



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Hope House

on 01/12/2017

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	Limited
1.07 Outreach Services	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 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 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 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory: 92.59%
Percent of indicators rated Limited: 7.41%
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

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Cindy Starling, Regional Coordinator, CDS East

Tracy Bryant, Business Analyst II, Hillsborough County

April Denney, North Regional Monitor Supervisor, Department of Juvenile Justice

Shawn Block, Program Administrator, Anchorage Children's Home

Persons Interviewed

- | | | |
|---|--|---|
| <input checked="" 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 type="checkbox"/> Direct-Care Part Time |
| <input 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 checked="" type="checkbox"/> Human Resources |
| <input type="checkbox"/> Nurse | | |
| 1 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 2 Program Supervisors | 1 Food Service Personnel | 0 Other |
| 0 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 4 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 9 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 4 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

4 Youth 3 Direct Care Staff

Observations During Review

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

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

The shelter has completed some “taking care of yourself” events this year. The youth learned how to make a rice bag to heat in the microwave to provide relief for sore muscles. They have had foot and spa days and learned how to make clothing items from fabric scraps.

Youth have built model cars, learned how to do origami, make a piñata, and sun catchers, explore career opportunities based on their own interest, attended a week-long Mission Okaloosa day camp program, and helped maintain a vegetable garden.

The youth and staff participated in a law enforcement appreciation week where they delivered baskets of goodies to local law enforcement partners. They have continued their involvement with the USDA food giveaway program along with the Feeding America program.

Standard 1: Management Accountability

Overview

Narrative

Lutheran Services Florida (LSF) Northwest operates both the HOPE and Currie House Shelters (Residential) and Non-Residential CINS/FINS Program located in Escambia, Santa Rosa, Okaloosa, and Walton County, Florida and is also the designated CINS/FINS provider for both Escambia, Okaloosa, 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 Residential Services Manager; Residential Direct Care Staff, Outreach Coordinator; Administrative and Maintenance staff.

The Regional Director and Shelter Manager oversee the operations and duties at two 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.

The program has an Annual Training Plan for each staff and orientation training is provided to all new hires.

LSF Northwest maintains multiple outside partnerships to provide various community agencies that ensure a continuum of services for its youth and families. The program has a highly active local food outreach program. In addition, the program has a regional outreach component across the service area. This program involves participation from staff and system partners to focus their outreach activities in designated high crime zip codes and low performing schools.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

Background screening for all employees, volunteers, mentors, and interns is required prior to the date of hire and every five years thereafter for rescreening. The Annual Affidavit of Compliance with Level 2 Background Screening must be submitted to the Department of Juvenile Justice Background Screening Unit prior to January 31st of each calendar year.

Each new applicant is screened for eligibility through the Department of Juvenile Justice Background Screening Unit. The hire date must not be before the screening results are returned with eligible results. Employees, volunteers, interns, and mentors must be rescreened every five years following the initial background screening.

A total of nine personnel files were reviewed (six new hired staff and three staff requiring rescreening). Each personnel file of those reviewed contained the required background screening documentation and it was completed prior to the date of hire. File documentation showed that each new hire was provided with information on how to obtain a livescan fingerprint card from local law enforcement to aid in the background screening process.

All new employees did not begin their orientation and new hire training until after the background screening was returned with eligible results. The three employees requiring rescreening had documentation requesting a rescreening in advance of their five-year employment anniversary date from the previous screening. All rescreened employees were found to be eligible by the BSU. The Annual Affidavit of Compliance with Level 2 Background Screening was completed, signed, notarized, and submitted on January 5, 2017.

There are no exceptions noted for this indicator.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place that ensures the staff provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any forms of abuse or harassment.

All program staff adhere to a code of conduct which prohibits physical abuse, profanity, threats, and intimidation. Each employee signs an acknowledgement of the code of conduct during their orientation and new hire training. Any person employed, affiliated with, or in residence at the program has uninhibited access to contact the Florida Abuse Hotline at any time. The program has a grievance process in place to include the ability to file a written grievance.

In the six months prior to the review the program had no reports to the abuse hotline and no grievances submitted. Five personnel and training files were reviewed. Each file contained an acknowledgement of the code of conduct and documentation of abuse reporting and abuse issues training. The Florida Abuse Hotline phone number is posted throughout the program and in the dayroom where the youth can clearly obtain the number. Although there were no reported abuse incidents the program has a policy and procedures to address any abuse allegations and incidents should the need arise.

The program utilizes a three phase grievance process consisting of an informal (verbal discussion), formal (written grievance addressed by the supervisor), and Program Director (if unresolved at the supervisory level the program director will render a decision and resolution to the issue within 72 hours) phase. Direct Care workers do not have access to or handle grievance documents. Grievance documents are submitted into a locked box that is checked by the supervisor or clinical supervisor to address during the formal phase.

There are no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for incident reporting. When a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident. The program shall complete any follow-up tasks and provide any follow-up information required by the CCC in order to close the case.

Each incident shall be recorded on the program's Incident Reporting Form and Incident Cover Sheet. DJJ CCC reportable incidents will be reported within two hours of the incident or two hours of obtaining knowledge of the incident. Incident reports will be maintained in a centralized log. Incident reports will be communicated to the regional director and maintained in a centralized file. Any requests made by the CCC will be followed-up on and documentation will be maintained in the incident log.

The program had a total of 39 documented incidents within the past six months. Eleven of the 39 incidents met the requirements to be reported to the Central Communications Center as outlined in the CCC

administrative rule. All reportable incidents were reported within the required two hour time frame. All follow-up actions and requests made by the CCC were completed as required with documentation of the follow-up maintained in the program's incident reporting log book. The follow-up documentation contained all email communications with CCC personnel as well as any requested documents, required training, and disciplinary action taken.

The program utilizes internal incident reporting forms and cover sheets and each incident had a corresponding form detailing the event. The CCC number and name of the CCC operator taking the call was documented on the incident reporting form along with the outcome of the communication as to whether or not the report was accepted. Management supervisors complete the review and signature process after the incident report is faxed to them at the Pensacola office.

There are no exceptions noted for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place called Training Requirements that was last reviewed on August 8, 2016. The policy outlines requirements for first year training and training following the staff's first year of employment. The trainings outlined in the policy follow the requirements of the Policy and Procedure Manual for CINS/FINS.

There were six training files reviewed (two files were first year employees and four files were staff that had been employed by the agency for over one year). The two first year employee training files reviewed documented 65 hours and 115.25 hours respectively. The staff that documented 65 hours of training had four months left in the training cycle to receive additional hours and training. This staff still needed CINS/FINS Core training, Title IV-E training, and Cultural Humility training. The staff that documented 115.25 hours of training had three months left in the training cycle to receive additional training. This staff still needed CINS/FINS Core training, PREA, Serving LGBTQ Youth, and Cultural Humility.

There were four staff training files reviewed for training requirements following the first year of employment. The 2016 completed training cycle was reviewed. All four staff documented more than the required 40 hours with 49.50, 61.50, 88.50, and 63.75 hours respectively. However, three of the four staff were missing some of the required training. All three of the staff were missing suicide prevention and one staff was also missing PREA.

A folder is maintained for each staff member that contains a printout of all training completed for the calendar year with a total number of hours for the year. Any supporting documentation was filed in subsequent sections, including: sign-in sheets, agendas, meeting minutes, and certifications. If the staff had been employed with the agency longer than one year, previous years training could be found in the file as well.

Exceptions:

The policy does not specify that first year required trainings are to be completed within the staff member's first 120 days of employment.

