



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Hope House

on 06/26/2014

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 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 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	Limited
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
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: 95.83%
Percent of indicators rated Limited: 4.17%
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, Lead Reviewer, FOREFRONT LLC/Florida Network of Youth and Family Services

Mark Shearon, Chief Compliance Manager, Arnette House

Patrick Minzie, Shelter Program Manager, Capital City Youth Services

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 3 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 3 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 7 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 type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" 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 checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 4 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 8 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 11 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 10 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 11 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Supplemental Contracts | 7 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> Telephone Logs | |

Surveys

- 4 Youth 4 Direct Care Staff 4 Other

Observations During Review

- | | | |
|---|--|--|
| <input checked="" 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 checked="" 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 checked="" type="checkbox"/> Youth Movement and Counts |
| <input checked="" type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

All Lutheran Services Florida-Northwest (LSF-NW) staff were professional and assisted upon request. The professionalism and timeliness in which staff were made available assisted in expediting the overall on site review process and provided clarity as it relates to the program's service delivery, staff competency and operations.

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 the Northwest region of the Florida Panhandle. Each youth shelter operates 24 hours a day, 365 days a year and serves a range of youth age 10-17 years of age in each program. At the time of this onsite Quality Improvement (QI) review, Hope House Currie had five (5) CINS/FINS youth in the shelter and three (3) Department of Children and Families clients.

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 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 LSF NW agency has therapists that serve the shelter and non residential youth and their families. LSF-NW has an 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. The Hope House youth shelter serves 2 different resident populations. 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 service offerings, interventions and treatment.

Standard 1: Management Accountability

Overview

Narrative

The Florida Department of Juvenile Justice (DJJ) is the State of Florida's agency 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 (LSF-NW) is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in the Northwest region of the Florida Panhandle. LSF-NW utilizes two (2) youth shelter located in Pensacola and Crestview, Florida respectively. Each youth shelter operates 24 hours a day, 365 days a year and serves a range of six (6) female and male residents in these facilities. At the time of this onsite Quality Improvement (QI) review, the Hope House residential program was caring for eight (8) residents; five (5) CINS/FINS and three (3) DCF youth.

The agency provides a broad range of service offerings to youth and families in the Okaloosa and Walton service region through strategic outreach and general marketing efforts. In addition, the agency has established and continues to seek several interagency agreements with local community stakeholders and partners. These local area stakeholders and partners include local schools, law enforcement, United Way, local area businesses, faith-based organizations, mental health and substance abuse partners, homeless shelters, and various other community-based organizations.

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. Further a Document Request List was provided in advance, listing specific documents and files to be available during the onsite visit. All of the LSF-NW staff members were prepared for the onsite review and cooperative with the monitoring team which resulted in a productive and hospitable monitoring environment.

The Hope House youth shelter serves 2 different residential group care populations. The LSF-NW has on-going contract with the Florida Network of Youth 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 a 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 the CIN/FINS and FFN residents receive similar service offerings interventions and treatment.

1.01 Background Screening

Satisfactory Limited Failed

Rating Narrative

The agency's policy and procedure meets the requirement for the background screening indicator. A review of eight employee personnel files was completed; this included six new employees, one intern and one 5 year-rescreen. The six new employee screenings were completed before their start date. Two of the six employees were terminated within six months of employment. The intern background screening was completed prior to the start date on file. The one employee five year re-screen has been submitted and is currently being processed. The 5 year re-screen is not due until 7/7/14 so it was sent in over a month early.

The annual affidavit for background screens was completed prior to the January 31st due date.

1.02 Provision of an Abuse Free Environment

Satisfactory Limited Failed

Rating Narrative

The Agency has a policy regarding an Abuse Free Environment that is clear and precise. There were 6 DJJ CCC incident reports reviewed since November of 2013 and none of those DJJ CCC reports involved incidents related to Abuse or Neglect. An interview conducted with the Regional Director resulted in her reporting that there have been no Corrective Actions documented on staff in the last year. The facility has abuse number signs posted throughout the facility and client rights are given at intake. There does not appear to be any graffiti present throughout the facility. There is a clear Grievance policy in place and all youth according to the surveys are aware of the process. There were 5 staff surveys conducted and 4 youth surveys conducted during the onsite QI program review.

