



Florida Network of Youth and Family Services

Quality Improvement Program Report

Review of Arnette House

on 02/25/2014

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

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 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory:100.00%

Percent of indicators rated Limited:0.00%

Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory: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%

Rating Definitions

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

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

Review Team

Members

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Brent Musgrove, Prevention Specialist, DJJ

Kristi Castaneda, Director of Program Support Services, Boys Town of Central Florida



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies

Danielle Husband, Program Director, Youth and Family Alternatives – RAP House

Phil Whitby, Nonresidential Manager, Family Counseling

Brian Dye, Residential Supervisor, SMA – Beach House

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 1 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 3 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 4 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 6 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 3 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 4 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | 0 Other |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

6 Youth 6 Direct Care Staff 0 Other

Observations During Review

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

Comments

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

Rating Narrative



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies

Strengths and Innovative Approaches

Rating Narrative

Since the last review Arnette House has built a challenge course with a rock climbing wall from donations from a local organization. This same organization is also in the process of collecting donations to provide outdoor exercise equipment for the youth served. The shelter also bought twenty new bikes for youth served and built a shed to store them. The agency is working with a trauma informed care approach, and trying to organize a sex trafficking task force in their area. The weekend prior to the review the shelter was struck by lightning affecting some of the telephone and computer systems. At the time of the review there were ten CINS/FINS youth in the shelter.



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies

Standard 1: Management Accountability

Overview

Narrative

The program management team is comprised of a Chief Executive Officer, a Chief Financial Officer, A Shelter Program Manager, a Human Resources Officer and an Assistant Program Manager. In addition to the Shelter Program Manager, the residential component of the program is staffed by one (1) Assistant Shelter Manager, four (4) Team Leaders, nine (9) full-time Direct Care Workers (DCW), and four (4) part-time DCW staff, an Education Specialist, a Food Service Coordinator, an Intake Coordinator, a Residential Care Manager, and a Maintenance Technician. In addition, the Non-Residential staff includes three (3) Family Counselors. The clinical component of the program includes one (1) Licensed Mental Health Counselor, and a mix of Master's and Bachelor's level counseling staff. At the time of the quality improvement review, the program had one (1) vacant part-time Direct Care Worker position and one (1) vacant CINS Case Manager Position.

The program is operated around three eight-hour work shifts. The shift times are: 7 a.m. to 3 p.m., 3 p.m. to 11 a.m., and 11 p.m. to 7 a.m. The shelter maintains individual training files for each employee. Annual training is tracked according to the employee's date of hire. There is also a Community Outreach Development Coordinator that conducts outreach activities, delivers presentations and marketing information related to programs services and establishes relationships with local areas system partners and community organizations.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The Program has procedures and practices to ensure all employees, volunteers, and interns meet DJJ background policy such as: Background screening prior to hire date, Re-screening every five (5) years of employment, and Annual Affidavit of Compliance with Good Moral Character Standards.

The Program was able to illustrate based on the information/evidence during the time period in question, the Program was able to validate employees complete the all the following requirements within indicator 1.01 Background Screening with the following information: Background screening prior to hire date, Re-screening every five (5) years of employment, and Annual Affidavit of Compliance with Good Moral Character Standards.

It should be noted; one employee completed his/her five-year re-screening Background Re-Screening, however, it was after the anniversary date. However, the program was able to produce documentation showing the program took steps to complete the employee's five-year background re-Screening prior to his/her anniversary hire date.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy on Abuse Reporting that was reviewed 1/13/14. The policy details what is the process for staff and client abuse reporting. Abuse hotline numbers were posted in the shelter as well as grievance forms. The policy includes the code of conduct.

There were six staff surveyed and the responses for how youth are allowed to call the Abuse Hotline answered that youth are allowed to call anytime. All six staff answered "no" to whether they have ever observed a co-worker telling a youth that they could not call the abuse hotline. Five staff have never observed a co-worker using profanity when speaking to youth and one answered yes. All six answered they have not observed co-workers using threats or intimidation when speaking to youth. The question about in the past year how are the working conditions

at this shelter, one staff said very good, four said good and one said fair.

There were six youth surveys completed and five responded that they knew about the hotline and that it was available to them, one answered no. Four youth knew where the hotline number was posted in the shelter and two said they did not know where it was posted. All youth said they have never been stopped or delayed when wanting to make a call to the hotline and five of the six had made a call before. When asked if adults here are respectful to the youth, five answered yes and one no. When asked if they have heard adults here use curse words when speaking to youth five answered no and one yes. Five youth said they have not heard adults here threaten youth and one answered yes. This one youth explained that, "some staff I heard them threaten kids that they are gonna call police or they are gonna kick them out of Arnette." Two youth said they did not know about the grievance process and four that said they knew about the process. Three of those four said the process was good and one said very good.

