



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Currie House

on 09/18/2012

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 | Limited |
| 1.04 Training Requirements | Satisfactory |
| 1.05 Interagency Agreements and Outreach | Satisfactory |
| 1.06 Disaster Planning | Satisfactory |
| 1.07 Analyzing and Reporting Information | Limited |

Percent of indicators rated Satisfactory:71.43%
Percent of indicators rated Limited:28.57%
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 Youth Room Assignment | Satisfactory |
| 3.02 Program Orientation | Satisfactory |
| 3.03 Shelter Environment | Satisfactory |
| 3.04 Log Books | Satisfactory |
| 3.05 Daily Programming | Satisfactory |
| 3.06 Behavior Management Strategies | Satisfactory |
| 3.07 Behavior Interventions | Satisfactory |
| 3.08 Staffing and Youth Supervision | Limited |
| 3.09 Staff Secure Shelter | No rating |

Percent of indicators rated Satisfactory:77.78%
Percent of indicators rated Limited:11.11%
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:85.71%
Percent of indicators rated Limited:10.71%
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

- Keith D. Carr, Principal Consultant, Forefront LLC
- Lydia Breaux-Davis, Prevention Specialist, Florida Department of Juvenile Justice
- Cindy Whitaker, LMHC, Clinical Director, Capital City Youth Services



Cindy Hetherington Hoskins LMHC, Clinical Supervisor, Anchorage Children's Home

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor | 4 Clinical Staff | 3 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 3 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|--|--|---|
| <input type="checkbox"/> Accreditation Reports | <input type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input type="checkbox"/> Logbooks | 6 Health Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input type="checkbox"/> Medical and Mental Health Alerts | 14 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 9 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 9 Training Records/CORE |
| <input type="checkbox"/> Egress Plans | <input type="checkbox"/> Program Schedules | 9 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | Other |
| <input type="checkbox"/> Fire Drill Log | <input type="checkbox"/> Table of Organization | |
| <input type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 4 Youth 4 Direct Care Staff 0 Other

Observations During Review

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

Comments

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

Rating Narrative

This review was conducted in accordance with Florida Administrative Code 63L-2 (Quality Assurance, 6/10/10 Hearing Draft), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and Mental Health/Health Services, which are

included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2012).

Lutheran Services Florida Northwest (LSF-NW) provides both residential and non-residential Children In Need of Services and Families in Need of Services (CINS/FINS). The LSF-NW program serves youth and their families in four (4) counties (Escambia, Okaloosa, Santa Rosa and

Walton) in the West Florida region of North Florida. The agency provides CIN/FINS Services through to two (2) service locations located in Pensacola and Crestview Florida respectively.

Strengths and Innovative Approaches

Rating Narrative

The Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency that is responsible for Prevention and Intervention Services that provide programming and services to reduce juvenile crime and increase public safety. According to Florida Chapter 984 the state must provide a continuum of services to prevent Status Offenders from entering the Juvenile Justice system. These services are typically referred to as for Children in Need of Services and Families in Need of Services (CINS/FINS). The Lead Agency for Children in Need of Services and Families in Need of Services (CINS/FINS) Services for the State of Florida is the Florida Network of Youth and Family Services (FNYFS). Lutheran Services Northwest is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in Northwest region of the Florida Panhandle.

Each youth shelter operates 24 hours a day, 365 days a year and serves a range of six (6) youth up to a maximum of ten (10) CINS/FINS shelter beds in each program. At the time of this onsite Quality Improvement (QI) review, Currie House had seven (7) CINS/FINS youth in the shelter. Further, the agency has currently provided CINS/FINS Non-Residential services to an estimated of thirty one (31) clients and their families for the current 2012-2013 fiscal year.

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

Lutheran Services Florida Northwest staff members (residential and non-residential) were very cooperative with the monitoring team in all phases of the monitoring process. Prior to the QI Team's on-site visit, the agency's personnel were notified of the monitoring visit and informed how to obtain all of the current monitoring tools that were to be utilized. In addition, a Document Request List was provided in advance, listing specific documents and files to be available during the onsite visit. All of the staff members were prepared for the onsite review and cooperative with the monitoring team which created a productive and hospitable monitoring environment.

The agency recently established a partnership with the local Homeless Coalition. In this partnership, the Homeless Coalition provides daily school transportation to pick up and drop off all Currie House shelter residents. Further, the agency recently submitted a Grant to Impact 100 Grant for 2012. The agency is a finalist for this grant and if awarded LSF-NW will use the funds to build a multi-purpose expansion area to increase the current amount of space for youth shelter residents.