There are no exceptions documented for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

There is a policy and procedure in place that was reviewed and found to meet the requirements for this Incident Reporting indicator. All documented incident reports were reviewed onsite. This review includes both the internal and CCC accepted incidents. The 6 accepted incidents included: two medical, two complaints against staff, and two program disruptions. The medical reports involved a missed medication due to youth being offsite and trip the ER where youth was admitted. The complaints against staff involved meds being missed on the previous shifts. The program disruptions included staff and youth involved in minor automobile accident and pieces of youth medication found on floor of room. All 6 incidents were reported within the required 2 hours. All 6 incidents were reported the day that they occurred, 2 of which were on the following shift.

There were not documented exceptions for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

There is a signed and approved written policy that outlines staff training requirements of 80 hours for the first year employees and following first year employment, 40 hours annually for direct care staff. CPR and First Aid is listed under included training topics in the policies and procedures but is missing from the list of required trainings. The agency has an annual training plan listing all trainings for the year and includes monthly training opportunities. The agency has individual training files for each staff that includes training plans, training tracking form, and supporting documentation. Seven training files were reviewed for this indicator. Of the seven, four were employees hired within the last year and three were employees following the first year. All four of the first year employees exceeded the 80 required training hours. All seven training files contained verification of completed CPR and First Aid training for the past year.

Exceptions are documented for this indicator. All but one of the employees following the first year met the 40 training hour requirement. The staff member that fell short was on maternity leave during the year. Two out of the seven training files pulled were missing training plans.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy meets the requirements for the Analyzing and Reporting indicator. There is a policy and procedure in place that states that the agency will identify Quality Improvement teams. These teams will include representatives from both Currie and Hope house, Ryan White, and the Guardianship program. Other program areas included in the quality improvement process are; Clinical, Residential and Non-Residential, and the Sex Physical Abuse program. Hope House also has a Safety and Risk Management, Incident/Accident and Grievance team which conducts safety inspections at each residential site. These inspections are done quarterly and reports any repair needs to maintenance. The agency also completes incident reviews and searches for trends bi-monthly.

The agency focuses on safety issues routinely. Data collected as well as the season will determine what topics will be addressed during training weeks. One example of the topics focused on would be the disaster and emergency planning facilitated by outside experts.

The agency also has the following teams; Consumer Satisfaction/Program Improvement, Outcome Measurement, and Case Review teams. The agency states that data collected by the Outcome Measurement Committee are reviewed and provide surveys to participants in all of their programs. This group looks for service satisfaction data and information from clients served. The agency has case review teams that meet monthly to review case file samples for accuracy and completion of client case files.

Agency states that although their Council on Accreditation certification expired on February 28th 2013, they were granted an extension through June 2014. This was said to be due to the adding of programs during the previous year. They are currently in the process of getting re-accredited and their site visit is scheduled for June.

Within the last year, Hope House has continued to utilize their relationship with community partners to serve more youth and families. This is done through radio commercials, schools, and continued involvement with Teen Court in Okaloosa, Walton, and Santa Rosa counties. They have also gotten a volunteer organizing multiple community projects.

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 positions. The LSF Hope House location includes one counselor that covers the local Crestview and Okaloosa area and another Counselor that services the outlying Ft. Walton and outlying Walton County region. According to the agency's organizational chart, these services are delivered through non-residential staff members located at each respective site.

Non-residential services are provided to program participants and their families. These services are delivered through the agency's non-residential component. Services 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 LSF Hope House agency has a policy and procedure that is detailed and includes the content to verify that the agency policy meets the requirements of the indicator. A sample size of 8 files were reviewed to determine their adherence to the requirements of this indicator. A review of the files indicates that the agency met all of the general service delivery requirements for this indicator. Further, review of the files found evidence verifying that services of the agency are offered and accessible 24 hours a day, seven days a week; and conducting initial screening for eligibility within seven calendar days of the date of referral.

Additionally, files reviewed document that clients and parents received written information related to the handbook, available service options, the rights and responsibilities of youth and their parents/guardians, the parent brochure, grievance procedures, the possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication). Documentation of the parent/guardian brochure is documented on the last page of the psychosocial assessment in all non-residential files. Documentation in the residential files was found in the shelter file, not the clinical file.

No exceptions are documented for this indicator.

2.02 Psychosocial Assessment

Satisfactory Limited Failed

Rating Narrative

The LSF Hope House agency has a policy and procedure that is detailed and includes the content to verify that the agency policy meets the requirements of the indicator. A total of eight (8) files were reviewed to assess the agency's adherence to this indicator. Of these files 6 out of 6 files reviewed have evidence that the psychosocial assessments were initiated within 72 hours of the youth's admission to the shelter. All of the assessments were completed within 24 hours after admission. All assessments reviewed were completed by a Masters level staff member and included dated signature to indicate a supervisory review upon completion.