There was a call placed to the Shelter Manager, Mark Shearon on 2/9/13, from a team leader stating that he received a call from another staff who heard from another staff that another male staff had taken a female youth behind the school house and exposed his genitals to her when she was here for a three week period in late 2012. The police were called and an investigation was initiated. Law enforcement had much difficulty reaching the employee to resolve the issue. The employee would schedule times for interviews and a polygraph and never showed. The agency took disciplinary action and the employee was terminated.

A recommendation would be in the Behavioral Management System Policy under the Discipline, Control and Punishment section to add how management would take immediate action to address incidents of staff using physical and/or psychological abuse, verbal intimidation, use of profanity, and excessive use of force.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There were four reportable incidents reviewed from September 2013-February 2014.

The Incident Report-Client policy was originally written in 1998 and was revised and signed by the CEO on 2/11/14

All four reportable incidents were called in to the CCC within the two hour time frame.

The incident from 12/11/13 was not in the CCC/OIG incident report book but the unusual event report was located when requested. This incident was not found to be documented on the agency form "Incident Report" as required by agency policy. Also, there was a time documentation error on the unusual incident report provided, as it stated CCC was called at 11:29 PM while CCC had the call logged in at 9:30 PM. The call would have been outside of the allowable time frame of two hours if it had been reported to CCC at 11:29 PM.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a written policy in place. They have a training plan that is reviewed and updated annually. The CEO, CFO, HR Officer, Shelter/Group Home Manager and Clinical Supervisor all sign off on the plan. All full time employees are required to obtain a minimum of 80 hours the first year and 40 hours annually after that. Supervisors are required to have 12 hours of their 40 annual hours in management theory and management skills training. Non-residential staff are required to also have 40 hours of training annually after the first year. They have outlined in the plan specific required training for direct service staff, orientation, Florida Network training, DJJ and DCF training. I reviewed seven training

files and they were all very organized and easy to navigate. I reviewed three files for first year required training and four files for annual ongoing training. The three files I reviewed for first year requirements will all be up for their year in March 2014. All three files did not have CINS Core training, Signs and Symptoms of Mental Health and Substance Abuse, Universal Precautions and Title IVE training. Universal Precautions training is in the agency's training plan as a mandatory training. One staff had not completed First Aid as well. All three staff have reached the 80 hour requirement.

In the policy it states that "All new employees will complete orientation with their supervisor or designee within 30 days of employment". On the New Employee Orientation form, one staff's orientation started on 3/13/13 and was completed on 7/6/13. These dates were the same on the Emergency Shelter Program Specific Training form, another staff's orientation began 3/25/13, and was completed 4/30/13 and the last staff started orientation training on 5/18/13 and there was no date of completion.

Four training files were reviewed for ongoing annual training. Two staff made the 40 hour requirement and two did not, one had 35.5 and one had 38.5. One staff did not take Suicide Prevention, all four staff did not have Crisis Intervention, and one staff did not have Universal Precautions.

In the agency's training plan it states that mandatory training for direct services employees includes: Crisis Intervention, First Aid, CPR, Universal Precautions, Fire and Safety, Suicide Prevention, CINS Core Training. Florida Network requires for ongoing training; Fire Safety, Suicide Prevention, First Aid and CPR.

The agency's training files are very organized and easy to navigate through. The page on the left hand side with the hire date made things easy from the start. The training status section was self explanatory and easy to see total hours and required training dates of completion.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy in place. The agency has a detailed Performance and Quality Improvement Plan. This plan explains the policy, purpose, authority, corrective action process, committee members, sub-committees, measurement outcomes, and internal monitoring. The PQI committees process is to look at annual data profile reports, client satisfaction results, domestic violence monthly reports, follow up service results, and risk factor reports. The PQI plan lists four sub-committees: the PQI, Safety/Health and Risk Management, Clinical/Case Review, and Human Resources. The PQI sub-committee meets every month and includes updates from the group homes and shelter, safety committee, finance, accidents, human resources, shelter staff moral builders, clinical, grievances, and monthly contract benchmarks. There were missing minutes for February, May, June, September and November. In the Safety/Health and Risk Management sub-committee meets monthly and reviews the disaster plan, health and safety issues, internal inspections, emergency drills, incident reports, accident reports, and any committee member concerns. There were minutes for all months except May. The Clinical/Case Reviews committee meets monthly and members perform file case reviews. Case file reviews were observed from August to November. The committee members completing the case reviews are all case managers, clinical and an intake staff. This committee also looks at incident or unusual incidents, shelter issues, baker acts, runaways, aggressive behaviors and recommendations/action plans. The Human Resources sub-committee meets monthly and goes over staff development and training, employee satisfaction results, staff turnover, employee satisfaction, deployment & supervision of personnel and morale and team building activities. Minutes were reviewed for each month in 2013 except March and May. In several committee minutes particularly in PQI and Safety/Health there was evidence of red flags and a corrective action plan in place with what to correct, how and by who. The minutes were very detailed and hit on all the standard requirements.



