



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

Review of Lutheran Services Florida/SW-Oasis  
Residential Program

December 5-6, 2018

**Compliance Monitoring Services Provided by**

 **FOREFRONT**



## Quality Improvement Review

Lutheran Services Florida/SW-Oasis – December 5 – 6, 2018

Lead Reviewer: Ashley Davies

### 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	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

**Percent of indicators rated Satisfactory: 100.00%**

**Percent of indicators rated Limited: 0.00%**

**Percent of indicators rated Failed: 0.00%**

#### Standard 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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	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 & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 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	Satisfactory

**Percent of indicators rated Satisfactory: 100.00%**

**Percent of indicators rated Limited: 0.00%**

**Percent of indicators rated Failed: 0.00%**

#### Standard 4: Mental Health /Health Services

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

**Percent of indicators rated Satisfactory: 100.00%**

**Percent of indicators rated Limited: 0.00%**

**Percent of indicators rated Failed: 0.00%**

#### Overall Rating Summary

**Percent of indicators rated Satisfactory: 100.00%**

**Percent of indicators rated Limited: 0.00%**

**Percent of indicators rated Failed: 0.00%**

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### 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.
Not Applicable	Does not apply.

### Reviewer

#### Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Marie Lockwood, Regional Monitor, Department of Juvenile Justice

Tiffany Martin, Project Manager, Florida Network

Charles Harris Jr., Program Coordinator, Sarasota YMCA

Baldwin Davis, Chief Administrative and Compliance Officer, Miami Bridge



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**Methodology**

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures) and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

**Persons Interviewed**

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Chief Executive Officer | <input 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 type="checkbox"/> Program Coordinator                | <input checked="" type="checkbox"/> Direct – Care Full time | <b>1</b> # Case Managers                            |
| <input checked="" type="checkbox"/> Direct – Part time      | <input type="checkbox"/> Direct – Care On-Call              | <b>1</b> # Program Supervisors                      |
| <input type="checkbox"/> Volunteer                          | <input type="checkbox"/> Intern                             | _____ # Food Service Personnel                      |
| <input checked="" type="checkbox"/> Clinical Director       | <input checked="" type="checkbox"/> Counselor Licensed      | <b>1</b> # Healthcare Staff                         |
| <input checked="" type="checkbox"/> Counselor Non-Licensed  | <input checked="" type="checkbox"/> Case Manager            | _____ # Maintenance Personnel                       |
| <input type="checkbox"/> Advocate                           | <input checked="" type="checkbox"/> Human Resources         | _____ # Other (listed by title): _____              |
| <input type="checkbox"/> Nurse – Full time                  | <input checked="" type="checkbox"/> Nurse – Part time       |   |

**Documents Reviewed**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Table of Organization            | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input type="checkbox"/> Visitation Logs                       |
| <input checked="" type="checkbox"/> CCC Reports                       | <input checked="" type="checkbox"/> Grievance Process/Records        | <input checked="" type="checkbox"/> Youth Handbook             |
| <input checked="" type="checkbox"/> Logbooks                          | <input type="checkbox"/> Key Control Log                             | <b>6</b> # Health Records                                      |
| <input checked="" type="checkbox"/> Continuity of Operation Plan      | <input checked="" type="checkbox"/> Fire Drill Log                   | <b>7</b> # MH/SA Records                                       |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | <b>16</b> # Personnel /Volunteer Records                       |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | <b>10</b> # Training Records                                   |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | <b>5</b> # Youth Records (Closed)                              |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Supplemental Contracts                      | <b>5</b> # Youth Records (Open)                                |
| <input type="checkbox"/> Exposure Control Plan                        | <input type="checkbox"/> Telephone Logs                              | _____ # Other: _____   |

**Surveys**

- |                  |                              |                         |
|------------------|------------------------------|-------------------------|
| <b>3</b> # Youth | <b>3</b> # Direct Care Staff | <b>0</b> # Other: _____ |
|------------------|------------------------------|-------------------------|

**Observations During Review**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Intake                                    | <input checked="" type="checkbox"/> Posting of Abuse Hotline         | <input checked="" type="checkbox"/> Staff Supervision of Youth     |
| <input type="checkbox"/> Program Activities                        | <input 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 type="checkbox"/> Meals                                     |
| <input checked="" type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts                   | <input checked="" type="checkbox"/> Signage that all youth welcome |
| <input checked="" type="checkbox"/> Medication Administration      | <input checked="" type="checkbox"/> Staff Interactions with Youth    |  |
| <input checked="" type="checkbox"/> Census Board                   |  |  |

**Comments**

Additional Comments regarding observations, other important findings of interest, etc.

## **Strengths and Innovative Approaches**

LSF SW CINS/FINS program applied for the Community Development Block Grant (CDBG) when it became available in August 2018. On 10/24/2018 LSF SW was notified that the submitted CDBG proposal was approved as follows: Oasis Youth Shelter Improvements \$43, 250, for an outside backyard screened in building and a renovated basketball court; CINS/FINS Non-Residential Counseling Program building improvement for \$36,750, for a new roof and floors. The total amount awarded is \$80,000. They are currently working with the CDBG contract manager to finalize the contract and begin construction.

The Intensive Case Management Services program has been fully implemented for a full year. There is no staff turnover in this program.

LSF was awarded the SNAP contract by the Florida Network in July 2018. LSF Non-Residential program under the leadership of Shelia Dixon has fully implemented the Stop Now and Plan (SNAP) program in Circuit 20, a five-county area. The program is staffed with two full time employees. LSF SW has made the SNAP facilitator part-time positions available to Youth Care Staff (YCS) and counseling staff at an enhanced rate of pay. This also provides the YCS growth in their professional development. The SNAP in schools has been implemented in Charlotte County.

CINS/FINS Non-Residential staff facilitated weekly counseling/psychoeducational groups for middle school aged youth in the Charlotte County area during summer camp. They were able to provide services to a population that generally would not have been identified as having a need for services by community providers. Several parents expressed gratitude for LSF providing prevention services and coping skills to the youth in the community. Similar groups were helped in Collier County; however, included youth who were on diversion to help them develop skills to divert them from going further into the DJJ system. This opportunity strengthened their relationships with law enforcement and diversion officers, as well as with youth in the community that needed services.

Two of the CINS/FINS counseling staff (one Residential and one Non-Residential) became Licensed Mental Health Counselors. Of the currently employed CINS/FINS counselors there is one Registered Mental Health Counselor and two Registered Clinical Social Work interns under the supervision of the Clinical Director.

At the time of the review, all CINS/FINS Residential and Non-Residential counseling programs were fully staffed under the leadership of the Clinical Director for the SW region.

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Under the leadership of Raymond Ballinger, Residential Oasis Shelter Manager, Ties on Tuesdays was implemented. The entire community continues to be involved. Donations of nice clothing, and many ties come in from all over the circuit. This is a program that helps young men learn to dress professionally and are mentored by staff to address others and how to present in many situations including job interviews. Male staff also wear Ties on Tuesdays.

Under the leadership of Raymond Ballinger LSF SW also implemented a “Right to Read” initiative, which encourages youth to read. Books are donated by the community, businesses, staff, and purchased if necessary.

Due to previous rain and Hurricane Irma, Oasis Youth Shelter flooded. This resulted in a finding of mold under the windows. All bedrooms underwent mold remediation for a period of approximately four to six months. Two bedrooms at a time were closed until completely remediated.

On February 5, 2018 in the parking lot next door to the shelter a vehicle accidentally ran into the side of the shelter, specifically the Shelter Manager’s office. The vehicle ran through the wall and window. The office was not habitable for several months. All repairs are now complete.

LSF SW continues to employ a “Child Welfare” Case Manager that oversees CMO youth for Oasis initial placement and placement transition from Oasis to a more permanent placement. This Case Manager works solely with the CMO youth at Oasis. They work in partnership with the CMO Case Manager, placement specialists, and other involved parties like the Guardian Ad Litem. The intent of this position is to assist the Case Manager and placement staff with identifying and transitioning the youth timely to appropriate placements as working with the youth while they reside at the shelter. The Case Manager is part of the Oasis team and is housed there as well.

LSF SW was awarded “Agency of the Year” by the Florida Network of Youth and Family Services at the annual awards meeting earlier in the year. In addition, Eric Scott YCS II, a long-time dedicated employee, was awarded “Youth Care Worker of the Year.”