Three of the staff training files reviewed for training after the first year of employment were missing suicide prevention and one staff was also missing PREA.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program shall collect and review data from several sources of information to identify patterns and trends. The program shall complete quarterly case record reviews, quarterly reviews of incidents, accidents, and grievances, annual customer satisfaction data, annual review of outcome data, and monthly NetMIS data reports. Findings should be regularly reviewed by management staff and communicated to staff and stakeholders. Strengths and weaknesses should be identified using the data collection. Improvements should be implemented and modified based on the results of data collection and review.

The program completes monthly, quarterly, and annual data collection reviews to identify patterns and trends. Continuous Quality Improvement (CQI) teams have representatives report information and data to Management Teams, their individual programs, and the Statewide Quality Services Manager (QSM). Weekly and monthly reports are made to the statewide QSM. Identified issues are discussed at monthly staff meetings along with recommendations for improvement and corrective actions.

A review of weekly and monthly report submissions for the last 6 months indicated that the program is reporting data in all required data collections areas and analyzing the data for trends and patterns. A review of monthly employee meeting minutes for the past 6 months prior to the review indicated that the management team share data results, improvements, and required corrective actions with staff members on a regular basis.

Weekly and monthly data is reported via a Google document that is maintained by the Statewide QSM. Evidence of monthly extracted NetMIS reports were provided to detail information and data collection during the last 6 months for data entry within 72 hours, service completion, 30-60 day follow-up surveys, number of youth served, performance benchmarks for the year-to-date for non-residential clients, and filled bed day benchmarks. Trend analyses were provided addressing incidents, grievances, safety (drills, vehicle inspections, and facility inspections), consumer/stakeholder satisfaction, chart reviews, and youth service data.

There are no exceptions noted for this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a transportation policy and procedure in place last reviewed on August 21, 2016. The basis of the policy is to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. The best practice to prevent such situations is to have a 3rd party present in the vehicle while transporting a client.

LSF is committed to ensuring that staff and clients are safe and are not put in situations that place them in danger of real or perceived harm or allegations of inappropriate conduct by either staff or youth when transporting clients. All agency approved drivers who transport clients have a valid Florida driver's license and are covered under LSF insurance. It is the policy of LSF to transport individual clients with a third party present in the vehicle. That person may be another staff member, an approved volunteer, an intern, or another youth.

Two or three clients may be transported by a single staff member. When transporting four to six clients, two staff members should be present with one staff positioned between the genders. Transporting seven or more clients requires three staff present. Clients may not sit in the front seat of the van without staffing it with 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.

The agency has two vans that are used for transporting shelter youth to various events.

The agency's transportation logbook was reviewed. There were several instances where there were one staff and one youth during transport.

Exceptions:

There is no process in the policy that addresses prior approval from manager for one staff to transport a single youth. In the vehicle logbook, there were twelve instances where there were single transports. Out of those twelve, there were eight that were bus stop transports which is located down the street from the agency.

Also, on the form it was hard to determine if the transport was for CINS youth or FFN youth as well as the driver not initialing off on the form.

When staff was asked about where they document when they get authorization to transport single youth, staff stated that they keep a separate logbook. A composition notebook was reviewed with a start date of October 2015 and the pro logbook. Documentation of the approval for single transport was not always being documented.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

LSF-Hope House has a policy and procedures in place for Outreach Services. It was last reviewed on August 21, 2016. The program participates in local DJJ board and council meetings to ensure CINS/FINS services are represented in a coordinated approach to increasing public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services. The program also maintains written agreements with other community partners that include services provided and a comprehensive referral process. The agency contributes to the implementation of Departmental objectives through participation in local and circuit level meetings. There is a lead staff member designated to attend local and circuit level meetings convened by the Department of Juvenile Justice.

The agency has a planned Outreach program. This component of service is supervised by the Regional Director and performed by an outreach coordinator or outreach specialists assigned to this specific function. The Regional Director, Clinical Director, Service Managers and Outreach Team develop annual strategic plans with specific projected prevention outreach goals, objectives and outcomes. Outreach efforts are made throughout Escambia, Santa Rosa, Okaloosa, and Walton Counties. The target audience includes runaway and homeless youth and their families as well as the community at large.

Efforts are made through school presentations, community presentations, fundraisers, distribution of materials, community events, and more. The agency makes a strategic effort to address the over-representation of minority youth entering the Juvenile Justice System. In this light, some of the prevention outreach efforts are specifically targeted at minority, high-risk communities, schools, recreational sites and places of worship. These efforts ensure that information about and access to agency programs is clearly understood and available to all individuals residing in a specific service area defined by contract or geographical boundary.

LSF-NW plays an active role in the National Safe Place Program. Joint planning efforts and formal interagency agreements are essential to establishing effective linkages between service providers. The agency diligently seeks out opportunities to form collaborative partnerships and develop interagency agreements to enhance the outcomes for the families and youth served. These agreements may be entered into by programs as long as they do not obligate the agency to any financial responsibility, service provision or liability that is beyond the scope of the existing contracts.

The agency has over fifteen (15) interagency agreements. Of those fifteen, seven (7) are with the local law enforcement agency. Hope House participates in the Safe Place program as well as feeding the community program. During the holidays, there were various church groups that donated goods and services to the program. Staff also transport youth to different events to expose them to other cultures.

The agency staff reported that they have a staff at another program that participates in the monthly DJJ Council Meetings.

There are no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services of Florida Hope House (HH) Residential and Non-Residential Counseling Programs provide CINS/FINS counseling services for youth and their families in Walton, Escambia, Santa Rosa, and Okaloosa Counties in Florida. The program continues to maintain working partnerships with local service organizations. Hope House provide individual, group and family counseling services. The program offers an experienced Licensed Clinical Director and three other residential and non-residential counseling staff members who all have master level degrees. The Hope House program receives referrals from local schools, the Department of Juvenile Justice, and the Department of Children and Families as well as the local courts. Hope House also maintains office space at various community sites in the Florida Panhandle area.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure which address the elements of the indicator related to Screening and Intake. The policy was reviewed by the Regional Director on September 7, 2016.

Section 2/Standard 2 Intervention/Case Management policies and procedures were reviewed by the Clinical Director on October 17, 2016 and the Quality Services Manager on August 21, 2016.

The policy states that centralized intake services are available 24 hours/7 days a week. Centralized intake services include screening for eligibility, crisis counseling, information, and referral. The initial screening for eligibility must occur within seven calendar days of referral by a trained staff member using the NetMIS screening form. The policy includes the written items that are provided to the parents/guardians and the information that is available to families in need of services. The procedures for this policy are explained in detail.

A total of eight files were reviewed: four residential files (two open and two closed) and four non-residential files (two open and two closed). All eight of the files reviewed contained intake documentation in compliance with the indicator. All screenings were completed within the seven calendar days of initial referral.

During the intake process, the parents/youth indicate that they have received information regarding all of the program's services, rights and responsibilities, grievance procedures, and possible actions that can occur through involvement in the program. This was acknowledged either in writing as indicated by signature or by a "check-off" box.

However, in reviewing the files there were three different forms utilized to provide "Client Informed Consent and Introduction to Services". The most current form is dated 6/22/16 and this form contains all of the required elements. This most current form was utilized in only one of the eight files that were reviewed. Three of the eight files contained a "Client Informed Consent" form dated 10/5/12 and four of the files contained a "Client Informed Consent" form dated 6/22/04. The older forms do not contain all of the required notifications.

Exception:

Seven of the eight files reviewed contained an outdated Client Informed Consent form which did not

include all the required elements.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy and procedure in place to address the Needs Assessment in accordance with the Florida Network CINS/FINS Operations manual and DJJ Quality Improvement Standards. This policy was reviewed on September 7, 2016 and signed by the Regional Director.

The policy states that the Needs Assessment is completed to gather and analyze information for all youth receiving services and that it should be completed by a Bachelor or Master's level staff member and signed by their supervisor.

