



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of LSF - SW- Oasis

on 10/08/2013

## CINS/FINS Rating Profile

### Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%  
 Percent of indicators rated Limited: 14.29%  
 Percent of indicators rated Failed: 0.00%

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	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

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

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

Percent of indicators rated Satisfactory: 95.83%  
 Percent of indicators rated Limited: 0.00%  
 Percent of indicators rated Failed: 0.00%

### Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

### Review Team

#### Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Nicole Hartsock, Program Director, Sarasota Family YMCA

Sonia Santiago, Clinical Director, Sarasota Family YMCA

**Persons Interviewed**

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

**Documents Reviewed**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports                        | <input type="checkbox"/> Fire Prevention Plan                        | <input 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 type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 2 Health Records                                    |
| <input type="checkbox"/> Continuity of Operation Plan                 | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 2 MH/SA Records                                     |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input type="checkbox"/> PAR Reports                                 | 15 Personnel Records                                |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 8 Training Records/CORE                             |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 0 Youth Records (Closed)                            |
| <input type="checkbox"/> Escape Notification/Logs                     | <input checked="" type="checkbox"/> Sick Call Logs                   | 21 Youth Records (Open)                             |
| <input type="checkbox"/> Exposure Control Plan                        | <input checked="" type="checkbox"/> Supplemental Contracts           | 6 Other   |
| <input type="checkbox"/> Fire Drill Log                               | <input checked="" type="checkbox"/> Table of Organization            |   |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              |   |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

**Observations During Review**

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

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency dedicated to helping all people. With its Headquarters located in Tampa, the Agency has more than 60 programs located throughout Florida. It's southwest program, Lutheran Services Florida - Oasis Youth Shelter, is a Children in Need of Services/Families in Need of Services (CINS/FINS) program located in Fort Myers, Florida. Lutheran Services Florida Southwest (LSF SW) is the designated CINS/FINS provider for Lee, Charlotte, Collier, Hendry, and Glades Counties. In addition to providing CINS/FINS services, LSF SW is the Lead Case Management program in southwest Florida, funded by the Florida Department of Children and Families, through the Children's Network, to provide Child Welfare services to approximately to children in Lee and Charlotte counties. Services provided under this contract include: protective supervision, foster care, and adoption services. LSF SW also provides Guardianship Services, providing protection to incapacitated individuals age 18 and over in DeSoto, Manatee, and Sarasota counties.

Lutheran Services Florida Inc. was accredited by the Council on Accreditation (COA) in 2005 and has been continuously re-accredited by COA through February 28, 2014. This consistent achievement demonstrates the organization's commitment to maintaining the highest level of standards and provision of quality services to its consumers.

LSF SW participates in the National Safe Place Program, a network of voluntary community sites such as Fire Stations, local businesses, and schools that partners with the agency to provide a safety net where youth in need of help can go for refuge. A designated staff is responsible for Safe Place site recruitment, training, and ongoing support as well as community and school presentations. The efforts of the program are evident by the more than 200 Safe Place signs displayed on county libraries, fire stations, and other prominent businesses in the region. Since the last QI visit, the provider has expanded its Safe Place sites to include all Walgreens, Goodwill Stores, United Way Houses, and Lee Transportation.

In addition to the collaboration with Safe Place sites, the program also has numerous interagency agreements that are used to network with the surrounding communities, such as low-performing schools, community parks, and various designated neighborhoods in an effort to make agencies, youth, and families aware that services are available to address the needs of troubled youth and families.

## Standard 1: Management Accountability

### Overview

#### Narrative

LSF SW operates both the Oasis Youth Shelter (residential) and Non-Residential CINS/FINS Program in Lee County, Florida and is the designated CINS/FINS provider for the surrounding counties namely Charlotte, Collier, Hendry, and Glades. The program has a management team that is comprised of the following positions: Vice President of Programs located in Tampa Florida; Statewide Director of CINS/FINS; Statewide Quality Assurance Director; Residential Services Manager; Clinical Manager (position is currently vacated by new Statewide QA Director); a Licensed Mental Health Counselor (Counselor III); a Youth Care Supervisor (YCS III); and a Senior Administrative Assistant. The Statewide CINS/FINS Director supervises the program managers responsible for oversight of the CINS/FINS residential and the non-residential programs as well as other programs operated by the provider in the Southwest Region. At the time of the review, the program had two vacant Youth Care Specialist positions.

The program has an Annual Training Plan for each staff and orientation training is provided to all new hires. Employees receive ongoing training from the program's local providers and the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received. Annual training is tracked according to the employee's date of hire.