Dr. Chris Card resigned from Lutheran Services Florida this past summer. Former DCF Secretary, Mike Carroll, is now the Executive Vice President of Programs. The Executive Director for the SW region, Shareet Pennino, reports directly to Mr. Carroll.



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### Standard 1: Management Accountability

#### Overview

The program management team is comprised of a Vice President of Programs located in Tampa, Florida; Executive Program Director located in Fort Myers; a Clinical Director (LCSW) who supervises Prevention/Intervention, Quality Assurance, and Residential and Non-Residential Counseling programs; a Residential Services Manager; a Youth Care Supervisor (YCS III); a Shelter Case Manager; a part-time Registered Nurse, and a Senior Administrative Assistant.

The program provides first year training, as well as annual training, to ensure that all staff are properly trained for the jobs they perform. The program staff, the Florida Network, the Fort Myers Fire Department, the Red Cross, and other outside agencies provide training.

The program has numerous inter-agency 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 youth at risk and their families.

#### 1.01 Background Screening of Employees/Volunteers

Satisfactory

Limited

Failed

The program has a policy and procedures to ensure background screening is conducted for all Department employees, contracted provider and grant recipient employees, volunteers, mentors and interns with access to youth. The background screening is completed prior to hire, utilizing the services of a volunteer, mentor or intern. Employees and volunteers are re-screened every five years in accordance with established policy and procedures. The background screening policy and procedures was last approved on August 28, 2018 and was signed by the Executive Director, Clinical Director and Residential Services Manager.

A review of the current staffing roster provided that nine staff had been hired since the date of the last annual compliance review. Staff were hired between February and December of 2018. A review of personnel files provided all newly hired staff were screened by the Background Screening Unit (BSU) in advance of their date of hire. There were no staff identified as requiring an exemption prior to working with youth.



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Each of the nine staff were deemed eligible for hire. According to the Residential Services Manager there are currently no volunteers working with the program.

Seven staff were identified as applicable for five- year background re-screening since the date of the last annual compliance review. A review of personnel files provided that each of the seven staff identified for five-year re-screening were screened by the Background Screening Unit (BSU). Each of the staff received clearance.

The program has implemented a policy and procedures to determine the criteria for a pre-assessment tool, pass rate, score or measure for suitability of direct care staff working with youth. The policy and procedures were implemented on August 28, 2018 and was signed by the Executive Director, Clinical Director and Residential Services Manager. All staff hired prior to the implementation of the policy and procedure are “grandfathered” and are exempt from participating in the pre-assessment tool. A review of the current staffing roster provided two staff were applicable for participation in the pre-assessment process. One staff was hired August 31, 2018 and the second staff was hired December 3, 2018. Each staff participated in the pre-assessment tool and attained a passing score. A score of seven to ten is considered a passing score for the pre-assessment.

Review of documentation provided that the program submitted an Annual Affidavit of Compliance with Good Moral Character Standards on January 4, 2018. The Affidavit was stamped as received on January 9, 2018.

### Exceptions:

No exceptions are noted for this indicator.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

The program has a policy and procedures for the provision of an abuse free environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. Program staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. Youth are not deprived of basic needs, such as food, clothing, shelter, medical care and security. The provision for an abuse free policy and procedures was last approved on August 28, 2018 and was signed by the Executive Director, Clinical Director and Residential Services Manager.



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The program will establish appropriate behavioral expectations for staff by developing identifiable standards, clear values and concepts that reinforce programmatic goals and objectives. Staff will sign a form stating they have read these behavioral expectations and agree to comply with them. This form will be maintained in the employee's personnel file. All agency staff are trained to immediately report all allegations of child abuse or suspected child abuse to the Abuse Hotline.

A review of current staff personnel files provided each employee and intern signed and dated the employee Code of Conduct form which is maintained in their respective individual personnel file. The Code of conduct prohibits the use of physical abuse, profanity, threats or intimidation. A review of documentation since the last annual compliance review provided one instance of a violation of the Code of Conduct in which a staff used verbally inappropriate language toward a youth. The incident occurred on November 7, 2018 and was immediately addressed by management, documented on the employee discussion form and resulted in suspension of the involved staff member for two days. Discussion with the Residential Services Manager provided the staff member has returned to the program and receives ongoing supervision and counseling.

Observation of the program provided there are postings of the Florida Abuse Hotline throughout the program. Postings were observed in common areas and in youth rooms. Youth are advised of their right to contact the Florida Abuse Hotline during the orientation process. The program does not maintain a child abuse log. As reported by the Residential Services Manager, any instance of abuse would be documented on an incident report; there have been no reported cases of calls to the Florida Abuse Hotline since the last annual compliance review. Youth have the opportunity to grieve actions of staff and conditions or circumstances related to the denial of basic rights. Grievance forms are available to youth who may directly access the forms located in the day room. Once the form is completed youth drop the grievance form into the grievance box located in the day room. Each day the Residential Services Manager retrieves and reviews any grievances filed by youth. All youth grievances are addressed by the Residential Services Manager or Designee within twenty- four hours. The Clinical Director serves as the Designee In the absence of the Residential Services Manager. Direct care workers do not manage complaint or grievance documents.

There were three youth surveyed. All three youth reported they knew the Abuse Hotline was available for them to call if they wanted, however, all three stated they have never needed to make a call. All three youth stated staff treat them professionally and they have never heard staff use threats or intimidation on them or any other youth. All three youth felt safe in the shelter.



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There were three staff surveyed. All three staff reported they have been trained on abuse reporting and all three reported they were aware they needed to report any suspected abuse to the Abuse Hotline. All three staff reported they have never heard a staff deny a youth access to the abuse hotline. All three staff reported they have never heard another staff use inappropriate language in front of the youth.

### Exceptions:

No exceptions are noted for this indicator.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

The program has a policy and procedures to ensure whenever 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 also completes follow-up communication tasks/special instructions as required by the CCC in order to close the case and assure the incident has been fully attended to as needed. The incident reporting policy and procedure was last approved on August 28, 2018 and was signed by the Executive Director, Clinical Director and Residential Services Manager.

The program's Executive Director and Clinical and Residential Management team review all critical and severe incidents to ensure the safety and well-being of both youth and staff. The Shelter Manager maintains a log and tracks the number the number and severity of incidents that have occurred on a bi-weekly basis. The team will review critical and severe incident events and meet with all involved providers to determine follow up and future prevention of similar events. Post incident the management team respond by presenting information for staff to review, assisting in the development of corrections and plans that will assist in the reduction of dangerous incidents. As part of quality improvement, additional trainings are provided as needed to provide skills necessary to eliminate risk to youth and staff. Trainings are available throughout the year for all staff. Incident reporting procedures will be reviewed with all staff and youth on a regular basis. If there is a specific and frequent trend in incidents, a corrective action plan will be implemented by the Management Team and enforced by the Residential Services Manager.

A review of reportable incidents from June 1, 2018 to December 5, 2018 identified two applicable medical incidents for review. One incident occurred on November 29, 2018 and the other incident occurred on December 4, 2018. Both incidents involved the same



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youth who required medical attention due to difficulty breathing. In each instance the youth was immediately addressed by staff and appropriate medical services were accessed to ensure the safety and wellbeing of the youth. Contact was established with the Central Communications Center (CCC) within two hours as required. Contact was also made with the youth's parent. Posting of the Central Communications Center (CCC) hotline number was observed in the program. A review of email documentation provided the program-maintained communication with the Central Communications Center (CCC) regarding requests for additional information and follow up to each respective incident. Each incident was documented on the incident report form and was also present in the program's electronic logbook. Review of the incident reports provided each documented the Supervisor's review of the incident, name, signature and date. A review of the logbook from June 1, 2018 to December 5, 2018 provided there were no additional incidents which should have been reported.

### Exceptions:

No exceptions are noted for this indicator.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

The program has a policy and procedures to ensure staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions. All direct care CINS/FINS staff shall have a minimum of eighty hours of training for the first one hundred and twenty days of employment and twenty-four hours of training each year after the first year. Direct care staff in residential programs licensed by DCF are required to have forty hours of training per year after the first year. The program's training policy and procedure was last approved on August 28, 2018 and was signed and dated by the Executive Director, Clinical Director and Residential Services Manager.