The procedures are described in detail for both residential and non-residential services. Specifically, the Needs Assessment must be initiated within 24 hours of admission into the residential program. The Needs Assessment must be completed within two to three face-to-face meetings following the initial intake for clients admitted into the non-residential program. There is also a comprehensive list of elements that must be included in the assessments. The procedure states that if the Needs Assessment includes a required suicide assessment, a licensed supervisor must sign and date the document. The Clinical Director is responsible for training and supervising staff in the implementation of these procedures and the counselors document all client contacts in the case file.

A total of eight files were reviewed: four residential files (two open and two closed) and four non-residential files (two open and two closed). All of the eight files reviewed did meet the elements required for this indicator. The needs assessments were initiated within the required time frames and conducted by a Master's level staff member. The assessments were written to include all pertinent information and contained excellent mental, physical, and emotional status exams.

All of the eight Needs Assessments were approved by the supervisor who is a licensed mental health counselor. Two (2) of the residential files contained an updated needs assessment in that the youth in each case had a prior, recent shelter stay. Both original Needs Assessments were contained within the file and had been completed within the past 90 days. Two of the eight files indicated an elevated risk and the youth in both cases were referred for a full suicide assessment which was completed and approved by a licensed mental health counselor.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency has policy and procedures in place specific to Case/Service Plan. The policy and procedures are consistent with the required elements as outlined in the Florida Network CINS/FINS Operations manual and the DJJ Quality Improvement Standards. The plan was approved and reviewed on September 7, 2016 by the Regional Director.

The policy indicates that the Service Plan is to be completed within seven working days of completing the Needs Assessment. It further states that the plans should contain clear identified needs and goals; the type, frequency, and location of services; the person responsible; the target and actual dates of completion; signature of the youth; parent, counselor, and supervisor and the date the plan was initiated. The procedure also outlines the required case plan reviews every thirty days for the first three months and every six months thereafter to assess progress towards service plan goals.

A total of eight files were reviewed: four residential files (two open and two closed) and four non-residential files (two open and two closed). The files reviewed indicate that all of the case plans were developed within the allotted time frames. In fact all but one case plan was completed on the same day as the completion of the Needs Assessment. However in one non-residential file the Needs Assessment was completed on 10/24/16, but the Service Plan was initiated on 10/10/16.

The residential files and non-residential files contain Service Plans which include all of the required elements. Both residential files and non-residential files contained Service Plans that were written to address the individual needs of the youth and were also written to include measurable objectives. Two of the residential files did not include the parent/guardian signature on the Case Plan and one of the non-residential files did not include the youth's signature on the plan. One of the non-residential files did not have timely case plan reviews at the 30 and 60 day required case plan review. The review was conducted after both 30 and 60 days and neither were signed by the parent. The 30 day review contained the initials of the client and counselor and the 60 day review contained the initials of the counselor only.

Exceptions:

Two of the residential files did not include the parent/guardian signature on the Case Plan and one of the non-residential files did not include the youth's signature on the plan.

One of the non-residential files did not have timely case plan reviews at the 30 and 60 day required case plan review. The review was conducted after both 30 and 60 days and neither were signed by the parent.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure that addresses Case Management/Service Delivery. The policy and procedure were approved/reviewed by the Regional Director on September 7, 2016.

The policy states that each youth is assigned a counselor/case manager who will follow the youth's case and ensure delivery of services through direct provision or referral. The policy also cites the steps of the case management process from establishing referral needs to implementation of the case plan and lists all elements through case termination with follow-up.

A total of eight files were reviewed: four residential files (two open and two closed) and four non-residential files (two open and two closed). All files reviewed were assigned a designated counselor/case manager. The counselor's case notes were clear and concise and followed a SOAP note format. The notes indicated that referrals were being made as needed.

There were two "informal" referrals made by the non-residential counselor. One referral was to Celebrate

Recovery and another client was referred for an educational evaluation. The counselor explained that the agency does not utilize a universal referral form but either makes a "formal" referral by telephone or provides a written referral with a case summary to the agency after getting the required release of information form signed by the parent/guardian. All of the files documented support for families and case plan implementation was demonstrated. The files reviewed indicated the counselor was indeed monitoring the youth's/family progress and documenting the progress in the case notes. There were no out-of-home placements indicated in the files reviewed and there were no cases referred to the case staffing committee or recommended for a CINS petition.

The residential 30 and 60 day follow-ups are completed by the administrative assistant and subsequently filed in the client record. The non-residential counselor advised that he usually completes the follow-ups on his clients. He also advised that he maintains a log book at his office that contains all of the 30 and 60 day follow-ups.

There were no exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy and procedure which addresses the elements of the Counseling Services indicator in accordance with the Florida Network CINS/FINS Operations manual and DJJ Quality Improvement Standards. The policy and procedure were approved/reviewed on September 7, 2016 by the Regional Director.

The procedure outlines the case coordination, case file organization, confidentiality, chain of trust, and self-monitoring.

A total of eight files were reviewed: four residential file (two open and two closed) and four non-residential files (two open and two closed). All files reflect that the youth and families are receiving counseling services that are consistent with the Case Plan/Service Plan. The youth's presenting problems could be found documented in the initial screening form, the Needs Assessment, and in the Case Plan and further indicated during the Case Plan reviews. The counselor's notes are written in a very clear, concise, clinical manner utilizing a SOAP format.

The non-residential counselor provides individual and family counseling with the plan to complete once per week or as needed. All eight files had documentation of "Staffing Notes" in the file to indicate the case had been staffed with a supervisor and feedback was documented by the supervisor with her signature and date of the case staffing. There were instances where the youth/parent/guardian did not attend family sessions once per week but the counselor documented when a scheduled appointment was cancelled/rescheduled by the family.

The residential clients are receiving individual, family, and group sessions. The group sessions during the past six months have covered various topics such as: anger management, coping skills, decision making, HIV/STD, substance abuse education, and dangers of gang involvement. The group log book is well-maintained and provides a brief description of the topic, date, time, counselor name, and the participants

who were present for the group session. The Group Log book also provides documentation as to why a group session is not completed such as when the shelter was closed due to flooding (October 10 through November 19), holiday, or participant outing.

There were no exceptions noted for this indicator.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency has written policies and procedures in place which correspond with the Florida Network CINS/FINS Operation manual and DJJ Quality Improvement Standards.

The policy lists the required composition of a Case Staffing Committee which must include a DJJ representative, a CINS/FINS agency representative, and a school representative. Other representatives such as State Attorney, local health, mental health, social services, law enforcement, DCF representative, the youth and parents and others invited by the family are encouraged to be included in the Case Staffing Committee meetings. The policy ensures that a case staffing meeting is convened within seven days of a written request by a parent. When case staffing committee meetings are scheduled, the family and all members must be notified no less than five working days prior to the staffing date.

The agency does not routinely hold case staffing committee meetings unless there is a written request by a parent. The agency advised that there have been no specific requests during the past year; therefore, no Case Staffing/CINS petitions have occurred within the past year.

There were no noted exceptions for this indicator.

2.07 Youth Records

Satisfactory Limited Failed

Rating Narrative

The agency has a written policy and procedure in place which is consistent with the Florida Network CINS/FINS Operation Manual and DJJ Quality Improvement Standards.

The agency policy requires all program staff to adhere to confidentiality laws and to maintain all client files in a secure room or in a locked file cabinet which must be marked "Confidential". The policy states that records that are transported must be in an opaque container that is marked confidential. Youth records are to be maintained in a neat and orderly manner so that staff can quickly and easily access information.

Procedure requires that all records are marked "Confidential" and that the agency maintain the strictest possible level of confidentiality for all clients. Therefore, at no time is information released concerning a client without obtaining permission from the parent/guardian. The exceptions to confidentiality are explained to clients through the Express and Informed Consent which is presented to the client and

parent/guardian at intake. The procedure outlines the exceptions to confidentiality.