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Arnette House is contracted to provide both CINS/FINS residential and non-residential services for youth and their families in Marion and Lake Counties. The program provides centralized intake and screening twenty-four hours per day, seven days per week for status offenders including runaways, truants, ungovernable and lockout youth. A three level assessment is offered, Intake, Basic and Comprehensive, depending on the specific needs and services provided to the youth and family. Case plans, based on the findings of the assessment, involving the participation of the youth and the parent/guardian, are developed for the purpose of identifying the services and treatments that will be needed to assist the youth/family in achieving their goals.

Residential services include individual, family and group services. Case management and substance use prevention education are also offered. Aftercare planning includes referring youth to community resources, on-going counseling and educational assistance. Non-residential services include individual and family counseling and case management services provided in both Marion and Lake Counties. School based and office based services are offered. Roughly 70% are school based and 30% are office based. Arnette House works closely with the public school system in both Marion and Lake Counties. In Lake County, Arnette House works closely with Truancy Court. In Marion County, a licensed mental health counselor provides counseling services. A master's level staff provides counseling and case management services. In Lake County, a registered mental health intern provides counseling services. A bachelor's level staff provides case management services. In Marion County, two school based youth groups are offered: an ongoing social skills group and a 6 week anger management group.

The non-residential program case management service is responsible for coordinating the Case Staffing Committee, a statutory mandated committee that develops a plan for persistent habitual truant, lockout, ungovernable and runaway youth when other services have been exhausted or upon the request of the parents/guardians. The Case Staffing Committee may/may not also recommend the filing of a Children In Need of Services (CINS) petition with the circuit court. The CINS case manager tracks each case through the Case Staffing Committee, implementing the plan developed by the Case Staffing Committee and, if needed, track each case that is referred for a CINS petition throughout the duration of the judicial process.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Arnette House has an Eligibility Criteria/Referral Process and a Centralized Intake policy and procedure in place to screen youth 24 hours a day/365 days a year to determine the eligibility, provide intervention in crisis situation and initiate the assessment process. Eligibility criteria is well defined in the Eligibility Criteria/Referral Process policy and procedure.

Four (4) residential client records were reviewed (2 open and 2 closed). All four screenings met the eligibility within 7 days. On the Voluntary Placement Agreement form - 1 file had all initials and was signed. Two files were signed but were missing 1 set of initials where the parent/guardian received the brochure. One file was missing the Voluntary Placement Agreement. All 4 had the Grievance process forms signed by the youth, parent/guardian and staff.

Seven (7) nonresidential client records were reviewed (4 counseling/3 case management: 3 opened/4 closed). Grievance procedures and available service options were evident in all client records. Rights/responsibilities of youth and parent/guardians were evident in all client records. However it was not evident, in writing, that a parent/guardian brochure was provided to the youth and parent/guardian. Nor was it clear that information concerning possible actions may occur through involvement with CINS/FINS services (case staffing committee; CINS petition; CINS adjudication) was available to youth and parent/guardians. The non-residential supervisor stated that the all youth and parent/guardians receive the parent/guardian brochure and information concerning possible actions that may occur through involvement with CINS/FINS services at intake.

2.02 Psychosocial Assessment

Satisfactory

Limited

Failed

Rating Narrative

Arnette House has an Assessment, Assessment-Basic and Assessment-Comprehensive policy and procedure in place that ensures specific needs and services provided to the youth and family are tailored to specific youth and family needs and service request and only on information collected from the assessment that is ongoing throughout the duration of services. The agency uses a Basic and Comprehensive Assessment

that are well defined in the policy and procedure.

Four (4) shelter client records were reviewed and all were initiated within the 72 hour time frame. All were signed by a Master level staff. All were reviewed by a supervisor upon completion. None of the client records reviewed identified an elevated risk of suicide so therefore none were referred for a suicide risk assessment.

Seven (7) nonresidential client records were reviewed. All had a psychosocial assessment including a basic and a comprehensive assessment. All were signed by a Bachelor or Master level staff. All psychosocial assessments included a supervisor review signature upon completion. No client record reviewed identified an elevated risk of suicide. Therefore no youth was referred for a suicide risk assessment. In one case management client record, a psychosocial assessment (basic/comprehensive) was in the shelter client record. It was located by the nonresidential supervisor after it was not located in the case management client record.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Arnette House has a Case Plan policy and procedure in place where service plans are developed for the purpose of identifying those services and treatments that will be needed to assist the youth and family in achieving their goals. The agency also has a Case Plan Reviews policy and procedure to insure case plan reviews are conducted to assess the progress in achieving treatment and/or service objectives and goals.

Four (4) shelter client records were reviewed (2 open and 2 closed). All case plans were initiated within 7 days of the psychosocial assessment. All were individualized according to the needs and goals identified on the psychosocial assessment. All had type, frequency, location, person responsible and target completion dates. The 2 closed case plans did have actual completion dates. The 2 open case plans actual completion dates are N/A. All the case plans had signatures of the youth, parent, counselor and supervisor.