All new employees' complete agency new hire orientation, as well as, program specific orientation training. Job specific training for Youth Care Specialists (YCS) is provided during the first forty hours of employment and includes at least two weeks of job shadowing. All staff that have continuous contact with youth must complete orientation and job shadowing prior to working a shift. Agency new hire orientation is mandatory for all new employees and is provided on alternate months. Non-licensed mental health clinical staff working in shelters under the supervision of a licensed mental health clinical staff person completing Assessments of Suicide Risk must have documented

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twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention and emergency mental health services. The non-licensed mental health clinical staff person's training hours must include administration of, at a minimum, five one-to-one assessments of suicide risk or crisis assessments individually conducted on-site in the physical presence of a licensed mental health professional. This training must be documented and maintained in the mental health staff person's personnel file.

The program maintains an individual training file for all full-time, part-time and temporary employees. The training year for new employees begins with their hire date. Documentation of in-service training sessions is recorded in the employee's training file by the Quality Services Specialist or the Program Manager. Employee training files are kept separately from personnel files. All staff in residential and non-residential services provide documentation of completed training to the shelter Manager or Designee for residential or the QA Specialist for non-residential staff.

Two staff training records were reviewed for compliance with training requirements within the first one hundred and twenty days of employment. One staff member reviewed was hired on July 3, 2018 and the other staff member was hired on May 16, 2018. Each of the staff reviewed was found to have received requisite training based upon their respective positions and agency training policy to include program orientation, managing aggressive behavior, suicide prevention, CINS/FINS core training, signs and symptoms of mental health and substance abuse, behavior management, understanding youth /adolescent development, child abuse recognition presorting and prevention, CPR, first aid, confidentiality and universal precautions.

Two staff training records were reviewed for compliance with training requirements within the first year, after one hundred and twenty days of employment. One staff member reviewed was hired on October 26, 2017 and the other staff member was hired on November 6, 2017. Each of the staff reviewed was found to have received requisite training based upon their respective positions and agency training policy to include Title IV-E Procedures, fire safety equipment, in-service component, medication distribution for non-licensed staff, serving LGBTQ youth, cultural humility, information security awareness, equal employment opportunity, PREA, sexual harassment, trauma informed care, suicide prevention and human trafficking.

Two clinical non-licensed mental health staff training records were reviewed for completion of assessment of suicide risk training within the first year of employment. One staff member reviewed was hired on April 4, 2016 and the other staff was hired on July 26, 2016. Each of the staff reviewed was found to have received and completed requisite training for the assessment of suicide risk. The program provided

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documentation of each non-licensed mental health clinical staff person's training form completed by a licensed mental health professional. The form documented the licensed mental health professional's signature, license number, date, and non-licensed mental health clinical staff person's signature.

Four staff training records were reviewed for compliance with annual training requirements. Staff members were hired on October 27, 2007, March 1, 2012, August 31, 2015 and July 26, 2016. Each of the staff reviewed was found to have received requisite training based upon their respective positions and agency training policy to include suicide prevention, CPR, first aid, managing aggressive behavior, fire safety equipment, PREA, sexual harassment and human trafficking. One staff training record reviewed found the staff member last completed managing crisis behavior on August 26, 2016 and is overdue for this annual training requirement.

### Exceptions:

No exceptions are noted for this indicator.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

The agency has a comprehensive Policy and Procedure that addresses all elements of this indicator. The Policy and Procedure manual was last reviewed and approved on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The policy indicates that LSF Southwest collects and reviews several sources of data to identify patterns and trends as per the indicator including:

- Quarterly Case Record Reviews
- Quarterly Review of Incidents, Accidents, and Grievances
- Customer Satisfaction Data
- Annual Outcome Data
- Monthly NetMIS Data Review

Case record reviews are done monthly which is over and above the Policy and Standards requirements. Incidents and grievances are reviewed at monthly team meetings and are



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compiled in a Corporate Companion report. Monthly review of NETMIS data is conducted as well as Outcome data and Client Satisfaction Survey.

LSF SW staff conducts monthly peer reviews for the Residential and Non-Residential youth files. One binder was reviewed that contained the completed checklist tools of the peer reviews. A review of the CQI monthly meetings and all staff meeting agenda's showed reviews/discussions of incidents, accidents, and grievances; customer satisfaction data; outcome data; and NETMIS benchmark data. Team Meeting minutes provides evidence of both Residential and Non-Residential team discussions and planning efforts. The Companion Report documents the program's plan for addressing any issues or developments and the staff who will be responsible for each of these. The Registered Nurse (RN) monitors Pyxis reports to track users, data, and discrepancies. The RN provides a Discrepancy Report for review to the Shelter Manager and team when necessary.

### Exceptions:

No exceptions are noted for this indicator.

### 1.06 Client Transportation

Satisfactory

Limited

Failed

The agency has a comprehensive Policy and Procedure for Client Transportation that addresses all elements of this indicator. The Policy and Procedure manual was last reviewed and approved on August 28, 2018 and was signed by the Executive Director, Clinical Director, and the Shelter Manager.

LSF Southwest procedure addresses the following:

- 1) Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle;
- 2) Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy;
- 3) Third party is an approved volunteer, intern, agency staff, or other youth; and
- 4) Documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.

In addition to the above, the procedures also outline other important aspects of client transportation such as:



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- Staff must ensure they are never in a one-on-one situation with any youth while transporting.
- When another Youth Care Staff is unavailable to assist with transportation, the youth care staff may utilize interns, volunteers, or may utilize other youth during transport.
- Only in extreme cases are staff permitted to transport youth one to one.
- For one to one transportation, staff must receive permission from the Shelter Manager and approval must be documented in the van log by the van driver.

A current list of authorized drivers was reviewed, this list is kept by the program's Senior Administrative Assistant. All staff are expected to make themselves aware of the behavior management alert code information and plans for the clients for whom they are transporting. Each vehicle has a logbook that records the name and signature of the driver, where they are traveling to, and the odometer readings. The log book sheets reviewed for the past six months were completed for each trip the van made. The agency has procedures for the annual inspection of all vehicles used to transport youth and they are to be inspected on a weekly basis by the designated staff. It states that all issues/problems will be reported to management as soon as they are observed. The expectation of this indicator is that whenever a staff is transporting a single youth in a vehicle, there must be evidence of the Shelter Manager giving permission and it is to be documented in the vehicle log. Permission is granted on a weekly basis when youth case planning takes place, including a review of behaviors. Appropriate designated staffing is considered for these one on one transportations of youth at that time also. All one on one transports reviewed between 06/01/2018 and 12/05/2018 had evidence of the Shelter Manager's approval on the log; however, one instance on 06/18/2018 did not have this approval noted. For added security and assurance, the Shelter Manager has the ability to review footage if needed as cameras are installed in two of the vans.

### Exceptions:

No exceptions are noted for this indicator.

### 1.07 Outreach Services

Satisfactory

Limited

Failed

The agency has an approved Policy for Outreach Services that addresses all elements of the indicator. The Policy and Procedures Manual was last reviewed and approved on



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August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The program provides presentations in all sections of the community and distributes written information about their services. These written documents include annual reports, brochures, and posters. The Executive Director, Managers, and the Outreach Specialist recruit collaborative partners based on identified needs.

The agency has a binder that includes a list for record keeping of twenty-eight interagency agreements that meet all contractual requirements. The agency also keeps an extensive and well-organized Outreach Binder with monthly outreach activities completed by the administrative or counseling staff. A sample of four outreach events were reviewed from 5/2018 – 11/2018 and they all had completed documentations and wherever possible attendance justification. The binder also contains meeting minutes for attendance to the DJJ 20<sup>th</sup> Judicial Circuit Meetings.

### **Exceptions:**

No exceptions are noted for this indicator.



## **Standard 2: Intervention and Case Management**

### **Overview**

The Lutheran Services Oasis Shelter provides an array of prevention services through a Residential and Non-Residential program for youth and their families who display risk factors such as truancy, ungovernability, runaway behavior, domestic violence, substance abuse, and family conflict. Referrals may come from the youth themselves, parents/guardians, schools, law enforcement, or other community entities.

The Residential program provides centralized intake and screening twenty-four hours per day, seven days per week. Trained staff are available to determine the needs of the family and youth. The youth and family participate in a screening and intake process in order to ascertain eligibility and develop an individualized plan of services meeting their needs. Residential counseling services include individual, family, and group therapy. Case management and substance abuse prevention services are also offered. 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. The Non-Residential services provided include individual, family, and group counseling along with case management services.