A total of eight files were reviewed: four residential (two open and two closed) and four non-residential (two open and two closed). All eight files were marked with a red stamp "Confidential" on the front cover and back cover of the file. All files are kept in a locked room which is accessible to authorized staff only. The files are maintained in locked file cabinets which are all marked "confidential". The records are maintained in a neat and orderly manner. Residential files are not typically transported outside of the Hope House.

Non-residential files are transported in an opaque, locked box type container that is marked "confidential". The non-residential counselor advised that the non-residential files are maintained in locked file cabinets which are located in a locked room.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Hope House Shelter is licensed by the Department of Children and Families (DCF) as an eight (8) bed Child Caring Agency.

The Hope House residential shelter provides short-term respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program. The shelter also serves youth referred from the Department of Children and Families. The Hope House youth shelter is capable of serving Special Populations youth including Staff Secure, Domestic Violence, Probation Respite and Human Minor Sex Trafficking populations.

The shelter program management team is comprised of a Residential YCS III Shelter Manager, two YCS II's and eight YCS direct care staff members. Each shift also has YCS that is the designated team leader. There are also two residential counseling positions.

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.

The facility has not been able to hire a part-time Registered Nurse (RN) as required by the 2015 CINS/FINS contract. The agency has advertised available positions on LSFNET.ORG, Employflorida.com and monster.com. Oversight of clinical mental health services is provided by the agency's Licensed Mental Health Clinician.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place, 3.01 Shelter Environment, which is located under section 3.0 Shelter Care. This policy was last reviewed/approved on August 12, 2016.

The policy covers all fourteen areas identified in the Florida Network standard. Hope House's procedure is to provide a safe and healthy environment for the youth in shelter care. The policy covers shelter facility and grounds, kitchen and dining areas, bathrooms, sleeping quarters, linens/bedding, structured activities, client safety, physical activities, faith based activities, and homework and reading.

Hope House is an eight bed shelter located off a side street in a residential neighborhood which appears to be centrally located in the community. The shelter is a residential home which has been converted into a shelter. The shelter is nicely painted and decorated. The staff reported late last year there was a major flood which resulted in the shelter having to close for a period of time in order to remodel. Walking through the shelter there were no visual signs there was ever a flood.

The outside of the building is nicely painted and appeared to be well maintained. There were no structural concerns noticed. There is a backyard area where the youth can do outside activities. There is a fence around the back and both sides of the property. The facility has a landscaped area in the front; due to recent rains the bedding has been washed around in some areas, however there are no concerns.

There were no signs of graffiti on any of the walls, doors, floors, or furnishings. This included the bathrooms, bedrooms, hallways, offices, dayroom, dining room, kitchen, and the outside of the building. There were no visible signs or concerns regarding insect infestation, which included the kitchen, dining room, dayroom, offices, bedrooms, bathrooms, and the outside grounds. In the kitchen, the inspection included looking around the appliances, behind the door, and the cabinets.

The facility has three bedrooms; at the time of the visit one room was designated for females and the other two for males. The female room has four beds; each bed had a mattress, sheet set, pillow, and blanket. The other two bedrooms have two beds each; each bed had a mattress, sheet set, pillow, and blanket. The beds were all made and linens appeared to be clean.

According to the staff, the linens are changed weekly and at the time a youth is discharged the bed are striped and clean linens are placed on the bed for the next youth. On one of the beds not currently being used, there was a card on the pillow saying welcome. All the shelter's furnishing appeared to be in good condition; this included the dining room, dayroom, and bedrooms. There were no identified broken or unusable furnishings during the review. The furnishings did not appear to be vandalized or have any signs of graffiti.

In the dining room there were two tables placed together to make one large table where everyone eats together. There's a fully functioning kitchen; including a gas stove, multiple refrigerators and freezers, and storage areas. In the dayroom there were two sofas, a bench, and two large chairs; there were also several stackable chairs available for additional sitting if needed. There was also a game table and foosball game. In the dayroom the youth have access to books, board games, and video games.

The three bedrooms at the shelter are set up accordingly: one bedroom is setup for four youth and two bedrooms are setup for two youth each for a total of eight beds for the shelter. Each room had the appropriate number of furnishings, one bed and one dresser per youth, depending on how many youth are in the room. The beds and dressers all appeared to be in good functioning condition, no broken parts.

At the time of the visit, the bedroom with the four beds was designated for females and the other two were designated for males. According to the shelter, they are able to adjust the bedroom configuration as needed depending on population. The facility has two bathrooms for the youth; one is located in the female bedroom and the other one is located in the hallway area outside of the bedrooms. This bathroom is designated as the male bathroom. The bathrooms looked and smelled clean. The male bathroom has a shower, toilet, and sink; which all appeared to be functioning properly.

The female bathroom has a shower, toilet, and two sinks; which all appeared to be functioning properly. The showers all had curtains. There were no signs of mildew. Each bathroom had a functioning vent fan. Throughout the facility the lighting was appropriate. The kitchen, dining room, dayroom, offices, hallways, bedrooms, bathrooms all had lighting appropriate to see clearly. All lights were observed to be functional. All lights turned on immediately when switched on.

The shelter has system in place to help secure important items of the youth in their care. There is a filing cabinet, which remains locked, which is used to store a youth's personal belongings. There is also a safe if there is a need to secure a youth's money. Both the cabinet and safe are in a locked staff office.

The shelter keeps a daily log sheet of the activities of the youth; these are categorized into education, recreation, life skills, crafts, outings, and physical activities. The staff completes this sheet each day of the week including weekends. For the youth who are not in school, the shelter has established daily educational time. They have a binder with structured activities for the youth to work on. The general daily schedule has specified time for multiple activities including reading and educational.

The facility also has scheduled outings listed on the staff schedules. The facility's general daily schedules are posted in the dayroom; one is for week days, one is for weekends and holidays, and the other is for summer time. The facility does have physical activities of the day scheduled however not every day. According to the staff, the youth go outside daily when weather permits. The general daily schedule reflects there is a voluntary Bible Study held weekly at the shelter. Staff also report, if a youth requests to attend Church they will make arrangements for the youth to attend. During this past summer the shelter participated in two summer camps which staff reported were very successful.

The shelter has all its required safety inspections completed and all inspections were current. The Health Inspection was completed on 4/15/2016. According to the inspection report, there were three identified violations in the areas of preparation/protection, maintenance, and screening. According to the report the violation in the area of preparation/protection was related to kitchen staff having to wear hair restraints. According to the report, this issue was resolved at the time of the inspection and was no longer an issue.

The violation in the area of maintenance involved securing the vent and light covers in the boy's bathroom. The violation in the area of screening involved ensuring the screening is secure for the new AC unit in the dayroom. There was no documentation showing any follow-up inspection by the Health Inspector nor did the report indicate that was required. However, based on the walk-through completed and the observations made of both bathrooms on the second floor, the vents and light covers appeared to be all secure. Based on the walk-through and the observations made in the dayroom, the screening for the new AC unit appeared to be secure.

A Fire Inspection was completed on 4/5/2016, according to the report, there were no violations. A Fire Extinguisher Inspection was completed on 3/30/2016, according to the report, there were no identified concerns. A Fire Detection and Alarm System Inspection was completed on 11/11/2016, according to the report, the "New alarm system operates as designed, signals tested and verified at the monitoring center."

There were no exceptions noted for this indicator.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place, 3.02 Program Orientation, which is located under section 3.0 Shelter Care. This policy was last reviewed/approved on August 12, 2016. This policy matches that of the Florida Network.

