



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Hope House

on 12/04/2012

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Limited
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
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	No rating
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	No rating
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory: 71.43%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care

3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	Satisfactory

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.29%
Percent of indicators rated Limited: 3.57%
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

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Latrice Covington, Contract Manager, Florida Department of Juvenile Justice

Lydia Breaux-Davis, Contract Manager, Florida Department of Juvenile Justice



Kevin Winship, Program Director, Capital City Youth Services

Peggy Vickers, Regional Coordinator, CDS Behavioral Health Services

Persons Interviewed

- | | | |
|---|--------------------------|-------------------------|
| <input type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 1 Clinical Staff | 3 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 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 type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input type="checkbox"/> CCC Reports | <input checked="" 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 | 3 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 0 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 12 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 7 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 8 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input type="checkbox"/> Table of Organization | |
| <input type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 0 Youth 0 Direct Care Staff 0 Other

Observations During Review

- | | | |
|--|---|---|
| <input type="checkbox"/> Admissions | <input type="checkbox"/> Posting of Abuse Hotline | <input type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage |
| <input type="checkbox"/> Facility and Grounds | <input type="checkbox"/> Recreation | <input type="checkbox"/> Toxic Item Inventory and Storage |
| <input type="checkbox"/> First Aid Kit(s) | <input type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input checked="" type="checkbox"/> Group | <input type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input type="checkbox"/> Meals | <input checked="" type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input type="checkbox"/> Medical Clinic | <input type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input type="checkbox"/> Medication Administration | <input 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 Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency that is 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 is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in Northwest region of the Florida Panhandle.

Each youth shelter operates 24 hours a day, 365 days a year and serves a range of youth age 10-17 years of age in each program. At the time of this onsite Quality Improvement (QI) review, Hope House Currie had five (5) CINS/FINS youth in the shelter and two (2) Department of Children and Families clients. Further, the agency has currently provided CINS/FINS Non-Residential services to an estimated of twenty-eight (28) clients and their families for the current 2012-2013 fiscal year to date.

The agency promotes its broad range of service offerings to those youth and families in need through Outreach strategies and partnerships in their service region. The agency has multiple interagency agreements with local community stakeholders and partners. The agency places a high degree of importance on creating opportunities and that promote getting the word out in the community concerning CINS/FINS services. The agency has strategic partners that include local schools, law enforcement, United Way, local area businesses, faith-based organizations, medical partners, homeless shelters, and various other community-based organizations. Along with LSF NW these community partners provide an array of services that help to work with youth and their family to resolve family issues and increase family stabilization and unification.

Lutheran Services Florida Northwest staff members (residential and non-residential) were very cooperative with the monitoring team in all phases of the monitoring process. 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. In addition, a Document Request List was provided in advance, listing specific documents and files to be available during the onsite visit. All of the staff members were prepared for the onsite review and cooperative with the monitoring team which created a productive and hospitable monitoring environment.

The LSF NW agency has therapists that serve the shelter and non residential youth and their families. The LSF-NW has an 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. The Hope House youth shelter serves 2 different resident populations. 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 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 groups of youth receive similar is not the same service offering, interventions and treatment.

Standard 1: Management Accountability

Overview

Narrative

The Lutheran Services Florida Northwest (LSFNW) Hope House youth shelter is located in Crestview, Florida and provides CINS/FINS services in Okaloosa and Walton counties. Lutheran Services Florida also operates a sister youth shelter called Currie House that is located in Pensacola, Florida and provides residential and non-residential services in Escambia and Santa Rosa Counties. The programs 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 both residential youth shelter locations. The agency also assigns the daily operation and direct responsibility of each shelter to a Youth Care Specialist III that acts as the Residential Supervisor at each youth shelter. Further, the agency has implemented uniform operating protocols for both service locations in the areas of screening, hiring and training. The agency conducts screenings prior to hiring of all staff members. Further, all staff members receive training at their respective service locations. In addition, many agency trainings combine staff members of both locations to be trained on various core training topics.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure that meets the requirement for the Background Screening indicator. A review of ten (10) employee files was completed that included the review of seven (7) new employees, two (2) interns and one (1), 5 year re-screen. The one (1) employee 5 year re-screen was completed 1 month in advance of its due date. Background screens were completed on the 2 interns but there was no documentation to support the interns start date. The volunteer/intern log book presented had an intern signing in on May 23, 2012, however there was a 2 month gap between this entry and the previous month's entry. The 7 remaining screens were all completed before the employee's hire date. Four (4) of the new employees were terminated within 6 months of employment.

The annual affidavit for background screens was completed prior to the January 30th, due date.

The 2 exceptions to this standard included No evidence of documentation to support the start dates for the 2 interns and termination of 4 employees within 6 months of their respective date of hire.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The policy manual contains procedures that comply with the requirements for the agency to adhere to the Abuse Free Environment indicator.

The agency has a policy on the provision of an Abuse-Free Environment for staff members/employees that interact and provide services under its CINS/FINS contract with the Florida Network of Youth and Family Services. This policy was last updated and signed by the agency on July 31, 2012. A total of three (3) youth surveys were completed onsite. All 3 youth surveys report that youth feel safe in the shelter. One (1) out of 3 youth surveys indicates that a youth states that a staff member made a threatening comment and could not be determined if it was directed at this youth or another resident. All youth residents commented on being aware of how to contact the Abuse Hotline and of general fire safety information. Two (2) of the 3 indicate that they are aware of the grievance process. Two (2) out of the 3 youth surveyed reported that they were knowledgeable of the abuse reporting process. There was one case of a youth making threatening remarks toward a staff member. Three (3) youth rated the care provided by the agency as Very Good and one youth did not respond.