Standard 1: Management Accountability

Overview

Narrative

The Lutheran Services Florida Northwest Currie House youth shelter is located in Pensacola, Florida and provides CINS/FINS services in Escambia and Santa Rosa counties. Lutheran Services also operates a sister youth shelter called HOPE House that is located in Crestview, Florida and provides services in Okaloosa County. The programs share the positions of Regional Director, Clinical director, Shelter Services Director, Outreach Manager and Human Resources Manager. The agency's Clinical Director oversees all counseling and mental health services provided to youth and families delivered at both service locations. The agency's Shelter Services Director is responsible for both residential youth shelter locations. The agency also assigns the daily operation and direct responsibility of each shelter to a Youth Care Specialist that acts as the Residential Supervisor at each youth shelter. Both residential shelters Further, the agency has implemented uniform operating protocols for both service locations in the areas of screening, hiring and training. The agency conducts screenings prior to hiring of all staff members. All staff members receive training at their respective service locations. In addition, many agency trainings combine staff members of both locations to be trained on various core training topics.

The agency also conducts outreach services through partnerships with local community stakeholders and various system partners. The agency has on-going initiatives with nearly twenty (20) partners including the Escambia Sheriff's Department, Escambia County School System, United Way and the Junior Achievement of Northwest Florida.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The agency has a detailed policy on background screening of employees that interact and provide services under its CINS/FINS contract with the Florida Network of Youth and Family Services. The policy manual contains procedures that comply with the requirements for the agency to adhere to this background screening indicator. A total of nine (9) employee personnel files were reviewed to assess the agency's practice in this area. Of these files, seven (7) were new/recently hired employees and two (2) were in-service staff employees. One (1) employee's file met the criteria for a five (5) year re-screen. There was documented evidence in all the files that background screens were completed before the employee hire or start date. The 5 year re-screen was completed before the employee's initial hire date. None of the employees required an exemption and the annual affidavit of compliance was submitted before the January 31st, deadline.

There is a policy and procedure manual that complies with the requirements for background screening. A total of 9 employee files were reviewed, seven new employees and 2 old or existing employees. Only 1 employee met the requirement for a 5 year re-screen. All files had clear documentation that background screens were completed prior to the employees hire or start date. None of the employees screens required an exemption and the annual affidavit of compliance with level 2 screening standards was completed before the January 31st, deadline. There were no exceptions for this standard.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy on the provision of an Abuse-Free Environment for staff members/employees that interact and provide services under its CINS/FINS contract with the Florida Network of Youth and Family Services. The policy manual contains procedures that comply with the requirements for the agency to adhere to this indicator. A total of four (4) youth surveys were completed onsite. One (1) youth survey completed supports that youth feel safe and respected in the shelter and staff received a very good rating for overall care. An additional survey indicates that 1 staff survey supports that youth are treated with dignity and respect. The surveys also support that youth have knowledge of and access to the abuse hotline. A total of 4 staff member surveys were completed onsite during this QI program review. Four (4) staff member surveys report that staff have not observed youth being sent to their rooms for punishment, have not observed a co-worker using profanity when speaking to youth, have not observed a co-worker using threats, intimidation, or humiliation when interacting with the youth, and have observed a co-worker telling a youth that they could not call the Abuse Hotline. This monitor observed that the abuse hotline number is posted in the shelter common area, administrative offices and a grievance box is posted in plain view.

The agency's personnel policies and procedures manual also include the employee code of conduct manual. The manual is dated April 1, 2001. There were two (2) employee warnings that did not involve or present a safety issue to any of the youth in the shelter.

The current employee manual that includes the employee code of conduct is outdated.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on the provision of Reporting for staff members/employees that interact and provide services under its CINS/FINS contract with the Florida Network of Youth and Family Services. There is a policy and procedure in place for this specific Incident Reporting indicator. At the time of this review, there are a total of six (6) incidents recorded, but only four (4) were documented as being reported to the Department of Juvenile Justice (DJJ) Central Communications Center (CCC). The two (2) unreported incidents were CCC reportable, but were only documented in the agency's internal incident reports.

It was recommended that the agency update their internal reporting procedures and specify mandatory reporting of incidents that meet CCC reporting requirements. The policy should include the reporting of incidents that classify as reportable such as negligence against staff (omitted medications, medication omissions, etc.).