A total of 8 youth files reviewed contained evidence of a suicide risk assessment completed by a Masters level staff member as part of its mandatory policy and procedure requirement.

No exceptions are noted for this indicator.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

The agency has a written agency policy and procedure for Case Service Plans. The said policy requires that the plan be completed within seven (7) working days of the completion of the psychosocial assessment. The agency's requires reviews to be conducted every 30 days for the first three (3) months and every six (6) months thereafter. As required by policy, all plan reviews are to contain evidence of documenting each youth's progress in working towards goal achievement and all necessary adjustments to the service plan.

A review of four (4) randomly selected client files resulted in all files containing documentation that verifies that the case/service plan was developed within seven working days of the psychosocial assessment being completed. In addition, this review confirms that these youth files contain reviews charting progress every 30 days for the first three months. No files reviewed required a six month review.

Exceptions are noted on this indicator. There are files that do not contain consistent dates with plan review signatures. Dates must consistently document when case plans are reviewed, updated or changed by all parties involved. In addition, a service plan was not in the file on the initial review of 1 case file. The service plan was found and placed in the filed during the on site review. No other exceptions were noted for this indicator.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that meets the requirements of the Case Management and Service Delivery. The policy requires that all youth are assigned a counselor/case manager to follow the youth's case and ensure delivery of services through either direct provision or referral. The standard and the policy both requires coordinating referrals for services based on the assessment of the youth's problems and needs, coordinating the service plan implementation, monitoring the progress in services, providing support for the family and monitoring any out-of home placement if deemed necessary.

A total of four (4) randomly selected client files were reviewed to assess agency performance related this indicator. Of these 4 files, all included documentation to indicate that the counselor established referral needs to services based upon the youth's psychosocial assessment. Some cases had coordinated service plan implementation and provided limited documented monitoring of the youth's/family's progress or clear documentation of support provided to the family. No referrals to the case staffing committee were identified by the facility.

Exceptions are noted for this indicator. Several cases are open for an extended period beyond the average service time of 12-16 weeks. Many cases observed onsite are open months beyond the average service period. Further the contact with the client is not documented to clearly explain or justify the extended service deliver period. Best practice would be to close cases after a 30-day period of non-activity. This would provide the agency with an opportunity to serve additional youth and families in crisis.

In addition, there is limited or minimal follow up documented for youth referred by the agency for Baker Act placement. Per the agency's policy these referrals should document follow up as to the status of the youth's and family's problems and needs, monitoring the progress in services and providing any needed support for the family.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The written agency policy and procedures for this indicator meets the requirements of this Counseling Services. The agency's policy requires provision of individual and family counseling and the provision of group counseling in shelter at least five days per week. The policy also requires non-residential program's provision of community-based services in the youth's home, a community location, or the provider's office.

A total of five (5) randomly selected client files were reviewed onsite. The findings from this file review resulted in the agency having documented proof that the youth had received counseling services in accordance with the case service plan for that youth. The filed documentation across the 5 files demonstrated evidence of both individual and family counseling is documented in the files. Files also incorporate information across multiple documents that include a residential client file, documentation of group notes in the clinical file, activity log and the log book.

Five out of 5 files reviewed documented that the youth's presenting problems were addressed in the psychosocial assessment, the initial case service plan. In general, each client file contained evidence of case notes being maintained for all counseling services provided. Client files also confirm generally consistent peer review processing that ensures clinical reviews of the case files and staff performance for all residential cases. Peer review process is not as well documented for non-residential client case file review.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has detailed policy that addresses the requirements of this indicator. A sample size of 1 file was reviewed to determine their adherence to the requirements of this indicator. A review of the sample indicates that the agency is not meeting some of the required components of this indicator. This case is the first Case Staffing requested in several years due to the local court's use of the local Truancy Program.

Exceptions were noted in the following areas:

- limited documented evidence of notification prior to staff;

- inconsistency and lack of documentation of regular Case Staffing meetings;

- Evidence of a written report withing 7 days of Case Staffing meeting; and

- Loose and unstructured internal procedures for the case staff process.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

The agency has detailed policy that addresses the requirements of this indicator. A sample size of 6 files were reviewed to determine their adherence to the requirements of this indicator. A review of the sample indicates that the agency met all of the general service delivery requirements for this indicator.