A total of three (3) staff member surveys were completed onsite during this QI program review. Three (3) staff member surveys report that staff have not observed youth being sent to their rooms for punishment, have not observed a co-worker using profanity when speaking to youth, have not observed a co-worker using threats, intimidation, or humiliation when interacting with the youth, and have observed a co-worker telling a youth that they could not call the Abuse Hotline. This monitor observed that the abuse hotline number is posted in the shelter day room and common areas. In addition, a grievance box and forms are also posted in plain view.

The agency's personnel policies and procedures manual also include the employee code of conduct manual. The manual is dated April 1, 2001. Section 12.0 Termination of Employment list provisions related to actions and work performance that warrant either personnel action or termination of employment. All employees must review and sign that they have reviewed this document. All staff background screenings were conducted as required. All required staff member training files do not indicate behavior or work performance issues.

At the time of this onsite review, there were no Grievances reported by residents within the last six (6) months.

There were two (2) employee incidents that required formal actions. The first incident involved a female staff member that participated in inappropriate contact with a male resident. The agency was made aware of this by the resident's parent issuing a complaint by (June 15,

2012). The alleged staff member was immediately placed on administrative leave the same day that the agency gained knowledge of the complaint. Incident reports were made to DJJ CCC and Abuse Hotline on the same day (June 15, 2012). Formal investigations were initiated by DCF Child Protection Investigation and DJJ Administrative Review Investigator with the office of the Inspector General. The local Sheriff's Office also conducted an investigation. The alleged female staff member was placed on leave and was never permitted to return to the shelter during the duration of these investigations. The agency terminated the staff member after receiving the investigative report from the Okaloosa County Sheriff's Office. A personnel action form (PAF) was issued that terminated their employment. This case was reported to the DJJ CCC as required.

An additional staff incident involved a staff member that was arrested for Driving while Under the Influence (DUI). The staff member reported this to the agency within forty-eight (48) hours. The staff member was required to be on administrative leave immediately as dictated by the agency policy. The staff member issued their resignation due to not being able to finalize the case proceedings which are required to be finalized prior to being able to return to considered for reemployment. This case was not reported to the DJJ CCC as required.

There were two (2) cases that document Supervision forms or Management Review forms regarding the work performance of two (2) staff members that were involved in medication errors. These incidents occurred in October 2012, but were not documented by management until December 2012. The incident involved a missed medication dosage and was reported to the DJJ CCC as required.

One (1) of the 2 aforementioned cases listed involved or presented a safety issue related to inappropriate contact with youth in the shelter. However, the agency followed internal policy requirements and protocols after becoming informed of the incident.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

There is a policy and procedure in place for the Incident reporting indicator. There were 6 incident reports documented between June 1, 2012 and December 1, 2012. The incidents included the following: staff engaging in inappropriate contact/relationship with a program resident, staff DUI while off duty, youth received medications outside the documented timeframe and 3 program disruptions. Five (5) incidents were reported within the 2 hour required timeframe. The staff DUI was reported after staff members received CCC training 3 months after the agency first gained knowledge of the incident. The incident involving youth not receiving prescribed medications was detected the day after it occurred when documentation failed to support youth receiving the previous day's 9 p.m. medications. The remaining incidents involved program disruptions that were reported on time.

The exceptions to this indicator included staff inappropriate conduct/relationship with youth, staff DUI and youth not receiving medication at designated time as required by their medication distribution instructions.

1.04 Training Requirements

Satisfactory Limited Failed

Rating Narrative

There is an approved written policy that outlines staff training requirements of 80 hours for first year employees and following first year employment, 40 hours annually for direct care staff. The agency has an annual training plan listing all trainings for the year and includes some training during monthly shelter meetings. The agency has an individual training file for each staff that includes a training plan, annual training tracking form, and supporting documentation. Ten (10) training files were reviewed for this indicator. Of the ten, five were employees hired within the last year and five were employees following the first year. Each of the five first year employees exceeded the 80 hours of training. All five employees following the first year exceeded the 40 hours of training. The training files for first year and following first year employees contained verification of completed CPR, first aid, and blood borne pathogens training annually. Five of the ten training files did not have documentation of some of the core training topics required by the Florida Network for first year and following first year employees such as Title IV-E, Signs/Symptoms of Mental Health and Substance Abuse, and Cultural Competency. One file did not have a training plan. And, the training plan was not signed in one file.

There was no documentation of one first year employee being trained on Title IV-E.

One first year employee training plan was not signed.

One first year employee file had no training plan.

Two on-going employee files had no documentation of signs/symptoms of mental health and substance abuse training.

One on-going employee file had no documentation of cultural competency training.

1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

A written policy is in place for this indicator. The agency has identified staff member in place for the specific purpose of community outreach. The agency has nine (9) interagency agreements or memorandum of agreements executed within the last three (3) months that includes services for: parenting classes, mentoring, mental health/suicide risk, run away, and alcohol/drug abuse services. Six (6) of the agency's agreements are nearing 5 years of the date in which they were originally executed; three (3) of which are with divisions of law enforcement. The agency provided copies of agreements pending signature with these entities. No current agreements exist for youth educational issues or emergency medical services. North Okaloosa Medical Center provides emergency medical services under an agreement executed April 18, 1997.