Lutheran Services Oasis 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 of 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

The agency has a policy in place for Screenings and Intake. The policy was last reviewed on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The initial screening which may be conducted by phone or face to face by a trained staff member is considered the beginning of the assessment process. Once a phone call or any referral for services is received attempts to contact the youth and family will begin in

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seven days. Upon acceptance for services, for Non-Residential clients, the central staff will assign the screening case to a designated counselor who will try to contact the child's guardian or caretaker to schedule an intake to complete the full assessment process. The Non-Residential counselor will initiate the Needs Assessment within 72 hours of completing the CINS/FINS Intake Assessment and within two to three sessions or visits. Counselors assigned the case will complete the NETMIS packet along with the Risk Factors as well as initiate the Needs Assessment within 72 hours. The Needs Assessment will be completed within seven days of the child's intake for Residential services.

There were ten files reviewed, five Residential (two open and three closed) and five Non-Residential (two open and three closed).

All files contained had the eligibility screening within seven calendar days of the referral. At intake the youth and parent/guardian received available service options, rights and responsibilities of the youth and parent/ guardian, and Parent/Guardian brochure. At intake both the parent/guardian and youth were also informed about the possible actions occurring through involvement with CINS/FINS and grievance procedures.

### Exceptions:

No exceptions are noted for this indicator.

## 2.02 Needs Assessment

Satisfactory

Limited

Failed

### 2.02 Needs Assessment

The agency has a policy in place for Needs Assessment. The policy was last reviewed on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

For youth admitted to the shelter, a Needs Assessment is initiated within 72 hours of admission. For youth receiving Non-Residential services, a Needs Assessment is completed within two to three face to face contacts following the initial intake or updated if most recent needs assessment is over six months old. Written Assessments should be written on all youth that receive services and should be completed by a bachelor's or master's level staff and include a supervisor review signature upon completion. When youth is classified as having suicide risk behaviors during the Needs Assessment, the



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youth shall be referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional.

There were ten files reviewed, five Residential (two open and three closed) and five Non-Residential (two open and three closed).

In all files the Needs Assessment was initiated and completed within 48 hours of the youth's admission to the program. Each Needs Assessment was conducted by a bachelor's or master's level staff member and included a supervisor review signature upon completion.

Of the five Residential files, four of the youth were identified with an elevated risk of suicide as a result of the Needs Assessment. Each of the four youth were referred for an Assessment of Suicide risk conducted by or under the direct supervision of a licensed mental health professional. There were no Non-Residential youth that were identified with an elevated risk of suicide as a result of the Needs Assessment.

### Exceptions:

No exceptions are noted for this indicator.

### 2.03 Case/Service Plan

Satisfactory

Limited

Failed

The agency has a policy in place for Case/Service Plan. The policy was last reviewed on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

A Case Plan is developed with the youth and family within seven working days following completion of the Assessment. The Plan is development based on information gathered during initial screening, intake, and assessment. The Case Plan is reviewed by the counselor and parent/guardian (if available) at a minimum of 30 days for the first three months, and every six months thereafter, for progress in achieving goals and making any necessary revisions to the Case Plan, if indicated.

There were ten files reviewed, five Residential (two open and three closed) and five Non-Residential (two open and three closed).

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Of the ten files reviewed all had a Case Plan developed within seven days of the completion on the Needs Assessment. The Case Plans included individualized and prioritized needs and goals identified by the Needs Assessments. One of the ten files reviewed one did not have the signature of youth and parent. One other file did not have a parent/ guardian signature but did have verbal consent listed. Two of the ten files did not have completion dates since neither youth was at the shelter long enough to complete a goal. All files contained the following: service type, frequency, location; persons responsible; target dates for completion; signatures (counselor, supervisor), and the date the plan was initiated. Where applicable all files were reviewed for progress every 30 days for the first three months and every six months after.

### Exceptions:

No exceptions are noted for this indicator.

## 2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

The agency has a policy in place for Case Management and Service Delivery. The policy was last reviewed on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

Case management provides clients with coordination of services that utilizes appropriate resources for children and families in need. At minimum, each client is assigned a counselor/ case manager who will follow the client's case and ensure delivery of services through direct provision or referral. The process of case management shall include establishing referral needs, coordinating service plan implementation, monitoring child/family progress in services, providing support for families, monitoring out of home placement, referrals to case staffing, and case termination with follow up.

There were ten files reviewed, five Residential (two open and three closed) and five Non-Residential (two open and three closed).

All youth files were assigned a counselor that was easy to identify within the files. There were five files that presented a need for additional referrals that they received. During an interview the Clinical Director provided a few community resources that are typically utilized: HEAD, Elite, Salus, and Beyond Barriers. In all files there was clear evidence of service plan coordination, monitoring of youth and family progress, support for families, termination notes (where applicable), and 30- and 60-day reviews (where applicable).



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### Exceptions:

No exceptions are noted for this indicator.

### 2.05 Counseling Services

Satisfactory

Limited

Failed

The agency has a policy in place for Counseling Services. The policy was last reviewed on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

Shelter programs provide individual and family counseling, as well as group counseling sessions held a minimum of five days per week, based on established group process procedures. Non-Residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out of home placement, and provide aftercare services for youth and families in the dependency systems.

Non-residential services will accept referrals from school guidance counselors, local law enforcement and the DJJ, as well as directly from any concerned adult. Through the process of screening and assessment, it may be determined that additional services are needed to appropriately serve the youth and family. The Non-Residential service provider will assess youth and families to determine needs and provide referrals to outside resources when necessary. All full-time Non-Residential staff carries, at minimum, an annual caseload of 69 cases. Non-Residential services across all families have annual coverage of twelve sessions, exceptions documented. Services that can be provided are intakes, suicide needs assessments, and case planning.

There were ten files reviewed, five Residential (two open and three closed) and five Non-Residential (two open and three closed).

All five Non-Residential files contained a Needs Assessment and Case/Service Plans. Case notes were well maintained for counseling services and were very detailed outlining youth progress and/or lack thereof. There is an ongoing process that occurs to review youth files and progress with the family, counselor, and youth. This process is clearly documented in youth files. All counseling services are being provided in accordance with the Case/Service Plan.

All five Residential files had group sessions documented at least five days each week with each group being at least thirty minutes, having a clear leader or facilitator, listing a clear and relevant topic, and offering an opportunity for youth engagement. The period reviewed was from November 1, 2018 to December 3, 2018. Group topics were listed



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as: MADD, Decision Making, Career Decisions, Arts and Crafts, Parenthood, warning labels, and WHY TRY teamwork.

### Exceptions:

No exceptions are noted for this indicator.

### 2.06 Adjudication / Petition Process

Satisfactory

Limited

Failed

The program has a policy in place that meets the standard 2.06 in reference to the Adjudication/Petition which was revised on 10/02/2017 and approved 8/28/2018. A case management staffing committee meeting is scheduled to review the case of any youth or family that the program determines, is in need of services or treatment under provided circumstances. A case staffing committee is convened within seven days from receipt of the written request from the parent/guardian. Within seven working days of the meeting, a written report is provided outlining the recommended services. The program coordinates with the circuit court for judicial intervention with the procedures outlined in the Florida statute and the Florida Network's policy and procedure manual. The designated personal completes a review informing the courts of the youth's behavior and compliance with the court orders as well as providing recommendations for further dispositions.

The TURN committee and the committee membership consist of the required number and types of individuals prescribed in the above policy. The TURN committee plays a role in the CINS process in ensuring the appropriate service is provided and the proper recommendations are made. The case staffing committee meetings will be scheduled as needed within specified locations and time convenient to all parties involved. The responsibility of all coordination and court work with DJJ falls on the case manager or designee. When the petition is complete and received along with the pre-deposition report the DJJ attorney is responsible for filing with the Clerk of Courts. The Court of Clerks will issue a summons with a date, time and location for the hearing. At this point a formal court day is established. The court shall hold a hearing 45 days after the deposition. If the child has been compliant the court is no longer involved, if the child fails to comply with the case plans and court order then will continue to be a CINS and reviewed by the court as recommended.

