folder for Families First Network-FFN; a red for CINS/FINS Staff Secure or Court-Ordered Clients; and a blue folder for all other CINS/FINS clients. The agency also requires that staff use a color-coded dot system that uses an orange dot for Sight and Sound clients; a red dot to indicate High Risk clients; a green dot for youth on medication; and a blue dot for client admitted to the shelter for a Domestic Violence Respite (DVR).

No deficiencies were noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy called Episodic/Emergency Care. The policy was last reviewed on September 7, 2016. The agency's Episodic/Emergency Care policy includes measures to ensure the provision of emergency medical and dental care. The policy includes a specific focus on collecting off-site

emergency services; parental notification regarding emergencies; incident reporting to the DJJ CCC and FNYFS; daily logging of events/activities; returns to the shelter, verification of medical clearances, discharge instructions and follow-up care. In addition, the policy addresses the provision of emergency equipment (first aid kits, knife for life, breathing barriers and blood borne pathogen kits); critique of off-site emergency care; root cause analysis and emergency situations. The policy also lists procedures for staff to follow in the event of a serious injury of a client (1-5 steps). The agency has four (4) CINS/FINS shelter sites in the state of Florida. The policy in use at this site is the same across all 4 LSF youth shelters across the State.

A training sample of ten (10) staff members' training files indicated a total of 5 new hires and 5 on-going staff members completed CPR and First Aid certification. A review of the agency's emergency training topics includes CPR/First Aid, Safety & Accident Prevention, Disaster & Emergency Response/MSDS, Blood Borne Pathogens, Program Safety & Emergency Plans, Security Awareness Training, HIV & Health & Medical Needs, Fire Safety & Equipment, Workplace Safety, Fire Drills, and Safe Use of the gas grill.

A review of on-site emergency events was conducted. A review of all incidents in the last 6 months was conducted from April 19, 2016 to October 19, 2016. There was a total of three (3) actual incidents that resulted in hospitalization on June 13, 2016 (injury/bruise under left eye), September 9, 2016 (seizures) and October 12, 2016 (headache, fainting). All agency emergency events were documented as incidents in the DJJ CCC Log with evidence of parent/guardian notification requirement and obtaining off-site emergency services (i.e. EMS) accordingly.

No exceptions are noted for this indicator.