The exceptions to this standard include no current agreements in place for educational or emergency medical services. While there has not been a break in emergency medical services under the agreement signed 4/18/97, a reasonable timeframe for current agreements is recommended to be within a 3 year timeframe.

1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that meets the requirements for all disasters under the Disaster Planning. The plan addresses specific emergencies individually and separately. Staff responsibilities are identified by teams that include Red team that represents the agency's evacuation team or staff working during a disaster. The agency also has a Blue team for staff working after the disaster. Emergency contact information for staff and emergency services is included in the plan and includes location and directions to emergency shelters and access or location of public telephones.

1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The policy manual contains procedures that comply with the requirements for the agency to adhere to the Analyzing and Reporting indicator. There is a policy and procedure in place that states that the agency will identify a Continuous Quality Improvement (CQI) team. This policy is comprised of four (4) separate teams with representatives that include staff members from Currie House, Hope House, Ryan White and the Guardianship program. Other program areas included on these internal quality improvement teams include Clinical, Residential and Non-Residential, Sex Physical Abuse Program. The agency also has a Safety and Risk Management, Incident/Accident and Grievance team conducts safety inspections at each residential site on a quarterly basis and reports to maintenance for repair. The agency conducts incidents review and searching for trends to bi-monthly.

The agency focuses on safety issues on a routine basis. The agency conducts two (2) major events per year called Safety Events in February 2012 each year. The agency focuses on topics such as Workers Compensation, Human Resources issues, Medication Safety, Ergonomics, Disaster and Emergency planning by outside experts and specialists. The agency conducts a week-long series of Hurricane drills that simulate emergency disasters.

The agency has three (3) other teams that include Consumer Satisfaction/Program Improvement, Outcome Measurement and the Case Review team.

With the last year, the Hope House Agency assessed low utilization numbers and implemented a plan to increase the number of youth served. Hope House staff members executed an enhanced outreach plan to go out to public venues to market and promote LSF programs and services. This plan also involved LSF staff going out in the community to reconnect with existing partners and going to summer camps in the summer (summer 2012) to market LSF NW programs. The agency also had the area's local news come out to do a story on Hope House (Channel 3 September 2012) to do a story on services and programming.

The agency reports that Outcome Measurement Committee reviews are reviewed to provide surveys to participants in all of their program participants. This group looks for service satisfaction data and information from clients that received LSF NW. The agency has case review teams that meet monthly to review case file samples for accuracy and completion of client case files. The Team leader meets with the management on a quarterly basis to present findings on a quarterly basis and reports on issues, trends and risks identified by each Team.

Agency states that they are Council on Accreditation (COA) Accredited and their certification effective through February 28, 2013.

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 and six (6) Counselor II positions. Some counselors are not assigned to provide CINS/FINS Services. According to the agency's organizational chart, these services are delivered through its non-residential staff members. The LSF-NW staff are currently serving a caseload of nearly thirty (30) non-residential clients.

Non-residential services are provided to program participants and their families. These services are delivered through the agency's non-residential component and 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.

Screenings are conducted by youth care staff and counselors twenty-four hours a day, seven days a week. A case plan is developed for each client. In addition, home visits are conducted on a case by case basis to offer support the client and their family and to ensure the completion of the case plan. If deemed applicable and after further evaluation, Family and Individual Counseling is offered by Hope House non-residential staff with shelter care as a viable option for youth that need additional support services.

The non-residential program also offers an intervention called a Case Staffing Committee meeting to address non-productive outcomes for either or both the youth and their family. The youth along with their family, representative from the local school board, Department of Juvenile Justice attorney and other social services agencies are gathered together to address the services that are being provided by the program or entities that are not doing their part or taking part in the services. The result of the meeting is that another Plan of Service is developed to meet the needs of the youth and family members. The Case Staffing Committee can also recommend a CINS Petition to be filed in court to order participation with additional treatment services to assist resolve issues faced by the youth and their family.

Marty Townsend, Non-Residential Counselor, Sherl Craft, Residential Counselor and Sherri Swann, Clinical Director were interviewed regarding services at Lutheran Services NW Hope House.

Primary referral sources come from the following sources: Lutheran Services Teen Court, Schools, Resource Officers, Law Enforcement especially involving Domestic Violence, Parents, usually at the suggestion of someone else, a few military family referrals. The non-residential counselor has an average of 34 clients, they are seen for 12 sessions, the counselor often sees clients after the crisis has subsided once every two weeks, allowing for contact to extend over several months. With the longest time period being 6 months. There were no Case Staffings in this area. There are two non-residential offices one is located in the Hope House Shelter in Crestview and one in Fort Walton. The schedule varies depending on the number of referrals by geographical area. Generally, the counselor is in Crestview on Monday, Tuesday and Friday and Fort Walton Beach on the other two days. Currently, the case load is larger in Fort Walton.

Screenings are completed by the counselor at any location where he is, office, school, phone. Mr. Townsend is able to schedule intakes within a week from the screening. Length of intake varies but counselor schedules an hour and a half for the intake first appointment. If they do not finish they will schedule a second appointment. Following intake the counselor enters his own data into Netmis. Counselor defines the discharge criteria as completion of goals on their service plans. Mr. Townsend offers a family treatment model and enjoys working with youth of all ages.