There is insufficient information that two (2) incidents were reported within the 2 hour requirement. Verification that the 2 incidents were reported within the required timeframe was confirmed by contacting the CCC onsite. It is strongly recommended that the staff person reporting the incident request that the DJJ CCC to record and document the time that the agency became aware of the incident, as well as the time that the incident is being officially reported on the CCC report.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive employee training policy for all staff members/employees that interact and provide direct services under its CINS/FINS contract with the Florida Network of Youth and Family Services. During the QI program review, a total of nine (9) employee training files were conducted. Of these files, seven (7) were new employees and two (2) on-going employees. Four (4) new employees terminated their employment due to family illness, new employment or acceptance into a nursing program. Not all new employees completed the eighty (80) hours of training required to be completed within the first year of employment. New employee files reviewed did not contain evidence demonstrating that these employees completed Title IV-E training. Staff members reported that primary/core training courses are provided during the new employee orientation. However, new employee orientation is an introduction and actual training is conducted under a separate training curriculum for Title IV-E. Specifically, 2 files lacked Title IV-E training, 2 files lacked suicide prevention training, and 1 lacked mental health/substance abuse and cultural competency training.

The standard for annual employee training did not include Title IV-E and all other training requirements were met. The two (2) exceptions include three (3) new employees that required Title IV-E training, 2 required suicide prevention and 1 required mental health/substance abuse and cultural competency training.

1.05 Interagency Agreements and Outreach

Satisfactory

Limited

Failed

Rating Narrative

There is a policy in place and the agency has established partnerships as evidenced by signed agreements dated 2007, 2008, 2009 and 2010. The only signed agreement with a current date is Big Brothers Big Sisters which was signed September 17, 2012. Copies of agreements pending signature include agencies such as Pensacola Police Department, United Way, Department of Children and Families and Lakeview Family First Network. The provider later included an agreement with Lakeview's DAART Program. Before receiving a copy of the Lakeview DAART agreement there was an absence of a strong partnership for alcohol/substance abuse and parenting class services. The exceptions in this area are the number of agreements that are dated three (3) or more years from their original start date.

The agency has partnerships with numerous agencies including Northwest Florida Prevention Coalition, Escambia/Santa Rosa DJJ Council, DJJ Circuit 1 Board (Secretary), United Way Day of Caring (Co-Chair), Florida Gang Reduction Task Force, Chamber PTA's, School Parent Teacher Association, Escambia County Sheriff's Department, Pensacola Police Department, Volunteer Fairs, National Night Out, Pensacola Fire Department, Neighborhood Watch Meetings, Teen Court and Junior Achievement.

1.06 Disaster Planning

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that meets the requirements for all disaster and emergency planning under this standard. The agency's current Disaster Plans are clear, concise and identify the roles and responsibilities of staff relative to the pending disaster. The agency's evacuation process and procedures are outlined, as well as parent and 911 notifications. There is documentation that fire drills are conducted monthly for each shift and that the fire safety plan is approved by the County Fire Safety Division.

The current plan includes various disaster scenarios. The current disaster plan also includes an emergency contact list of staff members.

1.07 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that states the agency will identify a Quality Improvement (QI) team. The team is scheduled to meet quarterly and focus on case reviews, incidents, accidents, grievances, consumer satisfaction data, outcomes and NETMIS data reports. The agency has identified strengths and weaknesses of each area make recommendation for improvement and quarterly follow-up. The program assembles a QI Team that is scheduled to meet on a quarterly basis. However, there is no evidence of documentation to support that these meetings are focused on the areas outlined above or risks and other quality improvement initiatives. In addition, strengths and weaknesses of the program are not identified on a routine basis and there is no documentation of follow-up or recommendations. Further, the agency does not have current examples or evidence demonstrating exercises that identifies and track trends, patterns and risks impacting its program. Nor does the agency have any current examples of monthly, quarterly and semi-annual reports.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services Florida Northwest (LSF-NW) delivers a broad range of services including Centralized Intake services. The non-residential staff members include a Clinical Director, a Counselor III and seven (7) Counselor II positions. According to the agency's organizational chart, these services are delivered through is non-residential staff members. The LSF-NW staff are currentlyk serving a caseload of over fifty (50) non-residential clients.