No exceptions were noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The LSF-NW Hope House residential component houses up to eight (8) residents. According to the agency's organizational chart the Hope House youth shelter staff consists of a Shelter Services Manager, a Youth Care Specialist (YCS) III (Residential Supervisor), a Dietary Specialist, two (2) YCS II, and thirteen (13) YCS I staff members. The Residential Supervisor oversees the day-to-day operations of the youth shelter. The Hope House youth shelter serves 2 different resident populations. At the time of this QI program review, there are a total of eight (8) youth in the youth shelter.

The program provides group sessions to clients a minimum of five (5) days a week on various topics that address issues including substance abuse prevention, anger management, effective communication, leadership skill building and many others. The agency utilizes an behavior management system that is also used in its other residential programs. The residential shelter is a converted large home that also houses the agency's administrative offices. The administrative offices are located on one side of the 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 facility has two (2) large bedrooms that are located on the second level and are separated by gender. Each room is equipped with four (4) beds. Each room also includes a bathroom. There is also a YCS work station and camera surveillance monitor located on the second level adjacent to the resident bedroom. All rooms, bathrooms and linens were clean at the time of this onsite program review. All kitchen areas were clean and food preparation, storage and disposal practice is satisfactory. All common areas are neat and orderly. In addition, all safety equipment is in place and operational.

3.01 Shelter Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The residential shelter is a converted large 2-story home that also houses the agency's administrative offices. In general the residential CINS/FINS shelter Agency has a very clean and well kept facility. The furniture is sturdy and functional. There does not appear to be any graffiti present and the agency should be commended for that. Staff and Client schedules are clearly posted through out the facility and appears to cover all contractual requirements for physical activities and faith-based activities.

There are no exceptions in this area.

3.02 Program Orientation

Satisfactory
 Limited
 Failed

Rating Narrative

Every youth entering the facility is given a handbook explaining all the programs expectations. The youth during intake reviews with staff the program rules, program expectations and behavior management system. The agency has a very clear and precise system in place for the youth to receive this information as well as the parents/guardians. The youth as well as the parent/guardian sign that they received the information and it is saved in the file. Seven charts were reviewed, 5 open and 2 closed charts and all of them had clear documentation on Program Orientation for the youth.

There no exceptions in this area at this time.

3.03 Youth Room Assignment

Satisfactory
 Limited
 Failed

Rating Narrative

The Agency uses the Florida Network CINS/FINS Intake Assessment form for gathering the required information about youth's history, status, trauma, and violence risk. The staff use this information to make decision on room assignments and risk potential as well as the agencies on forms. Seven files were reviewed, 5 open charts and 2 closed charts. All the files reviewed had clear documentation for room assignments

present in all the charts.

There are no exceptions in this area at this time.

3.04 Log Books

Satisfactory Limited Failed

Rating Narrative

The Agency uses a hard bound covered logbook that has a clear table on the front cover that explains the color code system of highlighters used throughout the log. All entries are clear and legible. Corrections were made correctly and no white out is present in the book. Program Manager makes entries regularly throughout the book and is done in a different color ink which makes it easy for reviewers to see. All entries give the date and time of the event and youth's name and staff involved are present. Statements are brief but gave appropriate information for the event.

There are no exceptions in this area at this time.

Rating Narrative

The agency has a very clear policy and procedure on Behavior Management and Behavior Intervention. Seven staff files were reviewed and all seven showed signs that everyone had been trained in the Behavior Management System and the Florida Network approved CPI Training for verbal De-escalating skills and restraint training. Upon interviewing the Director, she stated that even though staff are trained it is only a last resort and only if life threatening. The Behavior System is a very intense system with lots of chances for youth to get points and work on specific targeted skills, as well as receiving positive praise, and opportunities to practice social skills. A wide variety of rewards are used with the BMMS including snacks, video games, computer time, and a points store. The Program Manager meets with new staff to observe them using the BMMS and de-briefs with them afterwards to ensure the system was used correctly. Program Manager also meets with the staff on a quarterly basis to go over their job performance and expectations. Youth and staff review point cards at the end of each day and if youth do not have at least 10,000 positive points then their youths' privileges are taken for the next day.