Hope House's policy states that the orientation process is critical to successful placements. As a result the agency emphasizes the importance of the orientation process to all the youth and staff. Youth Care Staff are trained in how to develop rapport with youth and provide effective orientation for new youth. A youth's first impression of shelter life is a critical factor in their later cooperation with the program. For this reason, youth are greeted with cheerfulness and warmth. Generally, orientation is conducted individually with the youth immediately following the screening assessment as part of the admission process. Staff specifically and deliberately reviews each of the key intake and orientation issues and clarifies any questions that may arise.

The completion of the intake documents are done by direct care staff at the time of the intake. The staff uses the Client Intake Checklist as a guide through the intake process. This is a detailed form which helps guide the staff through the process. The staff initials off as each section is completed. Once the form is completed, the youth signs the form as well indicating that each of the items on the list were reviewed or completed with them.

A total of four files were reviewed (two open and two closed). All four files had documentation that the youth received a copy of the handbook, reviewed disciplinary action, reviewed contraband rules, were given a tour of the facility, and a copy of the daily schedule/activities (elements were found on the Client Intake Checklist Form and the Lutheran Services Florida Northwest Hope House Contract Form). Signed by the youth also were the grievance procedures (Grievance Procedure Form), emergency/disaster procedures (Client Emergency Procedures Form), room assignment (CINS/FINS Intake Form), suicide prevention/alert notification (Client Safety Agreement; this is also signed by parent), and abuse hotline number (Client Right Form).

The parents signed the CINS/FINS Shelter Voluntary Placement Agreement and the Photo ID of Parent/Legal Guardian Prescription Consent Form. The parents were also provided with a Parent Handbook at the time of intake (this is documented on the Photo ID of Parent/Legal Guardian Prescription Consent Form). The youth were provided with a copy of the Client Handbook; which has copies of the daily schedule as well as provides documentation regarding the areas just reviewed with them.

There were no exceptions noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place, 3.03 Room Assignment, which is located under section 3.0 Shelter Care. This policy was last reviewed/approved on August 12, 2016. This policy matches that of the Florida Network.

Hope House has developed procedures related to admission and room assignment to ensure the safety of all youth placed in agency residential facilities. Upon completion and approval of a NETMIS Youth Screening form, staff begins the shelter intake and makes an initial decision based on the youth's physical characteristics, maturity level, history (including gang or criminal involvement, exposure to trauma), potential for aggression, and apparent physical, medial, emotional and/or mental health issues. The Youth Care Staff also considers the initial collateral contacts, initial interactions and observations of the youth. If there are immediate needs such as medical, hygiene issues, hunger or other personal needs, the intake is temporarily postponed until those needs are met.

The shelter uses a number of forms to determine appropriate room assignment. This includes the CINS/FINS Shelter Intake Form, the youth's suicide risk assessment score, Needs Assessment Form, Screening Form, Shelter Intake Assessment Form, and the Intake Snapshot Form. The facility also uses a colored dot alert system: orange-sight and sound, red-high risk (this category includes history of depression, running away, aggressive behavior, etc.), green-medication/medical, and blue is for DV. In addition, staff report they assess the other youth currently in the shelter: Have the youth currently in shelter and the new youth been in shelter together before? What was the relationship? What are the reasons the other youth are in shelter and can that negatively impact the youth coming in?

A total of four files were reviewed: two open and two closed. All four files had documentation that staff assessed for the youth's history/past trauma, age, gender, history of violence, disabilities, physical size, gang affiliation, suicide risk, sexual aggression history, separation from siblings, and staff's initial observations. In addition, there was documentation of collateral contacts and the use of the shelter's alert system. The only area which is not specifically identified for assessment on a form is the youth's gender identity. According to the staff interviewed, the shelter does follow up with the youth regarding this area during the intake process; which is typically done when completing the Shelter Intake Assessment Form. The staff member reported it would be noted as needed on this form.

Exception:

Staff does not document the youth's gender identity when assigning the youth's room/bed.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses the elements of the log book requirements. Log books document routine daily activities, events, and incidents in the program and are reviewed by direct care and supervisory staff at beginning of shift. Significant log book entries will be highlighted. All entries are brief and legible, date and time, names of youth and staff, a brief statement providing pertinent information, and the name and signature of the person making the entry. All errors are struck through with a single line with an initial and date after the correction. The facility director or designee will review the log book weekly. The oncoming shift supervisor and direct care staff will review the log book for the previous two shifts.

The agency maintains a daily log book to document general program and operational information. The top of each page is dated to maintain an accurate chronological record of events. All entries must contain

either AM or PM along with the hour and minute to indicate the time of day. Intakes and discharges will be highlighted in blue, parent/guardian notifications and attempts in green, important items are highlighted in pink, and very important items are highlighted in yellow. All entries require a signature of the staff making the entry.

Staff members must log their time in and out individually along with the documentation of passing keys on to another staff member. Corrections are to be struck through with a single line and void is to be written at the end of the strike through. All entries are to be made in black ink and the use of whiteout is prohibited. The log book shall be hardbound with sequential page numbers and retained for a period of three years.

Log books are contained in a hardbound book with sequentially numbered pages. Each page was marked with the date and day of the week at the top of the page. Entries were made in black ink with times including AM and PM with a signature of the staff making the entry. Corrections were made with a single strike through with the word "void" and were signed and dated by the party making the correction. No whiteout was observed to be used. Late entries were documented and highlighted in pink.

Supervisor/management reviews were documented in red ink on a weekly basis, dated and signed with an initial on each page that was reviewed, and included recommendations, suggestions, and corrections. All incidents were documented clearly and contained dates, times, and names of those involved and highlighted in either yellow or pink. Supervision and resident counts were documented and highlighted in yellow. Safety and security information was documented and highlighted in pink. Parent contact and attempts were highlighted in green. Admission and discharges to include home visitations were documented and highlighted in blue. Staff members arriving and exiting as well as key exchanges were documented and highlighted in orange.

Exception:

Supervisors and direct care staff reviewed log books for the previous two shifts in most instances; however, some documentation of the review was not present or was documented inconsistently (e.g. "log book reviewed", "prolog reviewed", "prolog reviewed pages 80-85", or "received pass down/briefing") and did not specifically mention the past two shifts as the information being reviewed. Overall the information appeared to be reviewed and/or received by the required parties.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses behavior management strategies. The program behavior management system is designed to gain compliance with the program as well as enhance the coping skills of the youth. The program has a detailed description of the behavior management system and the behavior management strategies that are to be utilized. Consequences are to be applied logically and consistently. All staff are to be trained in utilizing the behavior management system and the theories behind the behavior management system practices. Supervisors are trained to monitor the use of behavioral interventions. The behavior management system is designed to be administered in the least restrictive manner and contains a wide variety of positive incentives.

The Behavior Management System (BMS) at the agency is described in the procedure as a Behavior Management Motivation System and is explained in the youth handbook as a Motivation System. The system has three system levels (assessment system, daily system, and achievement system) and two subsystem levels (straight fine and time-based) to address serious, inappropriate behaviors. The BMS provides points for positive behaviors and a reduction in points for negative behaviors. When points are reduced there are opportunities to earn back half of the lost points.

All staff are trained in the BMS and participate in refresher training. Staff performance evaluations address the staff member's use of the BMS and suggestions for improvements in administering the BMS in the most effective manner. The BMS is designed to never deny youth their basic rights including: sleep, meals,

clothing, health services, education, exercise, correspondence, and contact with parents/guardians or other protected services such as an attorney or clergy member.

During the first 1-3 days at the shelter, youth are placed on the Assessment System. During the time on the Assessment System, youth are observed by staff members and target skills the youth needs to work on are determined based on observed behaviors and interactions. After the assessment phase is completed, youth are automatically moved to the Daily System. While on the Daily System youth work towards improving and adhering to four target skills.