Seven (7) nonresidential client records were reviewed (4 counseling/3 case management). All nonresidential case plans had date the plan was initiated, target date for completion and regular monthly case plan reviews by counselor and supervisor.

In the 4 nonresidential counseling client records, case plans were developed within 7 days of the psychosocial assessment. Case plans identified and prioritized needs/goals identified by the psychosocial assessment. Case plans were reviewed for progress/revised by the counselor and parent every 30 days for the first three months and every 6 months after. All case plans had signatures of the parent, counselor and supervisor. 2 client records did not clarify service type, frequency, location. All but one had youth signature. One case plan did not have parent review and only one youth review. In 1 nonresidential case management record , 3 case plan revisions were evident, demonstrating updated revisions over time, at 6 month intervals.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Arnette House has a Case Management/Service Continuity and Coordination policy and procedure in place that ensures services shall be provided to all youth and family services through a system of coordinated care to avoid out of home placements and promote a youth's expeditious return to their home or an alternative safe living situation.

Four shelter client records were reviewed (2 open and 2 closed). In all 4 client records the youth were assigned a counselor/case manager. All client records showed the service plan implementation and monitored the progress in services. All 4 client records also showed that support was being provided to the family.

Seven nonresidential client records were reviewed (4 counseling/3 case management). In all 7 client records the youth/family were assigned a counselor/case manager.

In the 3 case management client records, referral needs were established with coordinated referrals to services based upon the on-going assessment of the youth/family's problems and needs were evident. The case manager coordinated service plan implementation, monitored the youth's/family's progress in services, provided support for families, and monitored out-of-home placement, if necessary. Referrals were made to the case staffing committee, as needed, to address problems and needs of the youth/family. Youth and parent/guardian were accompanied by the case manager to court hearings and related appointments. Referrals to additional services were made when appropriate. The case manager provided case monitoring and court order reviews.

Recommendation - add to section cover sheet where referrals are located in the client record.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

In the Arnette House shelter, the group book was reviewed and from 9/2013 to 2/25/2014, a good array of group topics and educational outings were evident. Five groups a week were reviewed with the exception of 12/31/2013 and the next group was not until 1/6/2014. 180 day follow-ups are being documented on the Florida Network of Youth and Family Services 180 day form. They have an organized binder by months. Residential and nonresidential youth follow ups are filed together.

Four nonresidential counseling client records were reviewed (2 open/2 closed). In the 2 closed counseling cases, the intervention closed prematurely. Therefore, counseling services were not implemented, however, it had very good case coordination of tracking youth from father's home to mother's home, as well as, coordination with the referral source. In the 2 open counseling cases, youth's presenting problems were addressed in the psychosocial assessment, initial case plan and case plan reviews. Case notes were maintained for all counseling services provided and documentation of youth's progress. In all cases, an on-going internal process was in place to insure clinical reviews of case records and staff performance.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

Arnette House has a Case Staffing Committee and a Child In Need of Services Petition (CINS Petition) policy and procedure in place.

The Case Staffing Committee policy insures a youth's case is reviewed to attempt to find a solution when youth or parent progress has not been made, youth or family will not participate or services/treatment selected, and/or services or treatment selected has not addressed the youth or family's problems and needs. If a parent/guardian/custodian of an active CINS/FINS youth requests, in writing, that a case staffing committee be convened, if requested by the parent, the case staffing must be held within 7 days, excluding weekends and legal holidays, of receipt of the written request.

The Child In Need of Services Petition (CINS Petition) policy insures a filing of a CINS petition when the case staffing committee or case manager recommends the filing of a petition and 1. the family/child have in good faith, but unsuccessfully used the services/processes recommended by the CINS provider and/or the case staffing committee. 2. the family or child has refused all recommended services.

All case staffing/CINS petition cases are managed by a CINS case manager. Three nonresidential case management cases were reviewed. The case staffing included a local school district representative and a DJJ representative or CINS/FINS provider. In all 3 cases, as a result of the case staffing committee meeting, the youth and family were provided a new or revised plan for services; a written report was provided to the parent/guardian within 7 days of the case staffing committee, outlining recommendations and reasons behind the recommendations. When applicable (applicable in all 3 cases), the program works with the DJJ attorney and the circuit court for judicial intervention for the youth/family. In all 3 cases, the CINS case manager completed a review summary prior to the court hearing.

Arnette House has an established case staffing committee and has regular communication with committee members and has an internal procedure for the case staffing process, including a schedule for committee meetings. This is evident by policy and procedure in place and by emails that were reviewed. Additionally, a case staffing committee schedule was on a visible black chalk board in the supervisor's office. Case staffing committees show a robust membership from different disciplines as evidence by notification memos/letters to members of case staffing's.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency maintains a secure file room in the shelter building. The residential and non-residential files are stored securely in the file room in locked file cabinets behind a locked door. The open files for the non-residential program are organized by counselor and then are filed alphabetically when the cases are closed. The open shelter files are maintained in a locked box in the 'master control' area of the shelter dorm and then are stored alphabetically when the file is closed.