There are no exceptions in this area at this time.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

Staff schedules were reviewed and the Agency met all contractual requirements for Staffing Ratio's. A 1 to 6 ratio is kept throughout all shifts and at least one male and one female is on every shift with some exceptions. The agency states they are looking for 2 part time employees to assist in this problem. The agency has a policy for bedchecks that exceeds the Networks requirements of 15min. The Agencies policy is every 10min bed checks. After interviewing Program Nutrientist it was reported that the camera system holds a backup of 2 weeks however it could be possible to get more if needed. Upon interviewing the Program Manager, it was reported that the video camera system is not functioning properly due to the recent storm that went through it causing the system to go down. A new system was purchased but is not working properly at this time but a work order has been put in for camera company to come out and fix it

There are no exceptions in this area at this time.

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

The Agency is listed as a Staff Secure Facility, however after interviewing the Regional Director she has stated that they have not ever had a staff secure youth. The Agency also works with the Domestic Violence Respite but due to low census and trying to bring up there monthly

benchmarks for the Florida Network the agency has not excepted any youth under the DVR contract within the last six months. The Agency however does have clear and precise policies and procedures on how to deal with the Special Populations Group.

With no charts to review in this area there is no exceptions in this area at this time.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The agency provides screening, counseling and mental health assessment services. The agency has twenty (20) direct care staff, six (6) 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 for 2012-2013. 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. The Hope House staff members 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 provides risk screening and identification methods to detect youth referred to their programs with mental health and health related risks. Specifically, the agency utilizes screening and a CINS Intake form to determine eligibility and various screening methods to determine the presence of risks in the youth 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 agency also uses a general alert board and colored dot system to inform all staff members on each shift of the health and mental health status of all youth in residential youth shelter.

The Hope House staff assist in the delivery of medication to all youth admitted to the residential youth shelter. The agency operates a detailed medication distribution system. The agency provides medication distribution training to all direct care staff members, first aid response, CPR, first aid, fire safety, emergency drills and exercises and training on suicide prevention, observation and intervention techniques. Agency staff members are also required to notify parents/guardians in the event that a resident has a health injury. At the time of this onsite Quality Improvement review, the agency has one (1) staff members that are licensed clinicians. This staff member is involved in the review of all residential clients that screen positive for suicide risk. The agency has a full complement of staff of both male and female staff members across all three (3) work shifts. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training. During this onsite QI review, the agency provided an up to date list of agency staff members that have received medication distribution training and are authorized to provide distributed medication to residential clients.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The Agency has developed there own Healthcare Screening form that is very clear and precise and captures more information about the youth than required contractually. Five open charts were reviewed and every chart has a Healthcare Screening within it and all the information is filled in. The Agency has a clear and well written policy and procedure on Healthcare screenings and it is followed by all the staff.

There are no exceptions in this area at this time.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The agency has detailed policy that addresses the requirements of this indicator. A sample size of 4 files were reviewed to determine their adherence to the requirements of this indicator. A review of the sample indicates that the agency met all of the general service delivery requirements for this indicator.

No exceptions were noted.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

The Agency has a clear policy regarding medications and the youth care workers appear very well versed in the medication process. Medications are kept behind two locks and controlled meds are locked in an extra lock box. Meds are counted at the end of each shift by the off going and the on-coming youth care worker. Over-the-counter meds are counted on a weekly bases on Sunday's. The youth's picture,full name,side effects, and allergies are listed on the med sheets. every staff responsible for assisting in the delivery of medications sign and initial every med sheet. There is a spot on the form for med verifacation with the pharmacy. A med count was observed and counts were accurate. There were 3 CCC incident reports during this evaluation period regarding missed dosages of medication. The Agency did provide proof that the staff that were involved in the incidents were spoken too and retrained if necessary.

There are no exceptions in this area at this time.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

The Agency has clear policy and procedure for there Alert Process and it is documented throughtout the clients chart and the pass down logs as well as the medication book. The dietician recieves a "Client Dietary Needs" sheet from the youth care worker which list food allergies and any special diet needs. Within the passdown log the Agency has a plan that list Med/Allegies,Side Effects,Mental Health,Appointments,etc. The Youth Care Workers sign the form at the beginning of each shift to acknowledge that they are aware of the forms.

There are no exceptions in this area at this time.

4.05 Episodic/Emergency Care

Satisfactory Limited Failed

Rating Narrative

The Agency has a very clear policy and procedure on this standard. At time of review there was only one incident that required emergency room visit. The incident was clearly documented in the logbook and on the Agencies Incident Report. The Agency does not have a Episodic/Emergency Care Log the use the Agency Incident Report which is very exact and collects lots of important information. The youth that was involved in the incident was discharged at time of admition to the hospital. Agency documented the incident very well and all parties were notified according to contract requirements.

There no exceptions at this time.