LSF Southwest maintains multiple interagency agreements with various community agencies that ensure a continuum of services for its youth and families. The program has an active outreach component with participation of all program staff who focus their outreach activities in designated high crime zip codes and low performing schools.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

LSF Southwest has a policy and procedures that address the screening of all Department employees, contracted providers, volunteers, and anyone who has direct and unsupervised access to youth. The agency's policy requires the screening to be conducted prior to hiring an employee or volunteer which is conducted using Live Scan. In addition to the DJJ Background Screening, the provider also conducts driver's license screening at hire and annually thereafter, annual local municipality and county screenings, and a drug screening upon hire and randomly thereafter.

A total of fifteen (15) background screening files for thirteen (13) staff and two (2) volunteers/interns were reviewed. All nine (9) new hires were screened and had eligible screening results prior to hire date. Three (3) of the four (4) staff eligible for a 5 year re-screening were rescreened prior to their 5-year anniversary date; however, one of the eligible 5-year re-screenings was not conducted prior to the employee's 5-year anniversary.

The program had two active interns during the onsite visit. One of the interns began volunteering in January 2013 in another agency program and received a DCF clearance. The intern volunteered briefly (3/2/13-4/28/13) for the CINS/FINS Program but the DJJ Background screening was not completed until 5/28/13.

The provider submitted its Annual Affidavit of Compliance with Good Moral Character Standards on January 3, 2013 prior to the January 31st deadline.

Exceptions:

The 5-year rescreening for one of the eligible employees was not submitted for re-screening until two days past the 5-year re-screening deadline.

One of the program interns did not have a DJJ background screening completed prior working in the CINS/FINS program.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

Agency Policy and Procedure, 1.02, addresses all of the requirements of the indicator. During orientation, new staff is informed of the agency's Code of Conduct via the Agency's Policy and Procedures and Personnel Policies and Procedures Manual. Staff acknowledge receipt of this information by signing an Acknowledgement Form which is maintained in their personnel files. New staff also signs an acknowledgement of

receipt of the Abuse Reporting Requirement.

During the tour of the facility, the postings of the abuse hotline number was observed in the lobby, dorm hallways, bedrooms, and common areas. Rights and responsibilities are posted in the individual bedrooms as well as throughout the facility. The rights and responsibilities are also reviewed with youth during intake and signed copies are kept in the youth's case file. There wasn't any visible sign of graffiti observed during the tour of the shelter facility.

Youth are allowed to file grievances and are given access to forms and a depository box. There are two grievance boxes which are kept under lock and are located in the dining room area and a hallway. None of the grievances reviewed onsite indicated staff's physical, psychological, or verbal abuse of youth. Additionally, the Senior Administrative Assistant stated that there are no personnel actions implemented as a result of employee violation of policy. Similarly, none of the CCC incidents reviewed for the review period involved staff abusing youth.

Three youth surveyed stated that they knew about the abuse hotline and location of the telephone number. They also stated that they feel safe in the shelter and feel that the adults are respectful when talking with youth. Similarly, the three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline; however, one staff indicated that they have observed staff using profanity, threat, intimidation, or humiliation when interacting with youth.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written Policy, 1.03, and procedures for the notification of reportable incidents to the Department's Central Communication Center (CCC) within the two (2) hour timeframe. Incident Report training is included on the provider's training plan for new staff during program orientation.

The provider's procedures require staff responding to the incidents/accidents to immediately notify their direct supervisor during daytime hours or supervisor/designee during evening or weekend hours. Any unusual incident is documented on the Incident Reporting Form by the witnessing staff member. Upon notification, determination is made by management regarding how to proceed. Staff is also required to document the incident in the log book. Additionally, the QA Specialist keeps track of the number and severity of incidents and provides a monthly report.

During the review period, thirteen (13) of the incidents reported to the Central Communications Center (CCC) were accepted. Of the thirteen incidents, five (5) were related to medication error/medical incident, four (4) were due to contraband discovered by staff, and four (4) were a result of youth behavior.

A review of the provider's documentation of the incidents was conducted along with a review of the provider's program logbook. All of the incidents were recorded on an Incident Report Form and included a summary of the incident, notification of appropriate authorities including the parent/guardian, and follow-up notes. One of the thirteen incidents reported during the review period was not reported to CCC within the 2-hour timeframe required.

In reviewing the program log book for verification of documentation of six CCC incidents reported in the months of July and August 2013, none of the six incidents accepted by CCC were noted in the program log book as required by the provider.

A review of three first year training files was conducted to determine receipt of Incident Reporting training during orientation. The training is listed on the training plan for the three staff and was completed during orientation.

#### Exceptions:

One of the thirteen incidents reported during the review period (6/18/13) was not reported to CCC within the 2-hour timeframe required.