Points earned each day on the Daily System are used to buy privileges the following day. Each youth has a balance sheet of daily points, which is maintained in a centralized log accessible to direct care and supervisory staff. Daily point sheets for previous days are also maintained in the log along with the balance sheet. Once a youth has mastered the Daily System target skills they are able to move to the Achievement System, which includes no longer needing to carry a point sheet at all times and the ability to earn extra privileges.

Should inappropriate behavior occur, the staff member on duty addresses the behavior, discusses the appropriate behavior and completes a role play of utilizing the appropriate behavior. The direct care staff will then address the inappropriate behavior and target skill again at a later time to reinforce the appropriate behavior and offer the youth an opportunity to earn up to half of their points back by completing the role play with the appropriate use of skills. An interview was conducted with the direct care staff supervisor and she was able to articulate how the BMS was to be administered and an overall understanding of the system.

A random selection of five staff training files indicated all five staff received a 5-day initial BMS training. The management training log indicates all staff have received initial training in the system as well as dates for refresher training annually. The BMS specifically states that the youth are not to be denied any basic rights and that physical punishment in any form is unacceptable. The BMS training curriculum was reviewed. The training reflected the policy and procedure for administration as well as detailed point administration gains and losses.

The supervisor stated during an interview that she conducts point card reviews and the direct care staff also receive ongoing counseling and feedback as to how they are administering the BMS. Management staff address use of the behavior management system during employee evaluations annually. Although the training curriculum does not reference specific point allotments except for point reductions, interviews and reviews of point cards indicated that staff have a standardized system for the administration of positive points.

Youth may earn 500-1500 points for positive behaviors in the shelter and up to 3,000 points for positive behaviors on an outing. Reviews of point cards and the system used to address negative behaviors or a lack of using the appropriate target skills indicate an overall positive manner for addressing negative behaviors through teaching and role playing the positive subset of skills associated with the negative behavior. Reward points are given for pro-social skills that are observed regardless of the identified target skills, which reinforces appropriate social behaviors. Rules and Consequences are clearly explained in the youth handbook which is provided to the youth at intake.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedure in place for this indicator. It was last reviewed on August 21, 2016. Adequate staffing is provided to ensure the safety and security of youth and staff. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract: One staff to six youth during awake hours and community activities; one staff to every twelve youth during the sleep period. There is always at least one staff on duty of the same gender as the youth. Overnight shifts must always provide a minimum of two staff present. The staff schedule is provided to staff or posted in a place visible to staff. There is a holdover or overtime rotation roster which includes the home telephone numbers of staff who may be accessed when additional coverage is needed. Staff observe youth at least every ten minutes while they are in their sleeping room, either during the sleep period or at other times, such as illness or room restriction.

The agency has a staff coverage schedule that provides adequate supervision of youth and ensures the safety and security of all youth and staff. This schedule includes a system to consider best practices, staff training requirements, regular days off, holidays, annual vacation and sick leave, diversity issues, budgetary issues, treatment goals and related service delivery issues. The shelter is staffed by a minimum of two YCS at all times, ensuring one staff to six youth ratio at all times.

Management attempts to staff one female staff member and one male staff member when possible. Two males are never to be on shift at one time without female staff. All staff need to protect themselves and clients by never being alone with clients out of view of a witness or a camera. Staff will conduct regular bed checks of youth at least every ten minutes, while youth are in their sleeping room, either during the sleep period or at other times, such as during illness.

The staff schedule is posted in the staff office which is visible to staff and identifies the days/shifts schedule. A review of the staff schedule from July 3, 2016 to the present included both male and female staff on shift and maintains two staff at night. The shelter maintains a staff list in the front of the logbook with telephone numbers.

Documentation of bed checks was visible in the logbook. The bed checks were conducted every eight to ten minutes. This was also confirmed by reviewing video surveillance of random nights, from the past thirty days, prior to the review. The overnight staff also does a summary of overall status count of how many youth and which program the youth is in.

There were no exceptions noted for this indicator.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that addresses Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite (DV), and Probation Respite. It was last reviewed on August 21, 2016.

Agencies that serve DV youth must meet the following criteria: Agencies that do not have assigned bed days must receive prior approval for a domestic violence respite placement. Youth must have a pending DV charge. Youth has been screened by the JAC/Detention or screening unit, but does not meet criteria for secure detention. Youth length of stay in DV Respite placement does not exceed 21 days; data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release; documentation in file of transition to CINS/FINS or Probation Respite placement, if applicable; case plan reflects goals for aggression management, family coping skills, or other interventions designed to reduce propensity for violence in the home; services provided to these youth should be consistent with all other CINS/FINS program requirements; and youth with DCF involvement are eligible.

DV respite services are provided as an intervention for youth and families experiencing severe conflict or who have a history of family issues which may not have been resolved. Eligible youth include those who have been previously adjudicated for other issues, as well as youth who have only been accused of being

involved in domestic violence. Youth with DCF involvement are also eligible. Services are provided to youth charged with DV, except for youth: having current or past fire setting behaviors; with violent or sexual offenses (except for DV); in need of acute inpatient care or crisis stabilization; and/or who is a security or safety risk to other youth or staff. If this is determined after a youth arrives at the shelter, the Department of Juvenile Justice is notified and arrangements for removal of youth will be made within forth-eight (48) hours of notification.

When a youth has been screened by DJJ and it is determined that the youth is eligible for DV respite care services and a respite bed is available, DJJ staff contacts LSF to refer the youth for respite care services. Upon admission a physical health, mental health, and substance abuse screening must be conducted within 24 hours and have access to necessary appropriate services performed by licensed mental health and substance abuse professionals or service provider(s).

Within the past six months, the agency has not served any Probation Respite, Domestic Minor Sex Trafficking, or Staff Secure Youth.

At the time of the review, the agency had two (2) youth that had been admitted to the program for DV charges. Both youth have pending DV charges and supporting documents are located in the file. There was documentation in the case plan that focused on interventions to cope with aggression.

Both youth did not exceed the 21 days of respite placement and services are consistent with all other CINS/FINS program requirements.

There were no exceptions noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

LSF-NW Hope House has a policy and procedure in place dated August 21, 2016 that addresses this indicator. 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 (this applies to cameras affixed in residential shelters, and group care facilities.) The video surveillance system shall be a means to deter any misconduct and provide video evidence to any situation that involves allegations.

The agency has a video surveillance system in place that ensures the following: Cameras are placed in the interior and exterior to cover general locations of the shelter to include hallways for sleeping rooms, and where youth and staff congregate and where visitors enter and exit. No cameras are placed in bathrooms or sleeping quarters. Cameras are visible to persons in the area and a written notice is conspicuously posted on the premises for the purpose of security. Recorded video is stored for a minimum of 30 days (90 days preferred) unless video is associated with a specific incident that is requested for review. Supervisory review of video is conducted bi-weekly and documented to assess the activities of the facility and review a random sample of overnight shifts.

There are a total of sixteen cameras that are located throughout the agency which covers the outside, common areas, kitchen/dining, entrance/exit area, etc. The camera stores videos at a minimum of 30 days up to 60 days depending on amount of activity.

The agency has a video surveillance logbook that has documentation of the camera's being reviewed bi-weekly. Interview with the supervisor indicated that they review the camera bi-weekly for compliance and documents in the logbook.

During the review, this writer reviewed the surveillance cameras for several overnight shifts (12/22/16; 12/25/16; 1/9/17; 1/11/17 between 12:45am – 3 am) for bedchecks. Staff were doing the required bedchecks every ten minutes and checks were documented in the logbook. Also viewed were staff watching youth

that was on sight and sound during the overnight shift bedchecks. As stated by staff, the youth bedroom door is kept open and staff place desk facing the bedroom where they are able to keep constant watch of youth.