Mr. Townsend, Ms. Craft and two other counselors from another area provide on-call service for the residential program. Counselors complete all residential intakes within 24 hours of admission, which exceeds DJJ standards. Counselors also provide support to the youth care workers in completing the Suicide Prevention Screening and Assessment. Their was documentation in the log book between youth care worker and counselor on call recommending a clearance by a Baker Act Receiving Facility.

Sherri Swann and Beth Deck both licensed consult on all residential youth who are assessed by a counselor who is not.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency provided their policy and procedure that include the requirements of the indicator including: services being accessible 24 hours a day, seven days a week; conducting initial screening for eligibility within seven calendar days of referral; and provision to the youth and parent/guardian of the service options, rights and responsibilities parent brochure, grievance procedures, rules and regulations of the shelter, and emergency procedures which are included in the handbook. For this review eight (8) youth files – three residential files and five non-residential files were randomly selected. Six files were open and two closed. Of the eight files reviewed, seven had their eligibility screening completed within the required 7-calendar days. Also, all of the eight files documented that youth and parents received in writing information pertaining to the available service options, the rights and responsibilities of youth and their parents/guardians, the parent brochure, grievance procedures, the possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS

adjudication). In non-residential files the receipt of the parent/guardian brochure is documented on the last page of the psychosocial for five/five files. The consent form was updated to add this document on 10/15/12, but is currently not being used. Documentation in the residential files was found in the shelter file, not the clinical file.

Exception 1- one non-residential chart had a screening completed more than 7 days following a referral. A written referral was in the chart but was not date stamped on the date received.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedures which includes the requirements that the psychosocial assessment be initiated (or attempted) within 72 hours of admission and completed within two to three face-to-face contacts or updated if the most recent psychosocial assessment is more than 6 months old. Three of three residential files reviewed all documented that the psychosocial assessments were all initiated within 72 hours of the youth's admission. All of the assessments were completed within 24 hours after admission. Five out of five non-residential psychosocial assessments were completed on the same day as the intake. All assessments reviewed were completed by a Masters level staff member and included dated signature to indicate a supervisory review upon completion.

All eight files reviewed included a suicide risk assessment. Two of the three residential files reviewed identified the youth with an elevated risk of suicide as a result of the psychosocial assessment and the referrals for an Assessment of Suicide Risk for that youth was completed by a Masters level staff member under the supervision and documented consultation of a licensed mental health professional (LMHC) as required by the standard and the agency policy and procedure.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The written agency policy and procedure for Case Service Plans requires that the plan be developed within seven (7) working days of the completion of the psychosocial assessment. The policy requires reviews to be conducted every 30 days for the first three months and every six months thereafter. The reviews document the youth's progress in achieving goals and for making any necessary revision to the service plan, if indicated which is in compliance with the requirements of this standard. Of the eight files reviewed, all eight files documented that the case/service plan was developed within seven working days of the psychosocial assessment being completed. The review documented that all of the eight youth files demonstrated reviews for progress every 30 days for the first three months. No files reviewed required a six month review.

There was one residential file missing a parent signature on one 30-day reviews.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedures which includes the requirements that each youth be assigned a counselor/case manager to follow the youth's case and ensure delivery of services through either direct provision or referral. The standard and the policy both require case

management to include establishing referral needs and coordinating referrals to services based on the assessment of the youth's problems and needs, coordinating the service plan implementation, monitoring the progress in services, providing support for the family, monitoring any out-of-home placement if necessary, referring to the case staffing committee as needed, recommending and pursuing judicial intervention in selected cases, accompanying youth and parents to court hearings and related appointments, if applicable, referral to additional services, providing continued case monitoring, and review of court orders and case termination with follow up.

Eight (8) of the files reviewed included documentation to indicate that the counselor established referral needs to services based upon the youths psychosocial assessment, had coordinated service plan implementation, provided monitoring of the youth's/family's progress in services, provided support for the family. One file monitored out-of-home placement was documented the needs of the youth. No referrals to the case staffing committee were identified by the facility. Two (2) of the files included case termination.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The written agency policy and procedures adheres to the requirements of this standard in that it requires provision of individual and family counseling and the provision of group counseling in shelter at least five days per week. The policy also requires non-residential program's provision of community-based services in the youth's home, a community location, or the provider's office. The agency policy and procedure adheres to the standard by including the requirements for counseling services as detailed in the standard. Eight of the eight files reviewed documented that the youth had received counseling services in accordance with the case service plan for that youth. Both individual and family counseling were documented in the files. Eight of eight files reviewed documented that the youth's presenting problems were addressed in the psychosocial assessment, the initial case service plan, and reviews; case notes were maintained for all counseling services provided. Documentation in the files supported the on-going peer review process that ensures clinical reviews of the case files and staff performance. Three residential files, included documentation of group notes in the clinical file, shelter file, activity log and the log book.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedures which includes the requirements of the standard. No youth/family have been identified as needing these services in the last six months.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The standard requires that the program maintain confidential records for each youth that are maintained in a neat and orderly manner, are marked "confidential" and kept in a secure room or locked in a file cabinet. The youth files reviewed were neat and orderly, each following the same order and table of contents included at the front of each section of the file. Youth files are kept in a locked file cabinet located in a secure room. All eight (8) files reviewed were marked "confidential" on the outside of the file.