None of the six incidents accepted by CCC in the months of July and August 2013 were documented in the program log book as required by the provider.

## 1.04 Training Requirements

Satisfactory

Limited

Failed

### Rating Narrative

The program has a comprehensive written policy and procedures to address staff training and has developed an annual Training Plan to ensure staff receives the necessary training to successfully complete job requirements. The agency provided a copy of their Annual Training Plan for the 2013-2014 Fiscal Year which includes a monthly staff training schedule. The Training Plan for FY 2012-2013 was submitted to the Florida Network on 9/14/12.

The agency maintains an individual training file for each staff which includes a tracking form, supporting training documentation, and attendance log. A review of eight training files for three first year and five in-service staff was conducted to assess compliance with the indicator.

Two of the three first year staff had completed or were on target for completing the 80 hours of training required; however, one staff had only received 21 training hours during the first 6 months of hire. Orientation training was not consistently provided and documented for the three new staff; two staff did not demonstrate completion of 40 hours of job shadowing. The provider states that job shadowing will be provided during orientation but it was not listed on one of the staff's training plan and proof of completion was missing for another employee. A third staff's training log shows 40 hours of job training provided but only 20 hours were documented.

During the first 6 months of hire, none of the two direct care staff had received Title IVE training and current CPR/First Aid certificates were not included in their training files, indicating the training had not occurred. Additionally, the two direct care staff had not yet completed Crisis Intervention and both had not yet completed some of the other mandatory trainings but still have a few months to complete these trainings. Behavior Management training is listed by the provider as a mandatory training for direct care staff but is not listed on the employee's training plan. Only one of the two new staff demonstrated proof of this training during job shadowing.

A total of five in-service staff training files were reviewed for three part time and two fulltime staff. In general, staff is non-compliant in completing the 24 hours of training required annually. None of the five staff demonstrated compliance in the most recent training year that was completed during the review period and none of the three part time staff had completed more than 3 hours of training during that training year. Two of the five staff did not complete any of the mandatory trainings such as CPR/First Aid or other training required by the Florida Network.

### Exceptions:

- One of the three first year staff is not on target for completing the 80 hours of training required annually
- Orientation training is not consistently provided and documented for the three first year staff including the 40 hours of job shadowing
- Two direct care staff had not received mandatory trainings such as Title IVE, CPR/First Aid, and Crisis Intervention
- Behavior Management training is required by the provider but is not listed on the employees' Training Plan
- Training files for all five in-service staff reviewed are non-compliant in completing the 24 hours of training required annually
- Two of the five in-service staff did not complete any of the mandatory trainings such as CPR/First Aid or other training required by the Florida Network

## 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

### Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports. The agency's management team includes the Executive Director, Non-Residential and Residential Program Managers, QA Specialist, program supervisors, and other key staff who are in charge of the local CQI committees.

The agency's clinical staff conducts peer reviews of all active client files on a monthly basis. In addition, the Non-Residential Clinical manager conducts case supervision on a monthly basis with all non-residential Counselors and Case Managers and any issues identified from the peer reviews are addressed. File review findings are documented on the Non-Residential Peer Audit Review Checklist for each record reviewed. The provider conducted peer reviews for forty-one non-residential case files in the month of September 2013.

Residential Case Staffings are held weekly and include the Shelter Manager, Counselor, and Youth Care staff. The file review checklist is maintained in the youth's case file.

The Residential and Non-Residential Manager prepare a Quarterly QIC Report which includes an analysis of incidents, accidents, and grievances. Reports for the first two quarters 2013 were reviewed. The reports include an analysis of incidents/accidents, grievances, and fire drills that occurred during the quarter, summary of case record reviews, reporting of performance measurements for the quarter, number and types of training provided to staff, and satisfaction surveys completed. Additionally, the program's QA Specialist tracks and reports incidents/accidents as well as trend data on a monthly basis.

Consumer satisfaction data is included in the quarterly QIC Reports. Findings are regularly reviewed by management and communicated to staff and stakeholders. Strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process.

Monthly staff meetings are held for all program staff and during these meetings, all incident reports, grievances, and accidents are reviewed. Staff meeting agendas for the past six months were reviewed. The agendas always included an item for CQI to discuss incidents, accidents, grievances, follow ups, and satisfaction surveys. An agenda and sign-in sheets are available for each staff meeting.



## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

The Oasis Youth Shelter provides an array of prevention services for youth ages ten to seventeen years of age and their families who meet the criteria for CINS/FINS services. Referrals may come from the youth, parents/guardians, schools, law enforcement, or other community organizations. The program provides centralized intake and screening twenty-four hours per day, seven days per week, each day of the year.