Non-residential services are provided to program participants and their families. These services are delivered through the agency's non-residential component and are provided twenty-four hours a day, seven days a week. The program participants receive program orientation materials upon their initial entry to the program. Program information provided to youth and parent/guardians includes confidentiality notices, release of information, service options and other orientation materials. In addition, participants are provided with information related to intake and grievance procedures.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The agency Policy and Procedure Manual requires a screening and intake according to the requirements of the Florida Network's Policy and Procedure Manual. Three residential and three nonresidential files were reviewed. One of the nonresidential files,E330-10,was going through the CINS process and had had two case staffing committee meetings.This youth had previous involvement with the agency. Five of the six files had eligibility screenings completed within 7 calendar days of referral. All files had documentation parents/guardians were given in writing the available service options and their rights and responsibilities. Three of the six files had documentation families were given a parent/guardian brochure. The residential files had a signature line for parents to indicate receipt of this brochure. Four of the files indicated the families had access to information on CINS/FINS services through the Parent/Guardian brochure.Although one file did not have documentation the family was given the Parent/Guardian brochure, they were involved in CINS services. Five files showed documentation of information on the grievance procedure. An eligibility screening for E330-10 was completed after the initiation of CINS services. E330-10, E152-12 and E303-12 did not have documentation parents were given Parent/Guardian brochure although staff reported the guardian of E330-10 came to appointments carrying this brochure. The availability of CINS/FINS services including the CINS process appear communicated through the Parent/Guardian brochure and this was not documented for E151-12 and E303-12. E330-10 while not having documentation of this brochure was involved in the CINS process. E151-12 did not show the family was given information on the grievance procedure. The Informed Consent and Introduction to Services for this youth was different than in other files reviewed and had a statement about dissatisfaction with services but not the detailed information on the grievance procedure found in all other reviewed files.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The agency Policy and Procedure Manual requires a Psychosocial Assessment according to the requirements of the Florida Newtwork's Policy and procedure Manual.Three residential and three nonresidential files were reviewed. All psychosocial assessments were completed within 72 hours of admission to shelter or within two face-to-face contacts. All were completed by a Bachelor's or Master's level staff and reviewed by a supervisor. Of the files reviewed, no youth was identified with an elevated risk of suicide so no Assessment of Suicide Risk was required. E151-12 had an Assessment/Intake form that was in compliance with the information found in a psychosocial but was not titled as such. No exceptions

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency Policy and Procedure Manual requires a case/service plan according to the requirements of the Florida Network's Policy and Procedure Manual. Three residential and three nonresidential files were reviewed. All case/service plans reviewed were individualized with appropriate interventions and goals as identified by the Psychosocial Assessment. All case/service plans specified the service type,frequency and location; persons responsible;target dates for completion;and actual completion dates. All reviewed case/service plans had a counselor and supervisor signature. File E330-12 did not have the youth's signature but file documentation showed the youth was refusing to participate in

CINS services. Three files had parent signatures on the case/service plan and one plan without a signature was a new admission to shelter. Of the six cases reviewed, only three were eligible for a progress review. Three files did not have parent signatures on the case plan but one was a new admission to shelter. E151-12 and E344-11/12 did not have a parent signature on the case/service plan. Of the three cases eligible for case/service plan progress review, E186-12 had a counselor's signature for a 30 day review and all signatures required for a 60 day review. E151-12 had no documentation of review by staff, the youth or the youth's parents. E273-12 had a progress note of 9/10/12 indicating a review of the case/service plan but no review signatures on the case plan indicating this review.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

The agency Policy and Procedure Manual requires Case Management and Service Delivery according to the requirements of the Florida Network's Policy and Procedure Manual. Three residential and three nonresidential files were reviewed. All files showed coordination of service plan implementation, monitoring of the youth's family's progress in services and provision of support for families. There were no out-of-home placements outside of shelter. There was one referral to the case staffing committee but no referrals for judicial intervention or need to accompany a family to court hearings. There was documentation of case monitoring and referrals for additional services when appropriate. The two closed cases reviewed were within 180 days so this follow-up was not noted or due. No exceptions

2.05 Counseling Services

Satisfactory Limited Failed

Rating Narrative

The agency Policy and Procedure Manual requires Counseling services according to the requirements of the Florida Network's Policy and Procedure Manual. Three residential and three nonresidential files were reviewed. All files indicated clients were receiving individual, family and group counseling services in accordance with their case plan which included group counseling 5 days a week for those in shelter care. There was good coordination between the presenting problems, psychosocial assessment, case/service plan and case management. Progress notes were detailed, clear and completed for all sessions. This indicator requires an on-going internal process that ensures clinical review of case records, youth management and staff performance regarding CINS/FINS services. There was supervisory review of all written case work. From speaking with clinical staff and observation during the peer review, there is discussion and review of case work and client's progress. Of the cases reviewed, there appeared an inconsistency between supervisor's review of casework and staff performance and the documentation of these staffings and supervisory review. E273-12 progress notes report the youth felt a translator was not accurate in interpreting sessions for her mother. There is no documentation in the file that this was addressed with the client or presented to a supervisor. Reviewer noted there was a change in translator at a subsequent session but no indication as to why this occurred or if it would continue. The Clinical Director indicated the counselor was responsive to the youth's concern and stated the translator was changed and this concern had been discussed with a supervisor. E151-12 opened on 2/17/12 documents a staffing on 3/2/12 to continue services but no further staffings were noted and the case was closed on 6/10/12. E186-12 opened 5/1/12 documents a staffing on 5/7/12 to continue services and no further staffings are documented. This file remains open. Staffings were noted on the contact sheet and there were no file notes as to discussion or supervisory recommendations.