Several files were pulled randomly and all of the files had a stamp that indicates the file is the property of Arnette House and contains confidential and private information.

The agency has a policy related to File Organization that was written in 1998 and the most recent review of the policy by the CEO was conducted 3/2011. It is recommended that the agency reviews/updates the policy, as it appears there are some forms that may not be used any longer included in the policy and some other forms that are not included in the policy as currently written.

Standard 3: Shelter Care

Overview

Rating Narrative

The Arnette House youth shelter is located in Marion County. The facility is in operation twenty-four hours per day, seven days per week, every day of the year and is licensed by the Department of Children and families for thirty (30) beds. The agency serves both CINS/FINS and DCF program participants. At the time of the quality improvement review, there were a total of ten (10) youth in the shelter. The shelter is comprised of a large central building that has two (2) separate hallways on opposite sides of the building, to house female youth on one hallway, and male youth on the other. Each hallway can house up to fifteen (15) youth. The hallways are separated by a dayroom, a kitchen and Direct Care Work Station. When not in school, the youth spend a majority of their free time in the dayroom either engaged in group activities, playing video games, watching television or completing homework assignments on the computers. Youth attend local area schools if they are not on suspension, expulsion or suffering from an illness. There is an industrial kitchen onsite where all meals are prepared. The large day room also acts as a cafeteria where the youth eat their meals.

The shelter staff includes a Shelter Program Manager, a Shelter Program Manager, four (4) Team Leaders, nine (9) full-time Direct Care Workers, four (4) part-time Direct Care Workers, an Education Specialist, a Food Services Coordinator, an Intake Coordinator, a Residential Care Manager, and a Maintenance Technician. A Residential Counselor is assigned to the residential youth shelter. The Direct Care Worker staff are primarily responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The shelter's direct care staff are trained to provide the following services for the youth: screening, medication administration; health, mental health and substance abuse screenings, first aid, cardio pulmonary resuscitation (CPR) and referrals. The supervisory and counseling staff members receive referrals and monitor service delivery on a consistent and on-going basis.

The medication and first aid supplies are stored in the staff office in a locked desk behind a locked door in the Direct Care Worker Office. The Direct Care Worker staff offices are located inside the youth shelter adjacent to the day room. The counseling offices are also now located in the youth shelter. Residential services, including individual, family, and group services, are provided to youth and families. Case management and substance abuse prevention education are also offered. The shelter is not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy and procedure in place that provides and ensures a safe and secure living environment. All Health and Fire Safety inspections are current. Fire extinguishers were inspected and tags were punched on June 2013. The Hood in the kitchen was inspected on December of 2013. The Food Hygiene Sanitation Certificate is hanging in the kitchen and expires in September of 2014. The shelter is inspected for insects Bi-monthly with the last inspection being on 1/3/14. The shelter can be serviced between scheduled visits if a need arises.

A general tour was given of the programs grounds and buildings by the Compliance Manager. The shelter environment was pleasant and inviting. The furnishings appeared to be in good shape and there was minimal graffiti. The graffiti that was observed was mainly in the youths bedrooms. The shelter has 12 male and 12 female beds. The rooms were well lit and each bed had its own linens, blanket, and pillow. The bathrooms are accessible by 2 rooms (jack and jill style). They were just newly renovated and were clean and odor free. Youth are allowed to keep hygiene supplies, except for aerosols, in their bathrooms or their bedrooms. There are lockers located on both the boys and girls wings for any items the youth want to lock up but use when they need to. There is a safe located in the Compliance Manager's office for items that are considered contraband. The outside is well maintained and landscaped. They have a basketball court and a newly constructed challenge course, which includes a "rock climbing" wall. There is ample space for outdoor/physical activities. Schedules, which are posted throughout the shelter, provide the youth with the opportunities to participate in activities such as education, recreation, counseling, skills training, faith based, quiet reading time and at least 1 hour daily for physical activity.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The shelter has policy and procedures in place to ensure that the youth are knowledgeable about the program rules and procedures. The youth, parent, and staff sign the Orientation checklist at intake that explains key staff and their roles, emergency evacuation procedures, tour the program, room assignment, contraband policy, daily schedule, rights and grievances procedure, how to contact abuse hotline, program services, how to access medical health care, how to access mental health care, visitation schedule, telephone procedures, program rules regarding youth conduct, consequences of when rules are broken, dress code and hygiene practices. The youth also receive a handbook at that time. At time of intake youth sign the Arnette House life contract that says that the youth will not harm themselves or others or if they feel like they may they will notify staff. Four residential files were reviewed (2 open and 2 closed). All 4 had the youth, parent and staff signatures that the items on the Orientation checklist was explained and that the youth had received the handbook. In all 4 files the life contract was signed by both the youth and staff at time of intake.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy and procedures in place that ensure the assignment of the youth's room will facilitate youth manageability and security. The shelter uses the Cins/Fins intake assessment on assigning a youth their room. Four files were reviewed (2 open and 2 closed). In all the charts nothing was checked in the 6 history questions. Direct Care staff was asked on the procedure for completing the room assignment section on the Cins/Fins intake form. Staff stated that if there is no history then nothing is checked.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The shelter has policy and procedures in place where a shift review log is maintained to pass along information between shifts. The current log is kept in the Direct Care Workers office. The logbooks reviewed were 8/25/13 to 10/22/13 and 10/23/13 to present date. All the entries were brief, legible and were written in ink. The shelter does use highlights in their logbooks but it was not clear on what highlighted colors meant what. Direct Care staff was asked about this and it was explained that safety concerns are highlighted but there is no color designated to certain situations. Direct Care staff did state they are working on a system that specifies a certain color for certain situations. It was observed that errors were crossed out with a single line but very few had staff initials, which is in the shelter's policy, nor the date, which is in the standard. No whiteout appeared to be used anywhere in the logbooks. At the beginning of the shift in the logbook staff documents what staff is on shift