The Non-Residential program is under the direct supervision of a Clinical Manager who supervises a Quality Assurance Specialist, seven Counselors (four funded by DJJ), three Administrative Assistants, and an Outreach Specialist. The Non-Residential program is divided into two components, clinical and prevention/intervention.

Trained staff are available to determine the needs of the family and youth. The youth and family participate in a face-to-face session in order for the staff to assess their individual needs and develop an individualized plan of services to accomplish specified goals. Residential counseling services, including individual, family, and group therapy, are provided. In addition, case management and substance abuse prevention services are also offered in non-residential settings. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, financial assistance, housing assistance, and educational assistance.

LSF SW coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee meets at a minimum six times monthly and can also recommend a CINS Petition be filed to court-order participation with treatment services.

### 2.01 Screening and Intake

Satisfactory

Limited

Failed

#### Rating Narrative

A written policy and procedure is in place regarding the centralized intake process. The policy clearly states eligibility criteria for Residential and Non-Residential services. The screening identifies the presenting issues and allows for placement in their programs, either Shelter residential services or Non-Residential services. If Non-Residential services are identified, the family is contacted for the intake appointment which is clearly documented. Five Non-Residential files and two Shelter files were reviewed and contained the CINS/FINS Screening, admission dates, and all forms indicating services options, rights and responsibilities of all parties. A mock file was also provided which contained brochures and information provided to parents regarding the CINS process.

In practice, the Non-Residential program files contained documentation regarding the screening and the services available. An appointment is scheduled to meet with the family. At that appointment further information is provided on the services available as well as an explanation regarding the forms they will be asked to sign so services can proceed. These forms include consent to services, release of information, confidentiality, grievance procedures along with information on the CINS process.

Shelter files contained the screening and intake information along with issues identified and notes regarding family contact and services to be provided.

### 2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

#### Rating Narrative

There is a written policy and procedure in place regarding the Psychosocial Assessment and its function which is to gather pertinent information regarding the youth and his family.

All seven files reviewed contained completed Psychosocial Assessments with signatures of both the Counselor completing the psychosocial and the Supervisor. The information gathered leads to the development of the Service Plan. All areas of the Psychosocial were completed and the summary captured the details provided by the youth and family including statements regarding substance use, and suicidal ideation. It also contained statements regarding referrals to be made. If during the psychosocial it was indicated that an additional assessment for suicidal ideation was needed, the additional assessment was included.

In general, the Psychosocial Assessments were initiated within the required timeframes, 72 hours (residential) and 2 to 3 face-to-face visits (non-residential) for all cases reviewed. The assessments were completed by Bachelor's or Master's level staff in the program.

## 2.03 Case/Service Plan

Satisfactory

Limited

Failed

### Rating Narrative

There is a policy and procedure in place regarding Case/Service Plans and how each step of the intake process helps in identifying the appropriate services needed to assist the youth and family.

All seven Service Plans reviewed were developed within seven days of the completed psychosocial assessment. Each plan laid out specific goals and actions needed to complete the goal. Specifics as to who would be responsible to complete each goal were stated. Frequency, target dates and the location of services were included on the service plans. Signatures of all parties (youth, parent, and counselor) were in place and dated. Supervisor's signature indicating review of the file was also evident. Objectives that had been completed were dated appropriately. Thirty (30) day service plan reviews were completed on time in six of the seven files. One file did not have a review date because it was not yet due. There were no files reviewed that required a 6 month review.

## 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

### Rating Narrative

The Policy and Procedure regarding Case Management and Service Delivery clearly states the coordination process for the delivery of services.

Seven files reviewed reflected the coordination of service delivery including referrals when indicated. The Case Manager/Counselor assigned is instrumental in providing the services identified and developed.

Service delivery and follow through was clearly documented in progress notes and attest to the strength of the program staff. Progress notes indicated the level of service to the youth, including referrals for additional services regarding substance use assessments and for further mental health evaluations as well as suicidal ideation. The Service Plan goals were the target of the individual sessions. The Case Manager/Counselor provided strategies and skills to improve the issues that were targeted. Contact with the parents was included and weekly meetings were documented. The documentation also noted the level of progress. Five of the seven files did not indicate a need for further Case Staffing services. Two other files reviewed were case staffed which resulted in petitions filed. Documentation was in place illustrating efforts made to address the issues of attendance.

## 2.05 Counseling Services

Satisfactory

Limited

Failed

### Rating Narrative

The Policy and Procedure regarding counseling services both in the Shelter Program and Non-Residential program, clearly states the process to address the identified needs of the youth based on the information gathered and the case/service plan developed.

The process includes addressing the individual needs of the youth based on the identified issues, and can include individual/family counseling, groups or referrals for more services. Interventions provide the key to assisting youth/family in changing their crisis status, keeping families intact, providing support and other services as needed.