There were three Petition files reviewed. All three files were initiated by the Non-Residential Counselor with proper notification to the family and committee no less than five working days prior to the staffing. The Case Staffing on all three cases included the local school representative, as well as the CINS/FINS provider. In the three files the parent did not initiate any of the petitions nor did the state attorney attend. In all cases the applicable representatives attended, the families were provided with a revised



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Service Plan, and the parents were provided a written notice within seven days of the case staffing outlining the recommendations and reasons for the recommendations with coordination with the circuit court for judicial intervention for the youth/family. The Review Summary was completed in the applicable file by the Case Manager/Counselor, the other two files were Case Staffing files.

### Exceptions:

No exceptions are noted for this indicator.

### 2.07 Youth Records

Satisfactory

Limited

Failed

The program has a policy in place that meets this standard which was revised last on 7/6/2012 and reviewed/approved on 8/28/2018.

The program maintains confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program. Records are to be kept in a secure room, marked confidential and are to be transported in a locked container that is opaque.

Upon the review of the files it was observed by the reviewer that all the records were marked “confidential” and kept in a secure room in a file cabinet that was marked confidential. The files are being maintained in a neat and orderly manner and when transported, a locked opaque container is being utilized.

### Exceptions:

No exceptions are noted for this indicator.

### 2.08 Sexual Orientation, Gender Identity, Gender Expression

Satisfactory

Limited

Failed

The agency has a Sexual Orientation, Gender Identity, and Gender Expression (SOGIE) policy in place. The policy was developed on August 28, 2018.

Youth will be addressed by their preferred name and gender pronouns. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of the youth based upon their actual or perceived sexual orientation, gender identity, or gender expression. All staff, service providers, and volunteers who have

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intentional contact with youth will have knowledge of this policy. Areas in which youth reside or are served will have signage indicating the program is a safe space of all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will be identified in the logbook and all public-facing documents by their preferred name and gender pronouns. Youth are to be assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room assignment was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.

The shelter has copies of the Zine hanging in the staff office for all staff to review when needed. There was also documentation that all staff had received training on the SOGIE policy. This training was completed during an all staff meeting. A copy of the meeting agenda, training materials used, and the sign-in sheet was provided. The shelter had one intern and there was documentation the SOGIE policy was reviewed with the intern as well. The shelter has not had any volunteers entering the facility since the implementation of this policy. However, there is a process in place to review this policy with the volunteers when applicable.

The shelter has signage located throughout the shelter including in the building indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Signage includes signs of rainbows and statements in rainbow colors. Some of the signs throughout the shelter are signs youth in the shelter have painted and made themselves. At the time of the on-site review the shelter was in the process of updating their intake screening to include a question asking the youth which gender they identify with.

### **Exceptions:**

No exceptions are noted for this indicator.



### **Standard 3: Shelter Care and Special Populations**

#### **Overview**

The Oasis Youth Shelter, operated by Lutheran Services Florida, is a twenty-two-bed residential shelter that is licensed by the Department of Children and Families (DCF). The shelter staff consists of a Shelter Manager, a Clinical Manager, a Youth Care Specialist Supervisor, Youth Care Specialists, Counselors, and a Case Manager. The Shelter runs three shifts per day and maintains a schedule consistent with staff to client required ratios.

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, 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.

This shelter is designated by the Florida Network to provide services for Special Populations as well. These populations include Staff Secure services, Domestic Violence Respite (DV), Probation Respite (PR), Intensive Case Management Services (ICMS), Family Youth Respite Aftercare Services (FYRAC), and Domestic Minor Sex Trafficking (DMST).

The LSF-SW Oasis shelter building includes a large day room, six bedrooms housing girls and boys separately, kitchen, laundry room, medication room, staff offices, and a secured internal courtyard area. The furnishings are in adequate condition and the rooms and common areas are clean. The sleeping quarters are divided into two separate areas, one for boys and one for girls. The bedrooms can hold up to four youth each. The bedrooms are equipped with two metal bunk beds and each youth has an individual bed, bed linens, and pillows. The bedrooms are also very well maintained and clean. The windows are fitted with blinds for privacy for the youth. There are two bathrooms-- one for each gender with two bathroom stalls, two showers, and a sink. The bathrooms appear to be very sanitary and clean. The bathrooms also have a checklist on the bathroom door for staff to check the cleanliness and a sign off section for staff accountability.

### 3.01 Screening and Intake

Satisfactory

Limited

Failed

There is a policy in place that was revised back in 2015 and last reviewed by the Executive Director on 8/28/2018. The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster healthy, social, emotional, intellectual, and physical development.

The procedure indicates that fire inspections be conducted annually and that the shelter building including the grounds be treated by a professional pest control company each quarter. Bathroom and shower areas are to be inspected by shelter staff at least once each shift and the rooms are to be inspected once each day for contraband and graffiti. At admission, each youth is assigned to an individual bed and issued a pillow, one blanket, one flat sheets, and one pillowcase. Linens are laundered at least once a week or as necessary at the youth's request. Each room is to have sufficient lighting to allow youth to read or perform other task. Youth can request to have personal belongings stored in a locked placed located in the Youth Care office.

During a walkthrough of the shelter with staff, the reviewer observed the shelter environment to be safe. The furnishings were in good condition and the program is free of insect infestation. There was minimal graffiti in one dorm and all dorms had adequate lighting. The exterior grounds were well maintained, there was a broken fence and it was explained that a youth ran away and broke the fence, but there is evidence of efforts to make repairs. The dumpsters and garbage cans were covered and there was minimal debris surrounding them.

The shelter has three vans. There were two vans present at the shelter and several staff vehicles in the parking lot. Out of the two vans both contained first aid kits, a fire extinguisher, a flashlight, a glass breaker, and seat belt cutter. In and out access is limited to staff members and key control is in compliance. A detailed map and egress plans for the facility, general rules, grievance forms, abuse hotline information, DJJ Incident Reporting number, and related notices are posted.

Each youth has their own bed and are assigned a pillow, lines, and a blanket. Laundry is done with the two washers and dryers that were operable and were in current use. All chemicals are listed, approved for use, inventoried, stored properly, and a MSDS are maintained on each item.

Annual facility fire inspection was completed (10/19/2018) and the agency completes a minimum of one fire drill per month within two minutes or less. All annual fire safety equipment inspections are valid and up-to-date. Agency has a current satisfactory

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Residential Group Care inspection report from the Department of Health. All cold food was properly stored, marked, and dry storage/pantry area was clean.

Refrigerators/freezers were clean and were maintained at the required temperature.

The refrigerators had thermometers inside as the built-in thermometers would malfunction at times.

During the walk through of the facility, this reviewer observed the daily schedule was posted and it included time designated for an hour of physical activity, as well as allotted time for meaningful, structured activities keeping idle time to a minimal. Daily programming includes opportunities for the youth to complete homework and or read quietly. When asked about faith-based activities it was stated that staff transports youth who desire to attend services on the weekend.

### Exceptions:

No exceptions are noted for this indicator.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

There is a policy in place that was revised on 9/2015 and was reviewed on 8/28/2018 that addresses all the requirements for the Program Orientation Indicator. The policy states that the youth are given an opportunity to learn about the program and its expectations through a positive orientation process. Within 24 hours and preferably immediately upon completion of each youth's intake, staff should begin the process by discussing the program's philosophy, goals, services, and expectations. Youth orientation should include the follow: Disciplinary action explained, Grievance procedure, Emergency procedure, and contraband rules.

Upon admission, program staff will interview the youth. An initial assessment will occur to determine the most appropriate room assignment factoring the youth's needs, issues, the current population at the facility, physical space, and the youth's ability to function effectively within the program rules. Staff conducting the initial interview and assessment will consider the youth's age, gender, physical characteristics, maturity level, and history of gang affiliation, criminal history, and apparent emotional or mental health issues.

There were eight open Residential files reviewed. All eight youth were provided a comprehensive orientation within 24 hours and signed off that they were provided with a residential handbook. On the form titled "Client's Rights", the disciplinary actions,

grievance procedure, emergency/disaster procedures, and the contraband rules are explained. All eight files contained this form and it was signed by both the youth and the staff who conducted the intake.

**Exceptions:**

No exceptions are noted for this indicator.

**3.03 Room Assignment**

Satisfactory

Limited

Failed

There is a policy in place that was revised back in 2015 and last reviewed by the Executive Director on 8/28/2018. The program demonstrates the goal to protect youth through a classification system that ensures the most appropriate sleeping assignment. A process is in place that includes an initial classification of the youth for the purposes of room or living area assignment with consideration given to potential safety and security concerns. An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as suicide, mental health, substance abuse, physical health, or security risk factors. While the sexual orientation, gender identity, gender expression does not pose potential safety and security issues, the circumstances will be taken into consideration along with the youth's preference for sleeping/room assignments.