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies

and youth that are currently admitted to shelter. It also states how the prior shift went and any other pertinent information. In reviewing the logbooks it was observed that the shelter Care Manager and Shelter Program Manager reviewed the logbook at least 1 time a week. It was not really clear on when or if Direct Care Staff reviewed the logbook for the prior 2 shifts.

Rating Narrative

The agency has a Behavior Management System policy that was written 10/2011 and was revised 12/5/13 by the CEO. The agency also has a Behavioral Interventions policy that was written in 2012 and was revised by the CEO 7/1/12.

Five shelter youth files were reviewed for the agency Behavior Management Plan. All five files contained a copy of the Behavior Management Plan in the file and four of the five files were signed by the youth (it appears the 5th youth did not sign any of his intake paperwork, which may mean he refused to sign, as shelter staff and guardian did sign the paperwork upon admission).

The Behavior Management Plan is also included in the youth handbook that is provided upon intake.

Staff interviews were completed with the Assistant Director, Intake Specialist, and Staff Supervisor related to the behavior management system. Both the Assistant Director and Intake Specialist confirmed the system is meant to allow for logical and immediate consequences to a youth's decisions. The youth can earn points or not earn points for different activities during the day, but once earned, the youth cannot lose points again. The agency has a point store where a youth can "cash in" earned points up to twice a week and upon discharge.

It was reported by the Assistant Director that the agency trains new employees within their first year of employment on the behavior management system through their week-long Advancing Youth Development training. It was also reported the behavior management system is reviewed as needed during monthly staff meetings.

The intake specialist also reported she feels this behavior management system has helped motivate the youth in the shelter to make more appropriate choices based on their desire for the opportunity to earn rewards.

The staff supervisor that monitors the point store and daily point balance further explained the Behavior Management System and Plan is designed to assist the youth in meeting their long-term weekly goals and the staff also utilize daily privileges to assist the youth with keeping their behaviors and choices on track in the program. A youth can have a privilege, such as additional phone calls, use of recreational items, etc. be removed for the day as an immediate consequence for a negative behavior. The agency works to ensure the staff in the program are not being overly punitive in the process of removing a privilege, as the staff has to inform a supervisor if a youth loses a privilege for the day. The supervisory staff also monitors that a youth is not continually losing a privilege or not earning points on a certain shift, with a certain staff, etc.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The shelter has a policy and procedure in place that provides adequate staffing to ensure the safety and security of the program, staff and clients. It also ensures that the programs mission, goals and outcomes can be achieved. Staff schedules were reviewed and the shelter is follow their policy and the standard on ratio's of 1 staff to 6 youth during waking hours and 1 staff to 12 youth during sleeping hours. There appears to be at least 1 male and 1 female on every shift even on the 11pm-7am shift. The schedules are posted in the Direct Care Workers station and are at least 3 weeks in advance. There is a call list that the shift supervisor has access to in the event that extra staff is needed to



Quality Improvement Review

Arnette House - 02/25/2014

FLORIDA
NETWORK
of youth and family services

Lead Reviewer: Ashley Davies

help cover a shift. Room checks are being done during sleeping hours. Direct Care staff explained that male staff does checks on the male youth and female staff does checks on female youth. They take turns while the other staff is in the office. The shelter has a monitoring system with cameras that are positioned in appropriate locations. The system holds recordings of 2 weeks back. Dates that were reviewed were 2/12/14 at the end of the 11 Pm - 7 Am shift, 2/20/14 at the beginning of the 11pm - 7am shift and 2/24/14 at the middle of the 11 pm- 7 am shift. Most are conducted within the 15 minutes. There were a few that did exceed the time limit, with 1 that was 21 minutes between checks. The checks that were reviewed did not correlate with the times in the logbook. The entries in the logbook were not in real time.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Arnette House is not a staff secure shelter and the agency has a policy in place to make referrals to one of the other staff secure providers in the state to meet the needs of a youth that requires staff secure level services.

Arnette House has a policy in place related to Domestic Violence Respite that was revised by the CEO in September 2013.