In practice, the Shelter staff meets with youth, identify the crisis issue, develop the plan, contact the family and include them in the process.

Individual/family sessions are provided as needed and daily groups are a mainstay of the interventions. Group counseling is provided at the shelter at least 5 days/week.

Non-Residential Service practices focus on the Service Plan once youth and family have agreed to services and all the information is gathered.

Interventions focus on the identified issues and can include referrals for substance abuse issues, as well as further evaluations for suicide ideations and mental health issues. Truancy, ungovernable behaviors, self-esteem issues are addressed, with skill building and strategies included in the counseling process. The files reviewed indicated youth were met at school or at home. Contact with parents and their participation are greatly encouraged.

All seven files reviewed included the youth's presenting problems in the Psychosocial Assessment, initial service plan, and case plan reviews. Case notes are maintained for all counseling services that were provided to the youth and were found in the seven files reviewed. The program supervisors meet with the clinical staff, weekly in the shelter and monthly in the non-residential program, to conduct clinical reviews of case records and ensure staff performance.

## 2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

### Rating Narrative

The Policy and Procedure for the Adjudication/Petition process is clearly stated and provides the guidelines for Case Staffing and the resulting Petition if required.

The Case Staffing committee meets twice a month in Lee County and once a month in the neighboring counties which the program serves. The Committee members include a School Representative, Law Enforcement, Judiciary, and an agency representative. Parents and youth are invited to participate. Referrals for the TURN program, which is referred to in the policies and procedures statement are often referrals from the schools, but can result from a youth disregarding the efforts of the assigned counselor. Of the two adjudicated files reviewed, one was a direct result of a youth either refusing to attend school after services had been provided and appropriate interventions had been implemented, and the other for refusing to attend Case Staffing.

The program practices the process outlined. The schedule for Case Staffing was reviewed as well as the letters to the representatives. Notifications were sent to the family and committee members no less than 5 days prior to the case staffing. The progress notes include efforts to contact the family and the Case Staffing meetings. The referral forms, letters to the parents, the Case Staffing recommendations and the petition are all contained in the file. The petition identifies the problem areas and the court recommendations to be complied with. The file contained the CINS petition and court recommendations were noted in the progress notes. As a result of the Case Staffing, the youth was provided a revised service plan based on the recommendations of the committee.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The policy and procedure established assures that a case record is maintained for each youth that receives services and is clearly marked confidential.

The case files for each youth are marked confidential, and contains the following: demographic information, all intake forms for services, Netmis, risk factors, service plan, assessments such as the Brief FAM, progress notes, referral forms, in fact any pertinent information regarding the case. If Case Staffing/Petition services were provided, that information was also included. Files for both Shelter and Non-Residential services are kept behind a locked door in file cabinets that are also marked confidential. File order is consistently maintained.

Nine files were reviewed, including two shelter files and two Case Staffing/Petition cases. All contained the above information and were clearly marked confidential. The program maintains a separate file for those youth that are in the adjudication process. All files were easy to read.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

Oasis Youth Shelter is a twenty-two bed facility that provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and youth from the Department of Children and Families (DCF). The shelter provides short-term residential services for youth ages ten to seventeen, who do not have any current open cases of delinquency or dependency. With the exception of court-ordered CINS youth, the services are voluntary in nature and no fees are charged to clients for CINS/FINS services. At the time of the quality improvement review, the shelter was providing services to twelve CINS/FINS youth. The shelter is designated by the Florida Network to provide staff secure services and Domestic Violence respite services but did not have any youth in the program during the review who met the criteria for either program. In addition, the shelter provides services to youth in the custody of the Department of Children and Families (DCF).

The shelter program management team is comprised of a Residential Services Manager, and a Youth Care Supervisor (YCSIII). Each shift also has a YCSII who is the designated team leader. An organization chart dated 9/13/13 shows an additional twenty-two Youth Care positions in the shelter program, two of which were vacant during the review. There are also three residential counseling positions, one of which is occupied by the Licensed Mental Health Counselor (LMHC).

Clinical services are supervised by the LMHC Counselor. Services provided include individual, group and/or family counseling, and any other applicable intervention required.

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The Shelter has a written policy and practice in place to ensure a safe environment that is well maintained. All doors are secure and only staff have in and out access. Guests have to be escorted into the facility by staff.

There are 16 cameras throughout the program and a monitor that staff can observe from inside the office. It is observed to be operational and can hold up to 30 days of recording.

During the tour, there was no sighting of insect infestation or graffiti. Staff check the program walls, doors, and windows daily for graffiti. Staff complete daily room searches which are documented and kept in a binder. Five (5) search forms were reviewed and only one (1) stated by staff that the dorm room was messy and the other four (4) stated rooms had no issues. Lights were checked throughout the program and are in working order. The floodlights on the outside of the building are all working.