Active residential youth has two (2) files, one (1) clinical maintained by the residential counselor and one shelter file. At discharge both files are combined. Initially this was confusing, because some required documentation will be found in one or the other.

Standard 3: Shelter Care

Overview

Rating Narrative

The LSF-NW residential component houses eight (8) residents. According to the agency's organizational chart the Hope House youth shelter staff consists of a Shelter Services Manager, a Youth Care Specialist (YCS) III, a Dietary Specialist, two (2) YCS II, twenty (20) YCS I staff members and 2 YCS Interns. At the time of this QI program review, there are a total of seven (7) youth in the youth shelter. The Residential Supervisor oversees the day-to-day operations of the youth shelter. The program provides group sessions to clients a minimum of five (5) days a week on various topics that address issues including substance abuse prevention, anger management, effective communication, leadership skill building and many others. The agency utilizes an behavior management system that is also used in its other residential programs.

The residential shelter is a converted large home that also houses the agency's administrative offices. The administrative offices are located on one side of the 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 facility has two (2) large bedrooms that are located on the second level and are separated by gender. Each room is equipped with four (4) beds. Each room also includes a bathroom. There is also a YCS work station and camera surveillance monitor located on the second level adjacent to the resident bedroom. All rooms, bathrooms and linens were clean at the time of this onsite program review. All kitchen areas were clean and food preparation, storage and disposal practice is satisfactory. All common areas are neat and orderly. In addition, all safety equipment is in place and operational.

The LSF-NW Hope House residential component houses up to eight (8) residents. According to the agency's organizational chart the Hope House youth shelter staff consists of a Shelter Services Manager, a Youth Care Specialist (YCS) III (Residential Supervisor), a Dietary Specialist, two (2) YCS II, and thirteen (13) YCS I staff members. At the time of this QI program review, there are a total of seven (7) 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 therapists, one to serve the shelter and one for the non residential youth and their families. The Currie House youth shelter serves 2 different resident 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 division of the Lakeview Center. The Lakeview Center is a provider under the Florida Department of Children and Families (DCF.) Under the terms of this contract, LSF-NW is required to provide reunification and or placement care for youth that are in the Foster Care system. Both CINS and FFN youth receive similar service offerings, interventions and treatment.

3.01 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

The program has an established policy and procedure dealing with client room assignment. Based on a review of the available client files, there is a clear and distinct portion of the intake process that deals specifically with room assignment. 7 youth files were reviewed (5 active and 2 closed.) Of these 7 files, all 7 contained evidence that all requisite domains were evaluated when assigning a client room. Interviews with the YCS supervisor and 1 staff member showed that YCS complete the shelter-specific portion of the intake and both individuals had a good working knowledge of the criteria for room assignment and what paperwork to review prior to assigning a room.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has an approved written policy outlining the program orientation process. The HOPE House Client Handbook (handbook) contains most of the required topics and includes several pages that require the client's signature as proof of discussion. The signed pages are kept in the client's case file. Seven case files were reviewed for this indicator. Of the seven files reviewed, five were open and two were closed. All files have an intake checklist of all topics discussed that is initialed by agency staff and signed by the client. Six of the seven files reviewed documented the date the orientation process occurred, which verifies the handbook was provided within 24 hours. The shelter has a grievance box and forms that are accessible to all clients. There were no grievances within the last six months. Client rights and responsibilities are in the handbook, signed by the client, and posted in the facility. One file did not have an orientation date on the intake checklist and it could not be determined if the handbook was received within 24 hours.

One file did not have an orientation date and could not determine if the handbook was received within 24 hours for one file.

3.03 Shelter Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The program consistently met all requirements of this indicator without exception. The agency's facility is a large, 2-story structure situated in a residential neighborhood. The grounds and exterior of the building appeared to be in good repair. A review of documentation showed that the agency has all applicable health and fire inspections for the prior year. All fire extinguishers had documentation that they were certified and in good working order. Observation of the common areas, bedrooms, and bathrooms showed that all furniture was in good repair. There were no plumbing leaks, odors, or other apparent building problems. Graffiti was minimal. All walls, floors, and electrical sockets/switches appeared to be in good repair. Emergency lights were tested and worked. Exit signs were clearly posted and emergency evacuation plans were posted in both Spanish and English at various points around the facility. Each youth had an individual bed that was in good repair. Motivational posters and decorations were posted all around the facility as well as postings that pertained to the facilities Social Skill/Behavior Management program. Linens appeared clean and appropriately fashionable. Bedroom/bathroom/common area lighting was suitable. Each youth had access to a dresser for storing their personal items and each youth was allowed to personalize their living area. All windows and doors were in good working order with working locks (as appropriate.) The facility maintained a locking safe for valuable items. All required postings (health inspections, licensing, abuse hotline, client rights, etc.) were posted appropriately.

3.04 Log Books

Satisfactory
 Limited
 Failed

Rating Narrative

The facility maintains a hardbound log book with numbered and lined pages. This log book is where they document all daily activities, incidents, bed checks, staff transitions, phone calls (youth), and unusual occurrences. The log also serves as their key control log. The current log book dates back to 10/25/2012. Review of the current log book showed a consistent pattern of legible, brief, and informative entries. Staff utilized the log book to coordinate appointments for clients, communicate important client information, and document reporting of incidents (as well as the required faxing/calling of managers and funders for certain incidents.) Dates, times, and signatures were generally legible. It appeared that all direct care staff reviewed at least the 2 prior shifts and noted their review appropriately. Errors were corrected in keeping with the standard and agency policy. There was no use of correction fluid/tape (White Out.)