2.06 Adjudication/Petition Process

Satisfactory Limited Failed

Rating Narrative

The agency Policy and Procedure Manual requires Adjudication/Petition Process according to the requirements of the Florida Network's policy and procedure Manual. Three residential and three nonresidential files were reviewed. Of these, E330-10 was involved with the CINS process. From talking with assigned counselor, the agency has few CINS cases and he has never worked with one before. He appeared to have familiarized himself with the requirements for the CINS process and was able to discuss the various time frames and case activities accurately. The family and committee members were notified of the case staffing committee meeting within specified time frames. The case staffing committee meeting included required attendees and involved community representatives. The family was provided a case plan and a written report was provided to the family within 7 days of the meeting. There has been no judicial intervention at this point. The agency has identified regular committee members and committee meetings are scheduled as needed. The assigned counselor was unable to locate the written request from the guardian requesting a case staffing committee meeting. Consequently, reviewer was unable to determine if the case staffing was held within 7 days of the guardian's request. It did appear to be within the general time frame of discussions with the guardian.

2.07 Youth Records

Satisfactory Limited Failed

Rating Narrative

The agency Policy and Procedure Manual requires Youth records be maintained in accordance with the requirements of the Florida Network's Policy and Procedure Manual. Files were observed in locked file cabinets and files were marked confidential. File information was accessible to program staff. Youth records were neat and orderly so that staff can access information. One shelter file was not marked confidential. The file number was not noted and staff was made aware of this. This was an exception and not indicative of any other errors noted on this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The LSF-NW residential component houses ten (10) residents. According to the agency's organizational chart the Currie House youth shelter staff consists of a Shelter Services Manager, a Youth Care Specialist (YCS) III, a Dietary Specialist, two (2) YCS II, and twenty-one (21) YCS I staff members. At the time of this QI program review, there are a total of seven (7) youth in the youth shelter.

The residential shelter is co-located with the agency's administrative offices. The administrative offices are connected to the main structure of the youth shelter so that all staff members have easy access to the residential facility to provide counseling, supervision and other support services. The program has two sets of therapists, one to serve the shelter and one for the non residential youth and their families. The Currie House youth shelter serves 2 different resident populations.

The LSF-NW has on-going contract with the Florida Network of Youth and Family Services to provide CINS/FINS services. This contract serves youth that are considered status offenders. These services include entry level of intervention and treatment for youth and families that are at risk for legal complications such as chronic runaway, lockout from the home or repeated school truancy. The agency also has a contract with the Family First Network (FFN), which is division of the Lakeview Center. The Lakeview Center is a provider under the Department of Children and Families (DCF) network. Under the terms of this contract, LSF-NW is required to provide reunification and or placement care for youth that are in the Foster Cares. Both groups of youth receive similar is not the the same service offering, interventions and treatment.

3.01 Youth Room Assignment

Satisfactory Limited Failed

Rating Narrative

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

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency had a total of six (6) client files were reviewed for adherence to all the requirements. Of these files, all 6 met the general requirements for this QI indicator. These requirements included that the agency completed checking youth admitted to the program for contraband, disciplinary actions, dress code, access to medical and mental health services, visitation, mail and telephone access, grievances, emergencies, map of the facility, room assignments, suicide prevention and ideas of self-harm.

All files reviewed indicate that each youth completed the agency's orientation process in less than 24 hours.