Four Domestic Violence Respite cases were reviewed from the last six months. All four of the cases reviewed showed evidence receiving approval from The Florida Network for the program and all four cases demonstrated the youth were screened by the JAC and qualified for Domestic Violence Respite, as the youth had a current arrest for a DV battery.

Of the four cases reviewed, two of the youth are current intakes and have not reached their allowed maximum 14 day stay.

Of the other two closed cases, one youth remained in the shelter less than the maximum allowed 14 days. The fourth youth remained in the shelter longer than 14 days. For this youth, the file did not clearly demonstrate an internal process for discharging the youth from a Domestic Violence bed and into a standard CINS/FINS bed. It is recommended the agency develop a process to easily identify when a youth is discharged from the DV program and immediately admitted into a CINS/FINS bed to continue services to meet the youth's needs.

Two of the files reviewed contained additional paperwork from DJJ or the court system, which helped reinforce the reason for the shelter admission and needs of the youth and family.

All three of the four cases included treatment plans which included goals related to anger or authority figure issues. The fourth case is a recent intake and does not have a treatment plan included in the file at this time. One youth did not have evidence of individual counseling sessions while in the shelter and another youth only had evidence of one individual session while in the shelter.

Of the two cases that were discharged, one youth received a referral to Arnette House Non-Residential Services for continued services and the other youth received a referral for substance abuse.



Quality Improvement Review

Arnette House - 02/25/2014

Lead Reviewer: Ashley Davies

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Arnette House program provides screening, counseling, and mental health assessment services. The agency has a Shelter Program Manager that oversees the daily operations of the youth shelter. The Arnette House program has direct care staff members that are trained to screen, assess, and notify all staff members of conditions and risks of all youth admitted to both residential and non-residential CINS/FINS programs. The agency utilizes screening and risk factor identification techniques to detect youth referred to their programs with mental health and health related conditions. Specifically, the agency uses a multi-step screening form that combines the components of the initial screening and the CINS Intake form to determine CINS/FINS eligibility status and the presence of risks. The form also captures the youth's past mental health status, as well as, their current status.

The agency also screens for the presence of acute health issues and the agency's ability to address these existing health issues. The Arnette House residential program assists in the delivery of medications to all youth admitted to the youth shelter with medication or over the counter medications that are prescribed by a Physician. The agency operates a detailed medication distribution system. The agency provides medication distribution training to all direct care staff members including first aid, CPR, fire safety, emergency drills and exercises and training on suicide prevention, close watch observation, and crisis intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health issue or injury during their shelter stay.

The agency's CEO is a LMHC and there is one other counselor working under the supervision of the LMHC, serving all youth in the shelter.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The Program has a policy, procedures, and practices to ensure medical care for youth admitted with medical conditions are provided the proper at the time of admissions. At the time of admission, each youth shall receive a preliminary physical health screening with Arnette House Intake/Assessment Form and Medical/Mental Health Form which includes:

- Current medications
- Specific inquiry in symptoms of active tuberculosis
- Physical health problems
- Allergies
- Report of recent injuries or illnesses
- Presence of pain or other physical distress
- Suicide Assessment
- Asthma

- Diabetes
- Head Trauma
- Hemophilia
- Petit mal seizure
- Pregnancy
- Tuberculosis

Furthermore, when the assessments are completed the Program utilizes a "master file", which allows staff to recognize any youth's medical or mental health problems based on the preliminary physical health screening with Arnette House Intake/Assessment Form and Medical/Mental Health Form. Furthermore, the Program staff denotes any issues such as "food allergies and/or medical issues" on top of the youth's file. The Program's Kitchen staff has a list of youth with food allergies.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for suicide precautions that was reviewed and updated on February 10, 2014. The policy indicates each youth admitted to the shelter will be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. The agency uses the Teen Screen to determine the presence or level of suicide risk and any type of MH symptoms (anxiety, depression, phobias, etc.). The Teen Screen is administered via a computer station. The Teen Screen is an automated electronic application that verbally asks youth to answer questions regarding the current presence of suicide, substance abuse, phobia, panic attacks, obsessive compulsive, eating issues, ADHD, Oppositional Defiant Disorder, Conduct, Marijuana use and other substance use in the last six (6) months. At the end of the survey all points are totaled. If there's a yes response to any of the Suicide Risk questions in the last six months, the child is placed on constant sight and sound supervision and staff complete the suicide precaution log. This log requires staff to document their observation and time and initial every ten (10) minutes. A Master's level Counselor meets with the client and administers an Assessment of Suicide Risk. Four (4) different outcomes are possible related to the completion of this form that include Emergency Transport – Baker Act, Continue the Youth on Constant Sight and Sound and reassess in 24 hours, Discontinue Sight and Sound – and Remain on Cot for close supervision, or Discontinue Constant Sight and Sound.