There was limited supervisory review. A review of the active log book showed that the YCS supervisor documented a review only 2 times between 10/25/12 and 12/4. There was evidence of other entries by the YCS supervisor during that timeframe but nothing that specifically indicated that she was posting a supervisory review. Similarly, there were limited supervisory reviews conducted by the Shelter Manager, one on 11/28 and one on 12/3. The Shelter Manager documented 3 other reviews that were concerning as they were documented over struck-through portions of the logbook and the reviews did not occur in keeping with the chronological order of the logbook. For example, a review note dated 12/3 by the Shelter Manager was written on a struck-through portion of the log book dated 11/14. This type of entry occurred in 2 other areas. This type of documentation (not in chronological order & writing over struck-through sections) is not in keeping with the agency's policy & procedure, FNYFS standards, or generally accepted documentation practices.

Rating Narrative

All areas of this standard were met with one minor exception. A review of the publicly posted daily schedule showed that the youth are scheduled to engage in a variety of educational, therapeutic, and fun activities. The activities include: physical activity, off-site activities, homework, group, and unstructured free-time. Observation of the program activities and review of the logbook showed that the schedule is generally being followed and that the youth are participating in activities as planned. According to staff interviews, faith-based activities were offered weekly and youth that did not wish to participate had the opportunity to participate in alternative, non-faith-based programming. During the time of the review, no use of the TV or gaming system was observed and the staff appeared to be constantly engaged with the youth that were on-site. There was a large library area in the common room and it appeared to be stocked with age-appropriate reading material. Group is provided at least 1 time per day, 7 days per week on various topics that were relevant to the population be served. The group topic and participants were documented in the facility's Activity Log.

The daily youth schedule has only 30 minutes per day specifically designated for physical activity. However, the agency has free time that, according to staff, is frequently used for physical activity and outdoor recreation.

3.06 Behavior Management Strategies

Satisfactory
 Limited
 Failed

Rating Narrative

The agency has a clear and informative policy and procedure relating to their behavior management system. The program utilizes a token

economy geared toward helping youth master certain social skills. Each youth is assigned 2 basic target skills at intake and other, more client-specific skills are added within the first few days of a youth's stay. Each time a youth demonstrates a social skill, they earn points. Each time an unwanted behavior occurs, the youth loses points. When youth lose points, they have the opportunity to earn back a portion of the lost points through processing the interaction with staff. A review of 2 staff files showed that staff have received training on how to implement and effectively use the system. Supervisors received specific training on how to monitor staff's use of the behavior management system. Interviews with the shift supervisor and YCS supervisor showed that they were able to intelligently describe their responsibilities and actions in supervising YCS use of the behavior management system. Feedback on the use of the system is provided to the YCS by supervisors verbally and, if necessary, through use of the agency's disciplinary process. Observation of the program operations showed that the system was being consistently used by staff. Posters and written materials pertaining to the behavior management system were posted all around the facility. Interviews with 2 youth confirmed that the system is being used consistently and both youth were able to coherently explain the system and how it functions. Interviews with staff showed that each staff member had a strong working understanding of the system and all staff members recited several examples of how they would interact with youth in various situations. A review of 3 youth surveys showed that all 3 indicated that they feel safe at the facility and all 3 youth denied being sent to their rooms or locked in their rooms as punishment.

3.07 Behavior Interventions

Satisfactory Limited Failed

Rating Narrative

A review of the agency's policy and procedure showed that there is a clear and informative policy regarding behavioral interventions with clients. A review of 2 training files showed that staff are certified in CPI. The parent handbook clearly explains the agency's philosophy on behavioral interventions and the communication a parent can expect should physical intervention be necessary. Interviews with staff revealed that the agency is a "hands off" facility and all staff interviewed reported that they would only use a physical intervention in a life-threatening situation. None of the staff interviewed had utilized or witnessed an instance where physical interventions were used. A review of the agency log book and incident reports did document one instance in which the staff utilized non-physical methods to de-escalate a crisis situation. Agency policy and procedure clearly prohibit any denial of basic rights or activities such as meals, exercise, education, health care, etc. According to staff interviews and a review of the policy, only staff are permitted to discipline youth, no group discipline is imposed, and they do not utilize room restriction or isolation to deal with unwanted youth behavior.

3.08 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

A review of the staff schedule and observation of the program showed that they maintain at least a 1:6 (staff:youth) ratio during awake and sleep hours. For off-site activities, the agency utilizes a 1:3 ratio to help ensure the safety and well-being of their clients in less-controlled environments. A review of the staff schedule showed where staff had been held-over or called in to cover shifts. Overnight shifts were consistently scheduled to have 2 staff members on-site at all times. A review of the log book confirmed that there were always 2 staff members present during overnight shifts. A review of the agency video surveillance system showed that they had 2 staff members on overnight shifts and that bed checks were being completed as documented in the log book.

The agency has very few male YCS and this is causing them to sometimes utilize 2 female YCS to cover the overnight shifts.