During admission of a client, staff will complete a CINS/FINS Intake Assessment, and the entire intake packet to gather important data used to make the most appropriate room assignment. Room assignments are based on age, disabilities, and other attributes of the youth. The CINS/FINS Intake Risk Assessment form is where these factors are documented. Every shift a room search is conducted and in the event contraband is found incident reports and the proper notifications will be made. Each time a youth enters the shelter a staff member will search the youth without physical touch. There is a procedure in place that details what constitutes a search and a procedure of what needs to transpire in the event contraband is found.

There were eight open Residential files reviewed. All eight files documented the CINS/FINS Intake Form was completed and documented all pertinent information required to make appropriate room assignments such as age, violence history, gender, suicide risk, aggressive behavior, and the youth's exposure to trauma. All eight files documented a room was assigned and seven of the eight files also documented a bed within the room was assigned. At the time of the on-site review the shelter was in the

process of updating their intake screening to include a question asking the youth which gender they identify with.

**Exceptions:**

No exceptions are noted for this indicator.

**3.04 Log Books**

Satisfactory

Limited

Failed

There is a policy in place last revised in 2015 and approved on 8/28/2018. Log books document routine daily activities, events, and incidents in the program, and are reviewed by direct care and supervisory staff at the beginning of each shift. Log book entries that could impact the security and safety of the youth and/or program are highlighted. The shelter manager reviews the logbook every week making any corrections, recommendations, and follow-up required and sign/date the entry. Direct care staff and YCS supervisors review a minimum of two shifts in order, to be aware of any unusual occurrences, problem etc.

The intent of the log is to be a running document of daily activities and its used to communicate issues or occurrences to the staff so that all staff are aware of what is transpiring. Entries shall be brief, factual, and include time/date of the incident or event. The name of the youth and staff should be involved, as well as the name and signature of the person making the entry.

The shelter utilizes the electronic log book. Log entries were well written and captured the events of the program as intended. Supervisors and direct care staff review the logbook when they come on to shift daily and review at least two shifts back. The Shelter Manager reviews the logbook weekly, dates, signs, and highlights in red to draw attention to the notes. Any safety concerns are highlighted in green. Incidents were in green highlight also and captured the youth involved and the staff that reported the incident. Counts were documented, as well as the coming and goings of the staff with the youth from the facility. Visitation and home visits are documented. Fire and Emergency drills are documented. All recording errors are struck through with a line and initialed or signed.

**Exceptions:**

No exceptions are noted for this indicator.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

The program has a policy in place that was revised 8/24/2016 and reviewed/approved on 8/28/2018 that meet the standard requirements set in regard to the Behavior Management Strategies.

Oasis has a behavior management strategy in place that is written and designed to change the behavior of the youth and increase accountability. The system uses a wide variety of reward, administers appropriate consequences in a timely logical manner. The Oasis Behavior Management System utilizes phases to encourage youth to decrease negative behaviors. All staff are trained in the behavior system to ensure logical and consistent rewards and consequences to the youth. There is a protocol in place for providing feedback and evaluation of staff regarding their use of rewards and consequences. All supervisors are trained to monitor the use of rewards and consequences as they are responsible for observing and evaluating staff in the use of these procedures.

The program has a detailed written description of the Behavior Management Strategies and it is explained to the client during program orientation. The Behavior Management Strategies is being used to gain compliance with program rules, influence positive behavior and increase accountability. A wide variety of awards/incentives (prize cabinet, movies, dinner, bowling, etc.) are being used to encourage participation and program completion. Appropriate Behavior Management Strategies consequences and sanctions are used by the program. Consequences for behavior are logical and designed to promote skill-building for the youth.

The program utilizes 3 phases (phase 1, 2, and 3), all of which offer different perks. Each phase requires an assignment by the client to move up to the next phase. Phase 1 requires the client to complete a goal setting paper and an I statement paper. Phase 2 requires the client to right a one-page letter to someone they hurt or victimized. Phase 3 requires a skit or group to be taught to the rest of the clients and staff. Loss of Privilege is used when consequences and accountability need to be utilized. Loss of Privilege includes early bed time, loss of privileges, or sit time where the youth writes a letter on various topics. The census board in the day room indicates what phase a youth is on, along with any loss of privilege or other sanctions.

#### Exceptions:

No exceptions are noted for this indicator.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

The program has a policy, as well as procedures in place that address all the requirements for the Staffing and Youth Supervision indicator. The Policy and Procedures Manual was last reviewed and approved on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The policy states that adequate staffing is provided to ensure the safety and security of youth and staff. The program will maintain a 1:6 youth ratios during awake hours and 1:12 youth ratio during the sleep period. There will always be at least one staff on duty of the same gender as the youth and authorization must be given to have same gender staff. Overnight shifts must always provide a minimum of two staff present. Staff schedule is provided to staff and posted in a place visible to staff. Staff observe youth at least every fifteen minutes while they are in their bedrooms, either during the sleep period or at other times.

The Shelter Manager creates a weekly staffing schedule that provides adequate supervision of youth and ensures the safety and security of all youth and staff. A list with the names and phone numbers of all employees are maintained and an on-call list is maintained to ensure adequate staff coverage for scheduled activities. The staff schedule is placed in the youth care office where it is posted on the bulletin board.

The Shelter Manager oversees staff scheduling responsibilities, monitors, and reviews this process. Schedules follow a consistent format that contains the names of individual employees and is easy to comprehend. Schedules are posted in the facility in an area accessible to all staff and take into account the needs of the youth, program schedules and routines, and individual employees' strengths, skills, and abilities.

Staff sign in and out of the electronic logbook making it easy to see who is coming and going for their shifts, as these entries are time stamped. A review of the electronic logbook from 09/05/2018 – 12/05/2018 documented appropriate staffing ratios were consistently maintained. The program met the staff -to-youth gender requirement consistently but whenever it was not possible, approval was noted in the logbook. There were generally three staff on the overnight shift, exceeding ratio requirements.

Log book entries were reviewed for the last three months and documented bed checks were conducted at least every fifteen minutes while youth were in their sleeping rooms. Video surveillance was also reviewed on random nights that confirmed these bed checks were being conducted.

### Exceptions:

No exceptions are noted for this indicator.

### 3.07 Special Populations

Satisfactory

Limited

Failed

The program has a written Policy and Procedure that address all the requirements for the Special Populations indicator. The policy was reviewed on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The program can be funded to provide staff secure supervision and assigned one staff to one youth as assigned by the court at any given time. The staff secure program will have a staff secure policy and procedure that outlines an in-depth orientation on admission, assessment and service planning, enhanced supervision and security with emphasis on control and appropriate level of physical intervention, parental involvement and collaborative aftercare. Only youth that have met the legal requirements outlined in Chapter 984 F.S for being formally court ordered into staff secure services will be accepted. A specific staff during each shift will be assigned to monitor the location and movement of the staff secure always. The program will document the assignment of specific staff to the staff secure youth for each shift through daily log book, a posted staff calendar or any other means that clearly denotes by name the staff person assigned to the staff secure youth.

Domestic Minor Sex Trafficking (DMST) services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. All requests may be approved for a maximum of seven days. Approval may be obtained on a case-by-case basis. Staff assigned to youth under this provision are to enhance the regular services available through direct engagement with the youth in positive activities designed to encourage the youth to remain in shelter.

The program must meet the following criteria to serve Domestic Violence (DV) Respite youth: Agencies that do not have assigned bed days must receive prior approval for any DV Respite placement. Youth must have a pending DV charge. Must be screened by JAC/Detention but does not meet the criteria for secure detention. Youth length of stay will 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



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the home. Services provided to these youths should be consistent with all other CINS/FINS program requirements. Youth with DCF involvement are eligible.

Probation Respite services may be provided to youth on Probation whose adjudication has been withheld. Referrals must come from the Juvenile Probation officer. Many factors are considered to include seriousness of past charges, behavior history, current population, bed availability, etc. Referrals are submitted through the Probation Referralator via the Florida Network and approval must be received prior to accepting the youth. The length of stay is determined at the time of admission. Length of stay is 14 to 30 days.