3.03 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

At the time of this onsite review, the majority of areas in the youth shelter environment are clean and organized. The shelter contains a Day Room, two (2) YCS offices, six (6) resident bedrooms, four (4) single bathrooms, dining room, kitchen, wash room and storage closet. The administrative offices are adjoined to the youth shelter which allow easy access for administration, clinical and counselors to program participants and staff members. During the facility tour the monitor observed that the ice maker in the kitchen had some minor evidence of small algae growth near the water/freeze basin. In addition, the youth shelter and transportation vehicleless did not have first aid kits that contained antibiotic ointment and eye wash. The agency did produce antibiotic ointment for the residential shelter and transportation vehicles prior to the close of the onsite QI review. One (1) staff member vehicle was found unlocked during the inspection of the agency parking lot. The agency reported that the staff member that owned the vehicle reported that the vehicle could not be locked due to a faulty locking mechanism. Dust accumulation was observed on some AC vents and on top of Emergency Light in the Day Room. The agency cleaned the aforementioned areas while onsite. Tiles in the Day Room entry way between dining room and day room shows evidence of small cracks. The tiles observed

appear to be set upon unlevel flooring which causes sbreaks due to the stress and pressure of daily foot traffic. This observation was reported to the Residential Supervisor. Two (2) clothes hangers with a metal hanging hooks were found in the locker of one of the girls bedrooms. These hangers were removed while onsite.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The shelter utilizes a program log book to document all major events, activities and incidents that occur in the residential youth shelter. The program log book is a large volume and contains 512 pages. The current logbook contains color-codes that represent several categories that include Yellow for very important; Pink for late entries; Blue for intakes and discharges; Orange for staff sign-in/out; Green for notification; Red Ink for incidents/accidents/fire drills/injuries; and Green Ink for medications/special medical conditions. In addition, the agency has more than twenty (20) abbreviated letter codes.

The monitor reviewed logbooks over the last six (6) months. The agency logbooks reviewed capture shelter alert color codes, incidents, client admissions, medication distribution, outings, staff member signing-on and signing-out, youth counts, visitation and supervisor review entries.

The current logbook contains some documented entries found written in blue ink. In addition, there were three (3) late entries found. Further, the Direct Care staff do not write that they have documented reading the previous 2 shifts.

Rating Narrative

The agency has a policy to address the Daily Activities and Schedule. The policy was revised in July 2012. The agency has four (4) schedules that include Weeday, Weekend, Summer and Holiday. A review of the current activities schedule was reviewed. This schedule includes Wake Up, Breakfast, Chores, Clean Up, House Meeting, Life/Social Skills, Free Time/Outside (Optional), Activities, Homework, Recreation Activity, Dinner, Card Conference (Role Plays), Privilege Options/Role Play, Wind Down, Personal Hygiene/Showers, Bedtime and Lights Out. During the QI review, the current daily schedule was followed as listed. The other three (3) schedules follow a similar format excluding the Weekend and Holiday schedule. The Weekend and Holiday schedule include increased outings, supervised free-time, recreation, faith-based options and community partners visiting the residential shelter.

3.06 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency a comprehensive policy regarding their Behavior Management System. The agency's current policy is labeled Behavior Management Strategies and was approved by the Agency Director on July 31, 2012. The current policy addresses the major components that include rewards on youth achievement, consequences and sanctions, effective balance of interventions that match the severity of the behavior. The current BMS is based the Boytown Model's behavior Management system that focuses on providing a syst A review of the training files indicates that there is evidence that staff members training have received BMS training (J.Hawthorne). The agency reported that the program conducts BMS training during the employee's initial training year. The agency has both an expanded 5 day training, as well as a 2 day training for all staff members. A review of work performance revealed that staff members are assessed by the Residential Program Director. The Director provided documents that include a formal observation tool. The most recent documented BMS Observation took place in March 2012. The monitor interviewed staff members (3) regarding their knowledge of the BMS system. The monitor interviewed Patricia Rock, Program Administrator regarding any observations or evaluations conducted by supervisors of staff member's ability to properly execute the behavior management system.

3.07 Behavior Interventions

Satisfactory

Limited

Failed

Rating Narrative

The agency have a comprehensive policy on Behavioral Interventions. The agency's current policy is labeled Behavioral Interventions and was approved by the Agency Director on July 31, 2012. The current policy addresses the major components listed in this CINS/FINS Indicator and includes references to counseling, verbal intervention, de-escalation techniques as the primary methods used prior to physical intervention. Staff are instructed and encouraged to utilize inteventions that are least restrictive. The agency policy does list Manual Restraint to be used as a measure of last resort. Parent and guardians are notified verbally and recie a copy of manual restraint procedures used by the agency. The only restrictive behavior intervention used the by agency is Crisis Prevention Institue (CPI)training. CPI is is a intervention method that is approved for use by the Florida Network of Youth and Family Services (FNYFS)in CINS/FINS and is a nationally recognized. A review of onsite youth and staff surveys, incident, grievances and iternal written discipline/work performance reports were reviewed to determine the presence of any

physical interventions. At the time of this onsite review, the agency verbally reported that there were no cases of physical intervention in the last. The agency training files indicate the staff receive training on CPI during their first year of training. A sample of six (6) training files indicated that all staff files contained evidence of CPI training.