Dorms are clearly numbered and each youth has an assigned bed. Youth are allowed to decorate their sleeping area with their own personal items that are appropriate. The dorms each had painted murals that created an inviting atmosphere for the youth. Also posted in each dorm room were the program rules and daily schedule. The daily schedule shows structure, homework time, and the allowance for physical activity daily. The program has access to a gym or the church located next door as well.

The lawn is well maintained and there is new landscaping around the building and throughout the property. A garden was recently added by a local Lutheran Church volunteer group that planted various vegetables and fruit trees with the assistance of the youth in the program. The dumpster area is clean and enclosed in a fence.

All required inspections, which include health and fire safety, were viewed and are up to date. The most recent satisfactory Department of Health Group Care and Food Inspection was conducted 3/27/13. Pest control is done every 3 months; however the program can call in between that time if needed. The file room provides a locked place for youth's personal belongings if needed. The DCF license is posted in the shelter and shows that the shelter is licensed for 22 beds through 1/31/2014. Egress plans are posted throughout the shelter.

There was 1 minivan on site that was inspected. The doors were locked and the van contained a fire extinguisher, first aid kit, flashlight, seat belt cutter, and glass breaker.

The program has 1 washer and 1 dryer and both are working and in good repair.

The chemicals are locked in the chemical closet and MSDS sheets are maintained and chemical counts are completed daily.

#### Exceptions:

- In the girls bathroom there is not a proper door on one of the toilet stalls. A shower curtain hangs instead of a door which does not provide full privacy.

- The shower curtain in the boy's bathroom was attached with plastic ties. The ties do not glide freely and causes the plastic curtains to rip/detach easily
  
- The pass through window between the kitchen and the dining room has a large crack

**3.02 Program Orientation**

Satisfactory
  Limited
  Failed

Rating Narrative

The Shelter has a written policy and practice in place that allow the youth to have a positive orientation process.

Three (3) residential case files were reviewed and all 3 files contained the required orientation documentation which was completed within the required 24 hours. In all 3 files the youth and parent signed that they received the handbook. The orientation to the program checklist was included in each file and initialed by each youth. The program has a private area available for the admissions to take place. At this time program staff reviews the program rules and expectations and the behavior management system with the youth and parent/guardian, if present. Each youth and parent are provided with a resident handbook which includes, description and map of the program, list of current program staff, program rules, grievance procedure, disaster plan, and client rights and responsibilities.

The grievance forms and boxes are placed in two designated areas, the hallway and the day-room. Five (5) grievances were reviewed and three (3) were addressed with the youth on the same same day and one (1) was addressed within 3 days. Four (4) of the grievances were resolved and 2 were not due to youth running from the program and then being discharged. Each bedroom has a board that posts the grievance procedure, clients rights and responsibilities, emergency plan, behavior management system, daily schedule, and program rules.

**3.03 Youth Room Assignment**

Satisfactory
  Limited
  Failed

Rating Narrative

The program has a written policy and practice in place to assign youth to an appropriate room placement. The process includes an initial classification that takes the following characteristics into consideration: youth's history, status, and exposure to trauma; age; gender; history of violence; disabilities; physical size/strength; gang affiliation; suicide risk; sexually aggressive or reactive behavior; and gender identification.

Three (3) files were reviewed and all 3 files contained documentation that demonstrate, upon intake, a classification system is in place to properly assign youth to a room. Documentation acknowledges a youth's history, suicide risk, age, gender, history of violence, disabilities, physical size, and sexual aggression.

If a youth is placed on sight and sound they will sleep on the couch in the day room where a staff member is always located. There is an alert system in place to notify staff of any special needs. The alert board is clearly labeled with the alert issue and a color coded dot. Two (2) files were reviewed for alerts and both youth were properly listed on the alert board.

During room assignment, the youth and a staff member complete the client room checklist to check for any graffiti, broken windows or other damage. The youth takes responsibility for any damage created while they are at the shelter and will help with repair prior to discharge.

**3.04 Log Books**

Satisfactory
  Limited
  Failed

Rating Narrative

There is a written policy and practice in place in regards to the log book.

The last 6 months of log books were reviewed. The log book is not being consistantly reviewed by staff when they begin their shift. The log book is being reviewed and signed weekly by the program manager and staff supervisor. Daily routines, important events, and incidents are documented in the log book. Youth outings and home visits with family were documented.

All entries included date, time, persons involved, brief statement providing information, and a signature of the person making the entry. Incidents and important information is highlighted throughout the log books. Eight (8) recording errors were found and 6 had a single line with initials and a date and 2 were scribbled out with no initial or date.