Security warning sign is posted on the outside of the building. During intake, the youth and parent are briefed on the cameras located throughout the facility.

There were no exceptions noted for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The LSF-NW agency has detailed policies and procedures related to the screening, health admission screening, classification, assessment and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. All youth receive an initial assessment to determine the youth's risks, needs and issues.

All staff members are trained on risk screening methods that immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health (acute and chronic), or security risk factors. Once risks are identified through the screening and assessment process, residents are placed on the appropriate supervision level or referred out to other local mental health facilities as needed. Depending on the risk identified, the residents are placed on the applicable alert status. The agency ensures that measures are taken to maintain a safe and secure placement and supervision are provided by direct care staff during the resident's shelter stay. The agency maintains a program log, general alert system, pass down/shift exchange forms, and other notification systems. Youth admitted to the shelter with prescribed medications are also provided their medications during their shelter stay.

Staff members participate and conduct emergency drills on a routine basis. The agency's staff receives orientation and annual training courses that include Universal Precautions, Safety and General Program Risk Management training, CPR and First Aid. In addition, the agency does have a certified Managing Aggressive Behavior (MAB) Trainer in the organization.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place called Healthcare Admission Screening that was last reviewed on September 7, 2016.

The agency has two health screening methods. The agency uses the two page CINS/FINS Intake Form as an initial screening form. The agency also uses a five page LSF health screening form, called the Shelter Intake Assessment, as the primary health screening instrument used by all LSF agencies.

The agency's policy for youth admitted with any chronic health conditions is to have the parent or guardian transport the youth to any needed medical appointments.

The CINS/FINS Intake Form contains a health screening section where the agency screens observable injuries, dental or health concerns; recent hospitalization for medical conditions/concerns; recent treatment for medication for a mental health disorder; currently taking any medication; allergies; dietary restrictions, nutritional concerns or fitness issues. The CINS/FINS Intake form also screens for 24 other potential health issues. The CINS/FINS Intake Form also captures health insurance.

The Shelter Intake Assessment contains general demographic screening questions; eligibility for CINS; emergency procedures; health screening; family assessment; basic needs assessment; and financial history.

There were five youth files reviewed. All five files documented the CINS/FINS Intake Form and the Shelter Intake Assessment were completed when the youth was admitted to the shelter. All sections on both forms were fully completed in each file reviewed. All the sections contained documentation of a signature of the staff person completing the form.

The agency also completes an Intake Snapshot form for each youth after the screening process has been

completed. This form is a quick reference for staff to see if the youth has any mental health or substance abuse issues, the youth's level of suicide risk, if the youth is on medication, has any alerts or allergies, without having to review all intake screening forms. This form was found in all five files reviewed.

There were no exceptions noted for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place called Suicide Prevention that was last reviewed on September 7, 2016. The policy is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

The shelter has a system in place to screen, assess, and protect youth with risk factors for suicide. Youth who are admitted into residential services immediately have a comprehensive shelter intake assessment completed by the Youth Care Specialist (YCS) which includes an initial mental health screening, a suicide risk screening, and an initial substance use screening using the CINS/FINS Intake Form. A screening of suicide risk using the Evaluation of Imminent Danger for Suicide (EIDS) is completed on all clients at intake and at any other time as indicated by behavior after admission to the program. A counselor is contacted by the YCS at any time during the shelter intake when the youth scores in high/imminent danger or when the youth is exhibiting behaviors that indicate excessive agitation or extreme withdrawal.

Following a clinical assessment of a youth who has been placed on sight and sound supervision, a counselor may determine there is no longer a need for intensive supervision. Prior to decreasing the level of supervision, the counselor who assessed the youth staffs the case with a Licensed Professional. This may be done in person or via the telephone. The counselor documents the explanation for the decrease, as well as the name of the Licensed Professional approving and the date the level was dropped on the Sight and Sound Supervision Form. This form is filed in the Testing section of the client's clinical file, under the Safety Contract. In both cases, the counselor also makes appropriate documentation in the professional log book and in the client's shelter file.

The agency has two levels of supervision for youth determined to be at risk for suicide. The first level is Constant Sight and Sound Supervision. This level is for youth who are identified as being at high risk of suicide but are not expressing current suicidal thoughts or threats. A staff member must have continuous, unobstructed and uninterrupted sight of the youth and be able to hear the youth at all times. The next level of supervision is One-to-One Supervision. This is the most intense level of supervision and will be used while waiting for the removal of the youth from the program by law enforcement or parent/legal guardian for the purpose of Baker Act assessment.

When a youth enters the shelter, a Youth Care Specialist (YCS) completing the intake will complete the Evaluation of Suicide Risk Among Adolescents immediately with the youth. If the youth score within a certain range on that evaluation the YCS contacts the counselor immediately, either by phone if after hours or on the weekend, or in person if the counselor is on-site. The YCS will go over the results of the evaluation with the counselor and general observations of the youth and the counselor will determine if the youth needs to be Baker Acted or placed on sight and sound supervision until the completion of the Suicide Risk Assessment. If it is after hours and the on-call counselor does not answer or call back within a specified time frame the YCS will contact the Clinical Director or the Regional Director on how to proceed with the youth. After the Evaluation of Suicide Risk Among Adolescents is completed the YCS will then complete the CIN/FINS Intake Form. If the youth happens to answer "yes" to one of the six qualifying

questions but did not score on the Evaluation of Suicide Risk Among Adolescents, the YCS will follow the same process as above and contact the counselor on how to proceed.

There were four youth files reviewed for suicide precautions. All four youth were screened at intake using the Evaluation of Suicide Risk Among Adolescents and also using the CINS/FINS Intake Form. Out of the four files reviewed, three of the youth were placed on sight and sound supervision immediately based on the results of the screenings and consultation with the counselor. All three of those youth were seen within twenty-four hours by a counselor for a Suicide Risk Assessment to be completed. The fourth youth was Baker Acted at intake and returned to the shelter three days later. Upon returning to the shelter the youth was placed on sight and sound supervision until being assessed by a counselor. The youth received a full Suicide Risk Assessment within twenty-four hours of returning to the shelter.

In all four files the Suicide Risk Assessment was completed by an unlicensed counselor; however, each one documented a telephone consultation with a LMHC prior to removing the youth from suicide precautions. The LMHC then signed the assessment the next time on-site. Three of the four youth were removed from suicide precautions and placed on normal supervision and one youth was still on suicide precautions at the time of the review. On-site observations were made during the review of staff documenting thirty minute observations of the youth.

The remaining three files contained forms in the files documenting observations of the youth at least every thirty minutes. During the overnight hours, observations are documented every ten minutes of the youth and staff are stationed outside the youth's bedroom door with the door open. Video recordings were reviewed, of multiple nights, during the on-site review that confirmed this practice. Any changes in the youth's supervision levels were documented in the shelter's log book, in the pass down note book, and also discussed at the shift briefings.

There were no exceptions noted for this indicator.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on medication. The policy was last updated on September 7, 2016. The policy has procedures for verification of Medication, Access, Inventory Procedures, Storage, Medication Distribution, Disposal, and Accountability.

The shelter provided a list of staff who are trained to assist in the delivery of medications. There were twelve staff on that list. Three of those staff are Super Users.

The shelter does not currently have an RN employed to provide medication oversight. An RN was hired; however, only worked for two weeks before resigning. Another RN was in the process of being hired and decided not to take the position. The agency currently has postings out on monster.com and employflorida.com advertising for the vacant position. The agency has not had an RN employed at the shelter, except for the two weeks previously mentioned, since implementing the Pyxis Med-Station in September 2015. The RN from another sister shelter operated by the agency does training for newly hired staff on medication administration and any subsequent re-training needed.