3.08 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive policy on Staffing and Youth Supervision. The agency's current policy is labeled Staffing and Youth Supervision and was approved by the Agency Director on July 31, 2012. The agency's policy is consistent with Florida Administrative Code, DCF Licensing, CINS/FINS contract and policy and procedure requirements. These requirements require that the program maintain a minimum staffing ratios of 1:6 to every youth during awake hours and 1:12 to every 12 youth during. A review of the staff schedule was conducted for the period of July 2012 and September 2012. All schedules reflect adequate staffing of Youth Care Workers across three (3) work shifts. The First shift (6:00 am – 2:00pm and 9:00am – 5:00pm) schedules a total of three (3) direct care staff per shift on Sunday - Saturday. In addition, on Monday – Friday this shift also includes the Residential Supervisor on Duty and/or On Call on a daily basis. If needed, a total of four (4) staff members are scheduled on Monday – Friday on both the first and second shifts. The second shift (2:00pm – 10:00pm and 3:00pm – 11:00pm) schedules a total of 4 direct care staff on Monday - Friday. In addition, similar to the first shift, if needed the Second shift also includes the availability to schedule an On Call staff member each day. The Third or overnight shift consistently schedules (10:00pm – 6:00am and 11:00pm – 7:00am) two (2) staff members (a minimum 1 female and 1 male staff member) seven (7) days per week. In addition, the Residential Supervisor is available on call 24 hours a day and is accessible to shelter staff members on a daily basis. The monitor observed that there are weeks documented between May 2011 and December 2011 on Mondays - Fridays on the schedule that reflect same gender staff members on the overnight shift. Exceptions: No real-time entries on the overnight Hard drive was malfunctioning with the agency camera surveillance system.

3.09 Staff Secure Shelter

Satisfactory

Limited

Failed

Rating Narrative

This location is not designated as the court-ordered Staff Secure agency for this CINS/FINS service area.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The agency provides screening, counseling and mental health assessment services. The agency has twenty-three (23) direct care staff, seven (7) counselors, a Residential Supervisor, a Shelter Services Manager and a Licensed Mental Health Clinician. The agency has a comprehensive policy that addresses requirements related to behavior, mental health and suicide assessments. The agency's current suicide assessment practices and policies have been approved by the FLorida Network of Youth and Family Services. The agency also has an active health screening process that detects for the existence of acute health issues of all residents screened for admission into the CINS/FINS residential program.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

There is a comprehensive written policy that addresses the Health Care Admission Screening. The policy covers all areas outlined in Standard 4.01 which include screening for current medications, existing (chronic and acute) medical conditions, allergies, recent injuries or illnesses, presence of pain or physical distress, observation for evidence of illness, and observation for presence of scars/tattoos/skin markings.

Additionally, the health screening policy outlines screening and follow up procedures for chronic medical conditions as defined in Standard 4.01. The policy also addresses how the agency handles approval of clients on medication and how emergency medical care is coordinated.

The Team reviewed the Health Care Admission screening paperwork in six (6) residential files - three (3) closed and three (3) open. Health Care screening paperwork is completed by Youth Care Staff at the time of the youth's intake. In each file review the information gathered was consistent with Standard 4.01 and with the agency's policy. Interviews support that communication occurs between shelter staff completing the intake and the counselor with regard to medical conditions of the youth.

Of the files reviewed the need for follow up medical care was not warranted. However, interviews conducted with shelter and clinical staff support that the agency's procedure for parental involvement in coordination of medical care and documentation of medical referral in the pro log are consistent with the agency's policy as outlined by Standard 4.01.

There were no exceptions noted in Standard 4.01

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive written policy that details the program's suicide prevention and response procedures. The policy includes roles of each staff, procedures for after-hours suicide assessment/screenings, guidelines for how youth are stepped down from constant sight and sound, and timeframes for completion of the suicide assessment. Upon intake youth are screened for suicide risk by the Youth Care Staff using the Evaluation of Imminent Danger for Suicide (EIDS). If the youth scores high risk/imminent danger then the youth is placed on constant sight and sound until a suicide assessment is administered by a counselor. The program's suicide assessment has been approved by the Florida Network. Interviews with staff indicate that the program's practice is consistent with their policy.