3.09 Staff Secure Shelter

Satisfactory Limited Failed

Rating Narrative

The agency has a specific policy and procedure regarding staff secure clients. Interviews with staff showed that each staff member was aware of the policy and procedure. The agency has not had a CINS secure client within the past 12 months.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The agency provides screening, counseling and mental health assessment services. The agency has twenty (20) direct care staff, six (6) counselors, a Residential Supervisor, a Shelter Services Manager and a Licensed Mental Health Clinician. The agency has a comprehensive policy that addresses requirements related to behavior, mental health and suicide assessments. The agency's current suicide assessment practices and policies have been approved by the Florida Network of Youth and Family Services for 2012-2013. The agency also has an active health screening process that detects for the existence of acute health issues of all residents screened for admission into the CINS/FINS residential program.

The Hope House staff members are that are trained to screen, assess and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth past mental health status, as well as their current status. The agency also screens for the presence for acute health issues and the agency's ability to address these existing health issues. The agency also uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The Hope House staff assist in the delivery of medication to all youth admitted to the residential youth shelter. The agency operates a detailed medication distribution system. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury. At the time of this onsite Quality Improvement review, the agency has one (1) staff members that are licensed clinicians. This staff member is involved in the review of all residential clients that screen positive for suicide risk.

The agency has a full complement of staff of both male and female staff members across all three (3) work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training. During this onsite QI review, the agency provided an up to date list of agency staff members that have received medication distribution training and are authorized to provide distributed medication to residential clients.

Rating Narrative

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on the Healthcare Admission Screening process for youth being admitted to the residential component of the LSF NW Hope House program. A review of the policy and procedure meets the requirements of this healthcare screening process. The reviewer for this indicator selected a sample of files to assess the agency's Healthcare Admission Screening process. Of these files, all contained health screenings that were reviewed and completed the same day as admission. The healthcare screening form utilized by the agency included current medications, existing medical conditions, allergies, illnesses, injury status, pain, physical distress, scars, tatoos, or other skin markings.

The reviewer found that files completed by staff members lack evidence that they were being consistently reviewed by a supervisor. Also some files have medication information documented on the health screening section in the CINS Intake that is not consistent with the information listed in the respective client's medication distribution record. All files are organized in the same format and are marked confidential.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The program has a comprehensive policy and procedure written to address the indicator regarding Suicide Prevention. All eight (8) non-residential and residential files reviewed contained a suicide screening during the initial intake, and were reviewed and signed by the clinical supervisor.

An additional two (2) residential files were reviewed for the suicide risk. Three out of the total five residential files were reviewed for compliance with this indicator. Three (3) out of the five (5) residential files reviewed require sight and sound supervision. There was evidence of sight and sound documented in the logbook, on the pass down logs and the sight and sound daily log. The log book contains night time bed checks and sight and sound of the clients in 10-19 min intervals, which exceeds the 30 min standard. During the two day site visit it was observed that the staff provide one-on-one or one to two ratio for youth on sight and sound during day time hours. Observations were confirmed by Lee Bandy,

Shelter Supervisor.

Two (2) out of the three (3) youth were sent to a Baker Act Receiving Facility for clearance, and one came to the facility from a Backer Act Facility. Two (2) of the youth were cleared. The Doctor's discharge report was included in the youth's file. The practice appeared to follow the agency's policies on Suicide Prevention. Interview with Ms. Craft, Residential Counselor explained the Suicide Prevention policy, Counselor on-call and Clinical Supervisor on-call system for review. Ms. Craft also described how an youth maybe put on or taken off of sight and sound or one-on-one supervision. Ms. Craft's description matched the documentation in the charts and the log book.

The program has a comprehensive policy and procedure written to address the indicator regarding suicide prevention. All eight non-residential and residential files reviewed contained a suicide screening during the initial intake, and were reviewed and signed by the clinical supervisor.

An additional two residential files were reviewed for the suicide risk. Three out of the total five residential files were reviewed for compliance with this indicator. Three out of the five residential files reviewed require sight and sound supervision. There was evidence of sight and sound documented in the logbook, on the pass down logs and the sight and sound daily log. The log book contains night time bed checks and sight and sound of the clients in 10-19 min intervals, which exceeds the 30 min standard. During the two day site visit it was observed that the staff provide one-on-one or one to two ratio for youth on sight and sound during day time hours. Observations were confirmed by Lee Bandy, Shelter Supervisor.

Two out of the three youth were sent to a Baker Act Receiving Facility for clearance, and one came to the facility from a Backer Act Facility. Two of the you were cleared. The Doctor's discharge report was included in the youth's file. The practice appeared to follow the agency's policies on Suicide Prevention. Interview with Sherl Craft, Residential Counselor explained the Suicide Prevention policy, Counselor on-call and Clinical Supervisor on-call system for review. Sherl also described how an youth maybe put on or taken off of sight and sound or one-on-one supervision. Sherl's description matched the documentation in the charts and the log book.

The sight and sound daily log is completed by youth care workers, however, it is pre-populated with times listed every 30 minutes, from 7:00 am to 10:00 pm. The form includes the correct time intervals of 30 minutes, comments and youth care staff initials. It is strongly recommended that the form be changed to reflect real time, observation of behavior, warning signs observed, staff initials, and documented review by supervisory staff each shift.