A review of the Pyxis Med-Station was completed with the shift supervisor. At the time of the review there were no open discrepancies. There were seven discrepancies documented for the past month. Most of the discrepancies were due to staff inputting the wrong beginning count when administering medication. All discrepancies were cleared out within twenty-four hours by either the staff member or the shift supervisor.

Staff are not currently using or printing out any reports from the Knowledge Portal.

The shelter has a few systems in place to alert staff what youth are on medications and times to be given. This ensures no medications are missed. There is an alarm clock located in the dayroom that is set to go off at certain times during the day to remind staff that medications need to be given.

The briefing board in the YCS office documents times medications need to be given. The shift pass down log contains a printout of all youth in the shelter, who is on medication and the name of the medication. This is completed each shift change. A shift briefing is also conducted between each shift with the outgoing supervisor and oncoming staff. During this debriefing, all youth on medication are also discussed. In addition to documenting on the youth's Medication Distribution Log (MDL) every time a medication is given, it is also documented in the shelter's log book. An entry in the log book is made with the youth's name, medication given, and the time it was given.

All youth medication is stored in the Pyxis Med-Station. After the youth's information is entered into the Pyxis Med-Station, a bin within the machine is assigned to the youth. Each medication is stored in its own separate bin within the Med-Station so topical medications are always stored separately. The youth's medication is placed in that bin and once it is closed it can only be opened during assigned medication times or for inventory purposes. Staff using the Pyxis Med-Station must enter a password as well as their fingerprint to gain access. Drawers two through five in the Med-Station are used for prescription and controlled medications. The first drawer is used for over-the-counter medications (OTC's).

The shelter has four OTC's available for the youth. The youth's parent or guardian must sign an approval form before the youth is allowed any OTC. The four OTC's used at the shelter are Acetaminophen, Ibuprofen, Antacids, and Triple Antibiotic Ointment. Inventories of the OTC's are completed weekly and as given. The weekly inventory for the OTC's was reviewed for the last six months. The inventories were documented weekly with the exception of three weeks in December.

The shelter has a total of ten sharps that are stored in a locked box inside a locked file cabinet. The sharps consist of three pairs of scissors, four tweezers, one nail file, and two pairs of finger nail clippers. There was not consistent documentation of the sharps being inventoried weekly. An inventory was provided that showed the sharps were inventoried once in November 2016 and once in January 2017.

The shelter maintains a medication log book that is divided into sections for each youth on medications in the shelter. Each section contains a coversheet that has a picture of the youth and also documents all medications the youth is taking and any allergies. The next page is a Prescription Consent Form filled out by the parents with a copy of the parent's driver's license. The next page is the OTC Approval Form filled out by the parent. Next are all the youth's Medication Distribution Logs (MDL's) for each medication the youth is taking. Behind the MDL's are side effect information sheets printed out for each medication.

All inventories for controlled and non-controlled medications are maintained on the MDL. Controlled medications are inventoried each shift and as given. Non-controlled medications are inventoried once per week and as given. The inventories for controlled medications are done with two staff members and are also documented in the program log book.

Medications are verified at admission and documented on a form signed by the parent or guardian confirming those are the right medications and the right dosage. Then a staff member will call the issuing pharmacy and confirm the prescription is the correct medication, when it was last filled, and that the instructions on the prescription are correct. This is documented on the youth's MDL.

The shelter does have a bio-hazard waste bin. The shelter's disposal procedures include dissolving the pills in a baggie of water and then disposing of the bag in the dumpster. An interview with staff revealed the shelter has not had to dispose of any medications for several years, that the youth's parent or guardian have always come and picked up the medication. The Pyxis Med-Station alerts the staff when a youth's medication is low, when seven doses are left. At that time, a staff member will contact the youth's parent or guardian and notify them to bring in a refill. This phone call is documented in the shelter's log book.

The shelter has had two CCC reports relating to medication errors in the last six months. The first report

was in September 2016. This report was due to a missed dose of medication. This was reported to the CCC. It was explained in the report the reason the medication was missed. Both staff members on duty had assumed the other staff member had given the youth the medication. There was documentation in the report of a telephone call with a pharmacist who reported the youth would have no severe side effects from missing the dose and to continue with the next schedule dose. Both staff members involved in the incident received a Medication Error Supervision and had to complete a Medication Delivery Remedial Quiz. Both these documents were reviewed for both staff members. This report was successfully closed out with the CCC.

The second CCC report was in December 2016. This report was due to a missed dose of medication as well. The youth missed her morning medication. The report documented the call with the pharmacist stating to continue with the next scheduled dose of medication. There was also documentation the staff involved received a Medication Error Supervision and also took a Medication Delivery Remedial Quiz. This report was successfully closed out with the CCC.

Exceptions:

The shelter has not had an RN since implementing the Pyxis Med-Station, with the exception of a two week period.

Staff are not currently using or printing out any reports from the Knowledge Portal.

Inventories of OTC's were missing for three weeks in December 2016.

Inventories of sharps were not consistent and only documented once in November 2016 and once in January 2017 for the past six months.

The shelter has had two CCC reports in the last six months relating to medication errors.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place called Medical/Mental Health Alert Process that was last reviewed on September 7, 2016.

The agency has developed and implemented a Medical and Mental Health Alert System to communicate essential medical conditions and other health related issues between staff in the program. The agency uses a dry erase board in the YCS office, a color-coded dot system on the youth files, the log book, the Shift Pass-down Log, and shift briefings to communicate all mental health alerts, medical alerts, and allergies with all staff. Any youth with an alert will have a color-coded dot placed on the front of the shelter file. There are four different colors used: orange is for sight and sound, red is for high risk youth, green is for medication or a medical condition, and blue is for domestic violence. If there are any special diets or food allergies, the form is placed in the kitchen for the cook and all staff to see.

There were four youth files reviewed. An interview with a YCS supervisor was also conducted. The four files reviewed documented any alerts identified during the screening process in the shelter's logbook under the intake note for that youth. The alerts were also documented on a form in the Shift Pass-down Log for each shift the youth were in the shelter and the form is initialed by staff each shift indicating they are aware of the alerts. The alerts were also documented on the dry erase board in the YCS office, however without the youth's name due to confidentiality reasons. The applicable color coded dots were also placed on the front of the youth's file. An interview with the YCS supervisor indicated staff are very well versed in the alert system.

There were no exceptions noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy for episodic/emergency care. The program must follow a written procedure that ensures the provision of emergency medical and dental care. The procedure must include obtaining off-site emergency care, parental notification requirements, incident reporting to the CCC and Florida Network, development and implementation of a daily log, and actions to be taken upon return for receiving outside medical care.

All staff members will be trained to respond to emergency medical and dental situations. Each staff member will be certified in CPR and First Aid. Each staff member will complete refresher training as required to maintain their certification. The program shall maintain an emergency procedure manual and episodic care log. Upon return to the facility each youth must have a medical clearance and instructions for follow-up care must be reviewed. Episodic and emergency care drills will be conducted.

The program did not have any episodic care or emergency care examples within the past six months prior to the review. The program has a policy in place and detailed instructions for staff to follow in the event of an emergency.

Each staff member is trained in CPR and First Aid. A random sample of 5 training files was reviewed and each file contained a current CPR and First Aid certification card. One file contained an Emergency Medical Technician certification.

Three drills that were inclusive of episodic and/or emergency care were conducted within the past 6 months. First Aid kits are maintained in both direct care staff offices, the kitchen, and both vans utilized for transportation of youth. The knife for life and wire cutters are located in the two direct care staff offices and each van contains a multi-tool capable of cutting seat belts and/or wire. Although there were no incidents requiring off-site emergency care, an episodic/emergency care log is maintained by the program.

There were no exceptions noted for this indicator.