The agency's Non-Residential program can be funded to provide Intensive Case Management Services (ICMS). The ICMS policy and procedure that outlines youth served under this contract must meet the following criteria:

- Court ordered or referred by case staffing
- Each youth and family must have six direct contacts and six collateral contacts per month
- Child Behavior Checklist must be completed within 14 days of intake
- An approved self-assessment is completed within 14 days of intake
- Approved self-report assessment completed at intake no less than every 90 days
- Case plan demonstrated strength-based trauma informed focus.

The agency's Non-Residential program can be funded to provide Family Youth Respite Aftercare Services (FYRAC). The FYRAC procedures outlines youth served under this contract must be referred by DJJ for the following reasons: a Domestic Violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating. All FYRAC referrals must have documented approval from the Florida Network office. All intake and case files must adhere to Florida Network policy requirements.

The program has not served any DMST, Probation Respite, or Staff Secure youth since the last on-site review.

There were two files reviewed for FYRAC services. Both youth were referred by their JPO. Both files reviewed had evidence to show that they were approved by the Florida Network office. Initial assessment for both cases met the indicator requirement of face to face intake and gathering family history and demographic information. Service plans were developed for both cases and evidence of orientation was on file, along with the

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necessary signatures. Both cases had evidence of 60-minute individual sessions with youth and family focusing on engaging and identifying strengths. For the FYRAC program, no group sessions have begun as there are not sufficient youth in the program in order to conduct these.

The agency has an active ICMS program and three case files were reviewed that met the criteria of the program. All three youth were referred by a case staffing committee, two of the three youth had six direct contacts each month and all had substantial collateral contact within that time frame, over the requirement of six. All documentation in the three files was completed within the contractual time frame, Child Behavior Checklist, self-reporting assessment (plus 90 day follow up). All three cases had strong case plans that were strength based and trauma-informed focus.

There were three files reviewed for DV Respite services. All three of the files documented that the youth were screened by the JAC and had pending DV charges. All three Case/Service Plans in the files reflected goals focusing on aggression management, family coping skills, or other interventions designed to reduce reoccurrence of violence. All other services provided to the youth were consistent with all other general CINS/FINS program requirements. One file had a youth that stayed in the program longer than twenty-one days and there was a form that indicated the transition from DV Respite into the CINS/FINS program. Two of the three files were discharged prior to reaching the twenty-one-day threshold.

### Exceptions:

No exceptions are noted for this indicator.

### 3.08 Video Surveillance System

Satisfactory

Limited

Failed

The program has a written Policy and Procedure that address all the requirements for the Video Surveillance System indicator. The policy was reviewed on August 28, 2018 and signed by the Executive Director, Clinical Director, and the Shelter Manager. It states that all Lutheran Services Florida (LSF) Youth Shelters shall utilize a video surveillance system to promote the safety of all youth, staff, and visitors.

The program has video surveillance system (VSS) procedures in place to complement its policy. The system captures and retains video photographic images which is stored for a minimum of 30 days. The VSS does record date, time, and location and maintain resolutions that enables facial recognition and vehicle license plate at a distance. Back-up capabilities consists of the VSS ability to operate during a power outage. Like all youth

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shelters, Oasis has a VSS with cameras placed in interior and exterior positions to provide coverage of the shelter to include hallways, locations where youth and staff meet, visitor entrances and exits. Cameras are not placed in bathrooms or sleeping quarters and are visible to persons in the location that it is placed. A written notice of the use of VSS is clearly posted on the premises for the purpose of security and transparency of use.

Consistent checks of the VSS is done by the Shelter Manager to ensure it is in working order as well as live feeds from the security videos are monitored at all times. The video surveillance system is only accessible to designated staff and a list of designated staff is maintained, per the agency policy. A supervisory review of surveillance system is conducted on a biweekly basis and noted in the logbook by the Shelter Manager.

Client information contained within the VSS or stored externally and is treated as confidential under LSF Confidentiality of Client Information Policy and Procedure. Video records utilized to make a decision which affects a client, family member, visitor, or employee is to be retained for a minimum of seven years or indefinitely upon management determination. Per the agency policy, saved video recording are to be disposed of in a secure manner unless retained as stated. For the purpose of system and agency integrity and purpose, LSF staff will not make any attempts to alter video recordings.

The VSS operates continuously 365 days and a written notice is posted outside the front door informing anyone entering the shelter that the VSS is in place. Cameras are placed in the interior and exterior locations of the shelter where staff and youth meet, and where visitors enter and exit. All cameras are visible, and none are placed in bathrooms or bedrooms. The VSS is connected to a generator and can continue to operate in the likely event of a power outage. Monitors are in the Shelter Manager's office, day room, and the room adjoining the staff intake room. Day room monitoring is limited to key access areas only, including the main shelter entrance. The monitor located in the Shelter Manager's office is limited to dayroom, lobby area, and both youth residential hallway views only.

At the time of the review, the staff able to review cameras are YCW III, the Clinical Director, and the Shelter Manager. The Shelter Manager reviews the cameras weekly and never goes over the fourteen-day window to document these checks. There is a process in place for third party review of video recordings and third parties requesting video footage which is handled directly by the Shelter Manager. There is no capability to review the VSS off-site.

**Exceptions:** No exceptions are noted for this indicator.

## **Standard 4: Mental Health/Health Services**

### **Overview**

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 surrender those medication to staff during admission. Medications are stored in the Pyxis MedStation 4000 Medication Cabinet, and topical and/or injectable medications are stored separately from oral medication. The provider installed the Pyxis Medication System and has trained their staff to use it. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication and ensures that an approved staff is scheduled on each shift. Medication records are also maintained for each youth and stored in a MDL (Medication Distribution Log) Binder.

### **4.01 Healthcare Admission Screening**

Satisfactory

Limited

Failed

The agency has a policy in place for Healthcare Admission Screening. The policy was last reviewed on August 28, 2018 by the Executive Director, Clinical Director, and Shelter Manager.

Immediately upon arrival of a youth to the facility, the staff, or nurse, if on premises, are to assess any obvious or immediate medical needs by completing the CINS/FINS Intake Assessment Form which includes specific physical health screening and a visual inspection of the youth. In the event the nurse does not conduct the screening they will review all intakes with five business days. If there is a medical, dental, or mental health condition that exists, the Youth Care Specialists will immediately alert the on-call Counselor about the issue. The on-call Counselor or the Residential Services Manager will contact the parent/guardian to discuss the medical needs and arrange for treatment of these needs and any special medical attention the client may require while in shelter.

There were six open youth files reviewed. All six files documented the CINS/FINS Intake Form was completed on the day of admission. There was one youth with Asthma

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and two youth with allergies. These conditions were documented in the file and also entered into the shelters alert system. There are procedures in place for follow-up care if it is needed. None of the files reviewed required any type of follow up care.

The shelter also completes a Healthcare Admission Screening Form and a body chart on each youth. This form is a more in-depth health screening. The Healthcare Admission Screening and the body chart were completed in all six files reviewed on the day of admission. Four files documented the RN signed and reviewed the Healthcare Admission Screening Form within five working days. One of the remaining two files was a new admission and had not yet been signed by the RN but still had time remaining to be reviewed. The last file (Chase) documented it was not reviewed within five days by the RN, the youth was admitted November 8<sup>th</sup> and the RN signed the form November 20<sup>th</sup>.

### Exceptions:

No exceptions are noted for this indicator.

### 4.02 Suicide Prevention

Satisfactory

Limited

Failed

The agency has a policy in place for Suicide Assessment. The policy was last reviewed and revised on August 28, 2018 and approved by the Executive Director, Clinical Director, and Residential Services Manager.

During the intake process, program staff will complete the CINS/FINS Intake Form that includes past and current suicidal behaviors. When indicated on this form that the youth has screened positive for suicide risk, the staff conducting the intake will refer the youth to appropriate agency staff or law enforcement for a clinical assessment of suicide within twenty-four hours or immediately if in imminent danger. The youth is to be placed on Constant Sight and Sound until this assessment is completed

The agency has four different levels of supervision. Regular supervision is for youth who have no known or reported risk factors. Elevated Supervision is for youth who have a history of previous suicidal/homicidal thoughts, gestures, or attempts. These youth have generalized suicidal/homicidal thoughts but no specific plan and no desire or intent to act on the plan. It provides a more intense level of supervision. A staff member shall conduct visual checks every ten minutes day and night. Sight and Sound Supervision is for youth who are a moderate risk for suicide. These youth may have a history of suicide attempts or behavior or have a family history. These youth have generalized suicidal thoughts but no specific plan and no desire or intent to act on the plan. These youth are within sight and reach of staff at all times. One on One supervision is for youth with a

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specific plan, who have verbally expressed a desire or intent to act on the plan, or who have had a recent traumatic event or significant loss. These youth are awaiting a Baker Act and are with a staff member at all times within arm's length away. This is the highest level of supervision and is for youth who are an imminent risk.