Exception 1 - The sight and sound daily log is completed by youth care workers, however, it is prepopulated with times listed every 30 min, from 7:00 am to 10:00 pm. The form includes the correct time intervals of 30 min, comment and youth care staff initials. It is strongly recommended that the form be changed to reflect real time, observation of behavior, warning signs observed, staff initials, and documented review by supervisory staff each shift.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

Onsite observations found that all medications in the shelter are stored in locked metal 4 drawer metal cabinet in the Youth Care Specialist area. This area is inaccessible to youth under the supervision of staff members. All medication was stored behind a double lock set up the included a locked top to bottom cabinet key and a locked drawer. All Oral medications are stored in a separate cosmetic box that is labeled with each client's name. Each medication is stored in its original packaging or bottle. These medications are stored in the same box and separated by baggies with the resident's name. There were no injectable medications on site, or identified as needed for any youth during the time of the onsite review. The shelter has a system in place for refrigeration of medication if needed. At the time of this onsite QI review, there was no medication that required refrigeration.

Controlled medications are locked in a cabinet behind two (2) locks that include the top to bottom exterior cabinet lock and an individual metal key lock box. At the time of this review, there were two (2) CINS/FINS youth that were on Controlled medication. The agency maintains a Medication Distribution Binder on each resident regardless if they enter the shelter on any prescribed or over the counter medications. The agency does provide over-the counter medication. The agency distributes Acetaminophen (Tylenol), Ibuprofen (Motrin), Antacids (Pepto Bismol, Milk of Magnesia) liquid or tablet form if needed during the resident's shelter stay.

Sharps are maintained in a locked cabinet. The sharps maintained in the shelter included of scissors, razors, finger nail cutters. The agency does not maintain are maintained in the filing cabinet in YCS II office. Inventories on sharps are conducted one time per week on the third shift. The agency provided the previous six (6) month sharps inventories dating back to June 2012 to date (December 2012).

Verification of Medication is now included in the Hope House's current written Medication practice. Verification practice is operational and being conducted by staff on each medication brought into the youth shelter.

First client's Medication count was started incorrectly on Sunday, December 2, 2012. This was detected by staff assisting in the delivery of medication on December 4, 2012. Staff indicated that when a new sheet was started the number of medications was carried over in error thus the count was then documented incorrectly by staff providing medication until it was detected. The reviewer observed the medication count and found the number to be accurate at the time of this onsite QI Review.

A second client's MDR did not include a staff initials for two (2) separate medications that were documented as given on December 2, 2012 on 1st Shift. Sharps are counted 1 time per week and documented in the program logbook for all sharps maintained. Shaving razors are secured on the second floor in a cabinet in the locked YCS office upstairs. Razors are documented in a binder when they are issued and when they are returned. However, the agency did have evidence that the sharps maintained upstairs are counted on a weekly basis.

Although Verification of Medication is now included in the Hope House's current written Medication practice, this requirement should be developed and added to the current Medication policy as soon as possible.

A medication error was reported to the DJJ CCC in October 2012. The resident was required takes the prescribed medication twice per day. The afternoon/evening medication was not provided to the youth as required. This was detected and the youth was provided the medication as required.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a written procedure to address Medical and Mental Health alert process for all youth admitted to the youth shelter. The shelter utilizes a color coded dots identification system to identify various medical/mental health conditions. The agency utilizes a color coded key that uses colored folders to differentiate the client and the program type. This key uses Shelter file folder Alert Codes. Yellow indicates Families First; a Red Folder indicates CINS/FINS Staff Secure or Court-Ordered clients; and a Blue Folder is used for all other CINS/FINS clients.

The colored dots used by the agency are comprised of three (3) dots. The Green dot refers to a client that has been place on medication or has a medical condition. The Orange dot indicates that the client is on Sight and Sound supervision status. The Red dot is place on the client's file to indicate High Risk and is defined as History of criminal offenses, History of Assault or aggressive behavior, history of current gang affiliation, history of sexual assault or misconduct, chronic runner, history of mental health or substance uses issues and a FFN client on a safety plan.

A review of several active CINS/FINS client files was conducted onsite. All client files reviewed contained the appropriate color coded dots which were documented in the individual client case files. All alerts are posted in two (2) places: front of youth's chart and in the agency logbook. All allergies are posted in two (2) places: front of youth's chart; board affixed to the front of the refrigerator; in the shift review binder and in an initial entry in the program logbook. Two (2) of the 6 open files did include alerts for each youth's respective allergies. Log book entries were reviewed indicate that staff were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy on Episodic Emergency Care. A review of the agency policy was conducted and found to meet the minimum requirements for this indicator. The agency provided documentation that indicated that it conducted episodic/emergency drills in the last six (6) months. The information provided contained documentation in agency binder. No other cases were documented. When applicable the agency has a documentation protocol that requires direct care staff to document all incident that requirement onsite or offsite medical intervention in the program logbook and notified the parent(s)/guardian(s).

The residential shelter has adequate first aid kits and a knife for life suicide prevention tool. The shelter maintains a set of emergency wire cutters. The shelter conducts frequent drills on a monthly three (3) per month. The Emergency drill schedule lists various emergency drills such as broken limbs, seizures, head wound, sprained ankle and other. A review of the agency's emergency drill form was conducted by the reviewer and it was recommended that the agency add a column and list what type of drill is being conducted. The shelter also has a staff person that is certified to provide CPR and other safety and emergency drill training to Hope House direct care staff members.