There were six (6) files reviewed. Of the six (6) files reviewed, three (3) youth were discharged while still on constant sight and sound. The program's policy indicates that when youth are discharged on sight and sound that the guardian will be notified. In one (1) of the three (3) cases there was not documentation that staff made the guardian aware of the elevated supervision level. In one (1) file there were three (3) days of daily sight and sound logs missing from the file. The pro log indicated that the youth was on sight and sound during the overnight shift, however day time documentation was missing. Four (4) of six (6) files reviewed did not contain supervisory review of the Suicide Risk Evaluation as outlined in policy. Interviews with staff confirm that this is an area of improvement in order to fully meet the Standard 4.02 requirements. In one (1) of the files reviewed there was not documentation in the pro log that the youth had been removed from sight and sound by the counselor. However, in further review of the youth's file it was confirmed the youth had been removed in accordance with policy, just not documented in the pro log. It should be noted that as a result of the missing documentation the oncoming shift began providing constant sight and sound, even though the youth had been removed.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive policy on Medications. The agency's current policy is labeled Medications and was approved by the Agency Director on July 31, 2012. The agency's policy contains written content that addressed the safe and secure storage, access, inventory, disposal and administration of medication in accordance with the DJJ Health Services Manual. Onsite observations found that all medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. All medication was stored in a double locked cabinet. Oral medications are stored separately from topical medications. There were no injectable medications on site, or identified as needed for any youth during the time of the onsite review. The shelter has a system in place for refrigeration of medication if needed. At the time of this onsite QI review, there was no medication that required refrigeration.

Controlled medications are locked in a cabinet behind two (2) locks. At the time of this review, there were no CINS/FINS youth that were on Controlled medication. The agency maintains a Medication Distribution Binder. The agency does provide over-the counter medication. The agency distributes Acetaminophen (Tylenol), Ibuprofen (Motrin), Antacids (Pepto Bismol, Milk of Magnesia) liquid or tablet form if needed during the resident's shelter stay.

Sharps are maintained in a locked cabinet. The sharps maintained in the shelter included scissors, razors, finger nail cutters. The agency does not maintain sharps in the filing cabinet in YCS II office. Inventories on sharps are conducted one time per week on the third shift. The agency provided the previous six (6) month sharps inventories dating back to March 2012 to September 14, 2012. The program utilizes a Medication Distribution Record (MDR) form that is specific to their agency. The MDR contained all the necessary information to include: youth's name (printed and signed), date of birth, allergies, side effects, picture of youth, staff and youth initials on MAR when medication is disbursed and received. A review of six (6) client medication records were conducted onsite. At the time of this onsite review, only one (1) CINS/FINS client was on medication. The other five (5) findings were closed files. All files reviewed contained the general documentation requirements. Exception: The agency had a total of 2 documented internal incidents that indicate medical errors. These 2 errors were not reported as required. These incidents were recorded in the agency's internal incident binder. However, these incidents had not been called as required by DJJ Policy 63-F 11.004 (j) Health or Mental Health/Substance Abuse Services Complaint: (3) Omitted medications.

Review of the agency policy revealed that the agency does not currently address Verification of Medication. Based on recent information from the DJJ Office of Health Services. The agency must revise its current policy to incorporate the agency's ability to verify all medications entering the residential youth shelter. Due to recent concerns regarding risks related to the distribution of medications, the FNYFS has deemed it necessary for all local CINS/FINS service providers to revise and implement Medication verification procedures. Your agency must update and its current practice in the area to be able to meet this requirement.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The agency has a comprehensive written policy to ensure that youth are properly identified as having medical, mental health or food allergy needs. The pro log and the youth's file are used to document such alerts. Colored dots are assigned to the files to indicate to staff which alerts a youth has been assigned. In six (6) files reviewed all contained appropriate assignment and use of the alert system.

Once a file is closed, the alert dots are removed from the file. Because of this, it was difficult to determine with certainty if the youth was correctly assigned to the alert system while they were in shelter. However, of the closed files reviewed there was evidence in the pro log that the youth had been properly assigned alerts.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

There is a comprehensive written policy that addresses Episodic and Emergency care with regard to obtaining off-site emergency services, parental notification requirements, and the use of a daily log. During the past six (6) months three (3) incidences were reviewed which required emergency medical care. In all three (3) instances the care was obtained, parents were notified and the pro log maintained the details of the incidences. In two (2) situations the youth were taken off-site by the parent/guardian. In one (1) instance emergency medical services (EMS) was contacted and the youth was taken to the hospital for further treatment.

In a review of the pro log it was difficult to determine if the agency has a consistent procedure for documenting off-site medical care. In one (1) of the incidences the specific type of on-site care was not described. It could not be determined if or what type of first aid was given to the youth prior to EMS arrival.