The shelter has two residential counselors. One counselor is a Licensed Mental Health Counselor (LHMC) who recently became licensed on October 23, 2018 and has a valid license effective through March 31, 2019. The other counselor is a Registered Mental Health Counselor Intern with an active license that was issued on March 17, 2017 and is valid through March 31, 2022. Both counselors are overseen by the agency's Clinical Director who is a Licensed Clinical Social Worker (LCSW) and has a license in effect through March 31, 2019. Both counselors had documentation of completing twenty hours of assessment training prior to completing Assessments of Suicide Risk.

There were seven total files randomly selected to review for suicide precautions. Out of the seven files, three were open files and four were closed files. In all seven files the CINS/FINS Intake form was completed at admission. All six files had a minimum of one positive suicide risk indicator documented on their respective CINS/FINS Intake forms. Each form was signed by the YCS completing the form and signed by a supervisor indicating a review of the form for accuracy.

All seven files contained evidence, through observation logs, of the youth being placed on Sight and Sound Supervision immediately after the CINS/FINS Intake form was completed. All seven files documented observation logs were maintained the entire time the youth were on suicide precautions. The logs documented observations at least every thirty minutes, with most observations being documented in increments of five minutes. The shift supervisor signed the logs for each shift, for all logs reviewed. The Clinical Director also signed all observation logs, indicating a review of logs for any warning signs. There was documentation in each file on the last observation log that suicide precautions had been discontinued, with the time and signature of the staff member making this notation.

In three of the seven files the youth were seen and assessed by a counselor, using an Assessment of Suicide Risk, within twenty-four hours of placement. In the remaining four files, the screening occurred after hours on a Friday and the assessment was completed the following Monday morning. All suicide risk assessments reviewed were completed by a master's level counselor or a licensed professional. Each assessment documented a consultation with the Clinical Director prior to the youth being removed from suicide precautions. A corresponding note was also found in the clinical section of the file documenting a more in-depth overview of the suicide assessment completed. This note also documented the consultation with the clinical director and method of contact, which was either by phone, email, or in person, in the seven files reviewed.

In all seven files reviewed the youth were removed from suicide precautions and placed on normal supervision levels after the first suicide assessment was completed. This



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information was communicated to staff, as observation logs were discontinued at the time of consultation with the clinical director.

### Exceptions:

No exceptions are noted for this indicator.

### 4.03 Medications

Satisfactory

Limited

Failed

The agency has a policy on Medications. The policy was last reviewed on August 28, 2018 by the Executive Director, Clinical Director, and Shelter Manager.

The policy requires that all medications, including over-the-counter and prescription medications, be stored in the Pyxis Med-Station 4000 Medication Cabinet which is stored in a locked room accessible only to authorized staff. Oral medications will be stored separately from topical medications, and medication requiring refrigeration will be stored in a refrigerator that has been designated for only that purpose. If the Registered Nurse (RN) is on the premises, it will be the responsibility of the RN to administer the medications. Medication which is expired and not picked up by parents or guardians or left at the shelter more than three weeks after the discharge of the client, will be disposed of by placing the unused medications into the appropriate locked box in the presence of another staff. The locked box will be taken to the Lee County Sheriff's Office monthly at their Operation Medicine Cabinet Disposal site. All disposals of medications will be documented in the Medication Disposal Binder.

The agency provided a list of thirteen staff who are trained to supervise the self-administration of medications. The Registered Nurse (RN) is listed as one of the Super Users of the Pyxis Med-Station as well as the Residential Services Manager and a Youth Care Specialist (YCS) II staff.

The shelter has an RN on-site various hours through the week but is always on-site at least twenty hours each week. The RN will distribute any needed medications when on-site. Trained YCS with access to the Pyxis Med-Station distribute medications when the RN is not on-site.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. The RN also conducts an additional refresher training, for current staff members, during the year. The RN conducts groups with the youth on various topics such as hygiene care, nutrition, and fitness.



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All medication is stored in the Pyxis Med-Station, including over-the-counter (OTC) medications which are stored in the top bin of the Med-Station. Prescription medications are stored in the second thru fourth drawers of the Med-Station. The fifth drawer is used for over-sized medications or liquid medications in bottles. Medications are verified at admission using one of the four approved methods by the Florida Network.

The RN reported there have been no major discrepancies with the Pyxis Med-Station. Reports reviewed for the last month revealed no discrepancies and there no open discrepancies in the Pyxis Med-Station. Staff were aware that should any discrepancy occur, it needs to be cleared out of the end of their shift.

The RN completes a weekly inventory of all medications on-site. Trained YCS complete an inventory every shift of any controlled medications. This inventory is documented on the youth's Medication Distribution Log (MDL) and a staff member from the outgoing shift along with a staff from the incoming shift initial the inventory. A perpetual inventory is also maintained on each medication as it is given.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. There is also a separate locked file cabinet in the kitchen where sharps are stored. All sharps are also inventoried weekly and signed out when used.

The RN reviews four different reports from the Knowledge Portal each month: a Discrepancy Report, a Summary by Transaction Report, a User Summary Report, and a Profile Overrides Report. The RN also goes into the Knowledge Portal at least once a week to view different reports.

The shelter has not had any CCC reports relating to medication errors since the last on-site review.

### Exceptions:

No exceptions are noted for this indicator.

### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

The agency has a policy in place for the Medical and Mental Health Alert Process. The policy was last reviewed on August 28, 2018 by the Executive Director, Clinical Director, and Shelter Manager.



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The agency uses a color-coded system for Medical/Mental Health alerts. The applicable color-coded dots are placed on the spine of the youth's file and also on the alert board in the YCS office. The agency uses: dark blue to indicate a medical condition, light blue for sight and sound, orange for allergies, red for medication, light green for substance abuse, black for mental health, dark green for physically aggressive, pink for chronic runaway, and yellow for elevated suicide risk.

There were six youth files reviewed. All files documented color-coded dots on the spine of the file that corresponded with alerts identified during the screening process. An Alert System Shelter Check List form was located in the front of each file reviewed. This form also documented the applicable colored dots as well as the specific alert identified with that dot. This form made it very easy for staff to open a file and immediately see the specific issues, concerns, and alerts for that individual youth. All alerts were also appropriately documented on the alert board in the YCS office. An interview with a YCS indicated staff are very well versed in the alert system.

### Exceptions:

No exceptions are noted for this indicator.

### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

The agency has a policy for Episodic/Emergency Care. The policy was last reviewed on August 28, 2018 by the Executive Director, Clinical Director, and the Shelter Manager.

All staff shall be trained in first aid and CPR procedures. All staff shall be trained on the use of the knife-for-life, and locations of first aid kits. First aid kits are checked by the YCS III Supervisor on a regular basis to ensure they are complete and up-to-date. Any emergency medical care administered to youth in the shelter shall be documented in the youth file with outcomes and resolution. Each facility shall perform an emergency first-aid drill at least once per quarter.

The program has had two instances of emergency/episodic care in the last six months. All both instances were documented in the shelters electronic logbook and on the shelters Emergency Care Log. Both instances were reported to the CCC. Both incidents had an internal incident report documenting the details of the incident and the notification of the supervisor, CCC, and the youth's parents. Follow communication with the CCC was reviewed in the form of emails, that indicated the both cases had been successfully closed and discharge/follow-up instructions from the hospital were noted.



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Each staff member is trained in CPR and First Aid. A random sample of eight training files was reviewed and each file contained a current CPR and First Aid certification card.

First aid kits are located in the nurse's office and also in the dayroom. These first aid kits are maintained by Zee Medical and stocked once a month. Shelter staff review the kits on a weekly basis to ensure they are stocked with necessary items.

There are knife-for-life and wire cutters located on the wall in the laundry room and also in the staff office.

The shelter conducts emergency medical drills on each shift, each month. These drills were reviewed and were found to be completed for the last six months.

### **Exceptions:**

No exceptions are noted for this indicator.