Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of LSF NW- Currie House

RE-VISIT
05/03/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.1	Background Screening of Employees/Volunteers	No Review
1.2	Provision of an Abuse Free Environment	No Review
1.3	Incident Reporting	No Review
1.4	Training Requirements	No Review
1.5	Analyzing and Reporting Information	No Review
1.6	Client Transportation	No Review
1.7	Outreach Services	No Review

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

Standard 2: Intervention and Case Management

2.1	Screening and Intake	No Review
2.2	Needs Assessment	No Review
2.3	Case/Service Plan	No Review
2.4	Case Management and Service Delivery	No Review
2.5	Counseling Services	No Review
2.6	Adjudication/Petition Process	No Review
2.7	Youth Records	No Review

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

Standard 3: Shelter Care

3.1	Shelter Environment	No Review
3.2	Program Orientation	No Review
3.3	Youth Room Assignment	No Review
3.4	Log Books	No Review
3.5	Behavior Management Strategies	No Review
3.6	Staffing and Youth Supervision	No Review
3.7	Special Populations	No Review
3.8	Video Surveillance System	No Review

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

Standard 4: Mental Health/Health Services

4.1	Healthcare Admission Screening	No Review
4.2	Suicide Prevention	No Review
4.3	Medications	Satisfactory
4.4	Medical/Mental Health Alert Process	No Review
4.5	Episodic/Emergency Care	No Review

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

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

Rating Definitions

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

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

Review Team

Members

Keith Carr, Lead Reviewer, FOREFRONT/FNYFS

Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Chief Financial Officer
- [ ] Program Coordinator
- [ ] Direct-Care On- Call
- [ ] Clinical Director
- [ ] Case Manager
- [x] Nurse
- [x] Executive Director
- [ ] Program Director
- [ ] Direct- Care Full time
- [ ] Volunteer
- [ ] Counselor Licensed
- [ ] Advocate
- [ ] Chief Operating Officer
- [x] Program Manager
- [ ] Direct-Care Part Time
- [ ] Intern
- [ ] Counselor Non- Licensed
- [ ] Human Resources

0 Case Managers
0 Program Supervisors
1 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

0 Clinical Staff
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [ ] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Logbooks
- [ ] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [ ] Egress Plans
- [ ] Fire Inspection Report
- [ ] Exposure Control Plan
- [ ] Fire Prevention Plan
- [ ] Grievance Process/Records
- [ ] Key Control Log
- [ ] Fire Drill Log
- [ ] Medical and Mental Health Alerts
- [ ] Table of Organization
- [ ] Precautionary Observation Logs
- [ ] Program Schedules
- [ ] Telephone Logs
- [ ] Supplemental Contracts
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [ ] Youth Handbook

0 # Health Records
0 # MH/SA Records
0 # Personnel Records
6 # Training Records
0 # Youth Records (Closed)
0 # Youth Records (Open)
0 # Other

Surveys

0 Youth 0 Direct Care Staff

Observations During Review

- [ ] Intake
- [ ] Program Activities
- [ ] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] Social Skill Modeling by Staff
- [ ] Medication Administration
- [ ] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [ ] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [ ] Youth Movement and Counts
- [ ] Staff Interactions with Youth
- [ ] Staff Supervision of Youth
- [ ] Facility and Grounds
- [ ] First Aid Kit(s)
- [ ] Group
- [ ] Meals

Comments

Items not marked were either not applicable or not available for review.
Rating Narrative

Purpose

The purpose of the re-visit is to evaluate the provider's progress in addressing the indicators that were rated as failed during the QI Visit on October 19, 2016. Specifically, the provider received a failed rating for indicator 4.03- Medications.

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida Northwest is contracted with the Florida Network of Youth and Family Services (FNYFS), to provide residential and non-residential services to Children/Families in Need of Services (CINS/FINS). 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 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.

4.3 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a Medication policy that was updated in Fall 2016. The basis of this review involved failure of the agency to address documented medical errors in a reasonable and timely manner and lack of supporting evidence/information verifying and confirming that the agency worked directly with staff that committed the error. The reviewer conducting the follow-up review is requiring the agency to provide evidence that they have addressed the findings from the October 2016 review that resulted in a failed rating.

The agency was represented by the agency's Regional Director, Program Manager and the Registered Nurse. Each representative was present at the entrance interview. The review conducted included direct interviews with these representatives.

Interview with the program manager resulted in verifying that the agency has implemented a new management oversight process to address medical errors in a more timely manner. This process includes direct involvement with the agency's registered nurse. Once an error has been reported it is reviewed by the registered nurse and the program manager. The agency then identifies a corrective action review and remediation approach directly with the staff person that committed the error. The agency uses a root cause approach to determine where the staff person committed the error that led to the medication error incident being reported to the DJJ central communications center.

The registered nurse is required to conduct a daily medication update that is submitted to the regional director, program director, YCS 3/Supervisor and the staffed that committed the error. Once the registered nurse has completed a review all the before mentioned people are sent an email regarding what the nurse found to be the cause for the error. The nurse typically is documenting all parties in 24 to 48 hours of the incident occurring. The review process also includes the nurse providing a refresher training directly to the staff that committed the error. The review process also includes a supervision and remediation who is being administered to the staff person that committed the error. Staff involved in committing a medication error are required to take a quiz following the incident.

Since the date of the last review, the agency has reported a total of six (6) errors. A total of five (5) errors were due to missed distribution of the medication times and one involved a late distribution of the medication. The supervision and review process and all documentation related to follow-up as a result of a

medication error are placed in the staff person's personnel file.

The agency has also revised their new staff training process related to medication distribution. The agency's new training process now requires the agency to have a medication training checklist that staff must sign off specifically related to medication distribution. This training includes staff knowing the five rights, understanding the medication distribution log, understanding the medication verification process, understanding the client formulary, and complete understanding of the Pyxis medication cart including registering a youth in the medication counsel; loading medication; unloading medication; and conducting inventory and resolving discrepancies.

The agency's nurse is required to verify and confirm the cause of all discrepancies. At the time of this review, the agency does not have a clear process for staff persons to resolve discrepancies in real time or prior to the close of their current work shift.

The agency does have familiarity and understanding of knowledge portal (KP). The knowledge portal provides statistics and comprehensive data on the number of loads, unloads, and medication discrepancies committed on a daily basis. The agency's nurse does know how to run KP reports on a daily, weekly, monthly, and quarterly basis.

Exceptions:

There are exceptions documented for this indicator. Since the last on-site review was conducted, the agency has committed a total of six medication errors. Of these errors, one was committed in November, two were committed in January, one was committed in March, one was committed in April, and one was committed in February 2017. A total of five (5) errors were due to missed distribution of the medication times and one involved a late distribution of the medication. The agency provided complete documentation of all of the aforementioned incidents and the agency's comprehensive response and retraining the staff as required.