Exceptions:

- Staff coming onto their shift do not consistently sign in or document that they are reviewing for the previous two shifts.
- Two of the errors reviewed were not corrected as required with a single line with initials, and date.

Rating Narrative

There is a policy and practice in place for behavior management strategies. The program follows the Boystown model. A youth begins with a Daily Skill Card pre-loaded with 200,000 points and they will have a deduction in points for positive behavior and have points added for negative behaviors. The goal is to deduct 10,000 points a day.

Each youth has a point card to monitor their daily points. The goal is to deduct 10,000 points per day from the card, eventually reaching zero points. The card lists the youth's particular target skills. An example would be a youth who uses a lot of profanity. They will first get a verbal warning and if the youth continues to use profanity then points are added. The youth are rewarded for various things throughout the day, from making their bed, no profanity, going to school, doing homework, and helping a peer.

The program uses a variety of rewards and incentives such as earning a gift card to Walmart, eating at a favorite location, or having a phone call with an approved friend.

Youth are introduced to the behavior management system during intake. Both youth and parent are provided a handbook as well which describes the behavior management system.

The provider's behavioral interventions utilize the least amount of force. Staff make attempts to use verbal intervention and de-escalation techniques first. If there is an incident where staff must physically engage they will complete an incident report and hands on report. Only staff disciplined youth; no group discipline is used.

A "weekend" log is maintained and reviewed weekly by the staff supervisor or a designee. This allows the supervisor to review the point cards to ensure staff are following the behavior system as well as track how the youth are doing in the program. This information is used to plan outings and to see which youth can participate in the outing.

Staff are trained in the behavior management system during their new employee shadowing. However, 3 of 2 training files reviewed showed that 2 of the staff did not have the documentation to support that they received this training.

**3.06 Staffing and Youth Supervision**

Satisfactory                       Limited                       Failed

Rating Narrative

The provider has a policy and procedures to ensure that adequate staffing is provided for the safety and security of youth and staff.

Staff schedules for the past 6 months were reviewed. Staff ratios are being met for the 1 staff to 6 youth during awake hours and 1 staff to 12 youth during sleeping hours. Both male and female youth are represented on all shifts by staff of the same gender. There were 6 situations where a female could not be found to cover a shift, however documentation shows that every effort was made to find a replacement and on site counselors would respond to any gender specific needs. Hold overs are in place if another staff member is running late.

The staff schedule is posted in the file room as well as in the staff schedule book located in the YCS office.

Staff complete bed checks every 10 minutes and documentation of the checks is maintained in the log book.

**3.07 Special Populations**

Satisfactory                       Limited                       Failed

Rating Narrative

The provider has a current policy and procedures in place to ensure proper protocols and utilized for youth meeting Staff Secure or Domestic Violence Respite criteria.

LSF SW is a designated Staff Secure Shelter and approved DV Respite provider. However, practice was not evaluated because none of the youth in the program during the QI visit, met the criteria for either of these placements.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

LSF SW has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2. Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The shelter manager and/or Youth Care Supervisor is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented in the daily log, on the alert board, shift exchange forms, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked cabinet, and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a Medication Distribution Log binder.

### 4.01 Healthcare Admission Screening

Satisfactory
  Limited
  Failed

#### Rating Narrative

The provider has a policy in place, 4.01, that includes procedures for the healthcare screening of youth during the admission process. Upon intake, youth are screened by youth care staff for health related conditions. The results of the health care screening are documented on the Healthcare Admission Screening Form as well as on the Physical Health Screening section of the CINS/FINS Intake Assessment Form. Notation of scars, marks, and tattoos are documented on a Body Chart Form. The preliminary health screening completed by the provider assesses all of the physical and medical health related conditions required by the indicator.

Five files were reviewed and all were found to include screening for current medications, existing medical conditions, allergies, recent illnesses and injuries, observation for evidence of illness, injury, pain or physical distress and difficulty moving as well as observation for presence of scars, tattoos, and other skin markings. The health screening was also completed in all five files for chronic medical conditions of diabetes, pregnancy, seizure disorders, cardiac disorders, asthma, tuberculosis, hemophilia and recent head injuries.

The provider's procedure includes a referral process and necessary follow-up of medical care for youth with chronic medical conditions who are in need of these services. The Youth Care Specialist will immediately call the On-Call Counselor or Residential Supervisor if there is a medical, dental, or mental health condition that exists. The parent is contacted by the On-Call Counselor or Residential Supervisor to discuss the medical needs and arrange for treatment of these needs and any special medical attention the client may require while in the shelter.