The shelter employs a master's level counselor, who works under the supervision of a Licensed Mental Health Counselor (LMHC), also employed by the shelter. This master's level counselor completes all suicide risk assessments and then consults with the LMHC. There were three youth files available for review for youth who had been placed on suicide precautions. Two of the three files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. The third youth was placed on suicide precautions after admission due to making comments of self harm. All three youth remained on sight and sound supervision until assessed by a qualified professional. All youth were seen and accessed by the master's level counselor, using a suicide risk assessment, within twenty-four hours. All suicide risk assessments contained documentation of consultation with the LMHC and a signature by the LMHC the next time on-site. Two of the three youth were placed on normal supervision levels upon completion of the assessment, the third youth was placed on close supervision and re-assessed in twenty-four hours. Two of three files documented the youth were on suicide precautions during the overnight shift and both youth slept on a cot in the hallway. All three youth had thirty minute observations documented the entire time they were on suicide precautions.

All changes in supervision levels were documented in the logbook.

There were three youth files available for review for youth who had been placed on suicide precautions. Two of the three files documented the youth were placed on suicide precautions at intake due to issues identified during the screening process. The third youth was placed on suicide precautions after admission due to making comments of self harm. All three youth remained on sight and sound supervision until assessed by a qualified professional. All youth were seen and accessed by the master's level counselor, using a suicide risk assessment, within twenty-four hours. All suicide risk assessments contained documentation of consultation with the LMHC and a signature by the LHMC the next time on-site. Two of the three youth were placed on normal supervision levels upon completion of the assessment, the third youth was placed on close supervision and re-assessed in twenty-four hours. Two of three files documented the youth were on suicide precautions during the overnight shift and both youth slept on a cot in the hallway. All three youth had thirty minute observations documented the entire time they were on suicide precautions.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place for Medication Distribution. The policy addresses requirements outlined in the DJJ Health Services Manual. The shelter provided documentation of all staff who are trained to help youth in self-administering medication.

Observations of medication storage revealed medications are stored in a locked cabinet, inside a locked box, in the staff office. Each medication is stored in individual zip lock bags with the youths name on the bag. A separate box is used for all topical medications so they are stored separately from oral medications. There is a small refrigerator located in the staff office for any medications requiring refrigeration. At the time of the review there were no medications requiring refrigeration. The shelter does not provide over-the-counter medications, unless the youth comes in with it and has a doctor's order, so they did not have a stock of over-the-counter medications.

The policy also requires that staff members must follow measures/steps to ensure that all medication entering the shelter originate from a licensed pharmacy. The policy addresses that all medications that enter the facility with a resident admitted to the program must be accompanied by a doctor's prescription. Of the cases reviewed onsite, all cases had evidence that the medication entering the facility included documentation that the agency verification process was completed by a staff member. The Verification section on the Medication Distribution Log (MDL) included the actual date that the verification was conducted, the person verifying the medication at the pharmacy, and the staff member that completed the process.

There were three youth currently in the shelter on medication, all three of the files were reviewed. The shelter maintains a binder for all youth currently in the shelter that contains all the MDL's, shift-to-shift inventories and a cover sheet documenting the youths name, date of birth, allergies, a picture of the youth, and the full printed name and signature of each staff member. Two of the three files reviewed did not document the full printed name and signature of the youth, the remaining file did contain the signature of the youth due to the youth signing his full name when receiving his medication instead of initialing. An individual MDL is maintained for each medication the youth is on that documents the medication the youth is taking, the dosage, and side effects. All MDLs documented medications were given at the time specified or within the one hour time frame before or after the time specified. One file documented seven separate occasions when a staff member did not initial the MDL when the youth self administered a medication. The other two files each documented two separate occasions of this happening. A perpetual inventory with running balances is maintained on a separate sheet located behind the MDL, that is completed each shift. There was one youth on a controlled substance and there were five occasions this medication was not inventoried on the over night shift. All non-controlled medications were inventoried daily on first and second shift.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

All youth alerts are entered into a computer system, printed out each shift and placed in a binder for all staff to review. The form is updated each shift as needed and is color coded. All youth files reviewed documented all applicable alerts on the outside of the file coincided with alerts documented on the alert form located in the binder for staff to review. All dietary alerts were also documented in the kitchen.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The Program has a policy in place regarding Episodic/Emergency Care. Staff are made aware of the policy. The Program's policy provides direction/guidance for staff to follow if and when an incident should occur and the order in which staff should follow:

- Law Enforcement or Medical Assistance as needed.
- Shelter Program Manager or Designee.
- Parent or Guardians.
- Counselors or Case Managers

Program Policy dictates Program Supervisors to evaluate incidents and determine if incidents are CCC reportable, complete Incident Report, and Shift Log Book. Parent notifications, follow-up care, and medical clearance were all documented as required. In addition, Program was able to illustrate Shift Log Books were record appropriately during Episodic/Emergency Care events.

The Program supplied Knife for life and wire cutters as required within the indicator 4.05 Episodic/Emergency Care. First Aid Kits/Supplies were produce within the Shelter and Program Vehicle.