During the intake, one of youth stated that he has seizures/blackouts sometimes; however, medical follow up was not initiated by staff indicating that this was discussed with the parent or a referral for this condition was recommended. No medical follow up was initiated by staff indicating that this was discussed with the parent and a referral for this condition was not recommended for the youth.

### 4.02 Suicide Prevention

Satisfactory
  Limited
  Failed

#### Rating Narrative

There is a policy and procedure in place regarding Suicide Prevention as well as a Medical/Mental Health Alert systems.

The procedures are clearly stated and provide a road map for identifying and providing the needed services for those identified with suicidal ideation during the intake process. The procedures include placing the youth on sight and sound until an Assessment of Suicide Risk is completed by a Masters Level Counselor under the supervision of a Licensed Mental Health professional. The procedures also refer to observation by staff of behavior which may be concerning regarding the youth's mental status and placing them on sight and sound for further evaluation.



All youth admitted to services are screened for suicide. In the Shelter setting, if the youth admits to suicidal ideation, they are placed on sight and sound until an Assessment of Suicide Risk has been completed by the Masters Level staff under the supervision of a Licensed professional. Two files were reviewed for Suicide Prevention, one for past suicidal attempts and the other based on observation by staff. The youth who admitted suicidal attempts and whose ASR was completed was placed on sight and sound due to his past history and his level of hopelessness. Staff continued to monitor, observe him until another ASR was completed by the Masters Level staff who is supervised by a Licensed Person. At that time the youth was removed from sight and sound. The other youth was observed by staff scratching a sore with a card and was placed on sight and sound. At that time youth denied his intent to hurt himself, stating he did not hear the staff redirecting him. The Masters level staff completed the ASR, and the youth was removed from sight and sound after conferring with the Licensed staff.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The program has a written policy and practice in place to address the safe, and secure storage, access, inventory, disposal, and administration/distribution of medications. All medications are stored in the medication room/office that is only accessible to staff. The narcotics and controlled substances are stored in the locked office inside a locked box. The program does not currently have youth on topical or injectable medications; however, when they do, they are not stored together. The medication refrigerator was working and was cold upon observation. Currently no medications are needed to be stored in the refrigerator.

Syringes and sharps are stored in the locked file room. Sharp counts for the last 6 months were reviewed and they are completed daily by staff.

The last 6 months of over the counter inventory sheets were reviewed. Over the counter medications are inventoried daily and perpetually by staff. When over the counter medications are given it is documented on the over the counter distribution log for each youth.

A list of approved staff who can distribute medications is posted in the medication room. Two staff members are present during the distribution of medications. The training files of two designated staff was reviewed and medication training was demonstrated.

Two (2) youth's MDLs were reviewed and both showed the medications are being counted shift to shift. Both staff and youth are initialing their MDL. One (1) of the MDLs had youth's full name printed along with signature but one (1) did not. Staff initials everytime they count the meds and the youth initials along with staff when the medications are given. The MDLs reviewed contained the youth's name, date of birth, allergies, side effects, and picture of youth. The 2 files reviewed demonstrate that the staff document on the MDL 1 hour after the youth ingests the medication if the youth experiences any side effects. A supervisor reviews and documents on the MDL that they review the medications weekly.

The program provides a binder for staff which contains information on medications most often seen in the shelter. Staff access the internet to look up medications they are not familiar with.

The program has a medication disposal binder to document the disposal of any medications. Two staff are present when medications are disposed.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

There is a written policy and procedure to address how medical and mental health alerts pertinent to the youth are conveyed to program staff. The program also uses a color coded system of alerts. The alerts are added to the youth's file, the alert board, alert binder, and program logbook.

Two youth files were reviewed. One of the youth had a medical condition requiring medication and the other youth had a mental health condition. The two youth were appropriately placed on the program's alert system and the alerts were documented in the four places required by the provider.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

There is a written policy and procedure (4.05) in place to address when, where, and how staff obtains offsite emergency services. The parental notification element of the indicator was also addressed in the 4.04 of the provider's procedures. The procedures include the training and usage of the knife-for-life and first aid kits; documentation of emergency care provided; communication among staff of potential emergency situations; and offsite transfer of youth to for emergency situations. The program has a Medical Log Book that has been in place since 2007.

The case files for two youth who received medical services were reviewed. Offsite medical services for the two youth were documented in the Medical Log Book. In both cases, the parent were notified and parental notification was documented on the CCC report for one youth and in the progress notes for the other youth.

A knife for life and wire cutters were accessible in three locations: medication room, Residential Services Manager office, and the file room. First aid kits/supplies are available in three locations throughout the facility and one in each van.

Staff training in First Aid/Emergency Medical Procedures was not evident in four of the eight training files reviewed.