



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

Review of LSF NW- Hope House

on 04/14/2015

## 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 Needs 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 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory:80.00%  
Percent of indicators rated Limited:20.00%  
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 Carr, Lead Reviewer, FNYFS/FOREFRONT LLC

Pamela Purnell, Residential Supervisor, CDS Behavioral Health Services - Palatka

Mark Shearon, Compliance Manager, Arnette House

Brooke Brown, Family Counselor, Anchorage Children's Home



Katherine St. Fil, MS Intern, Florida Network of Youth and Family Services

**Persons Interviewed**

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

**Documents Reviewed**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Accreditation Reports                   | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input 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                         | 7 Health Records   |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 MH/SA Records  |
| <input type="checkbox"/> Contract Monitoring Reports             | <input checked="" type="checkbox"/> PAR Reports                      | 9 Personnel Records  |
| <input checked="" type="checkbox"/> Contract Scope of Services   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 14 Training Records/CORE                                       |
| <input checked="" type="checkbox"/> Egress Plans                 | <input checked="" type="checkbox"/> Program Schedules                | 10 Youth Records (Closed)                                      |
| <input checked="" type="checkbox"/> Escape Notification/Logs     | <input type="checkbox"/> Sick Call Logs                              | 12 Youth Records (Open)  |
| <input type="checkbox"/> Exposure Control Plan                   | <input type="checkbox"/> Supplemental Contracts                      | 6 Other  |
| <input checked="" type="checkbox"/> Fire Drill Log               | <input checked="" type="checkbox"/> Table of Organization            |  |
| <input checked="" type="checkbox"/> Fire Inspection Report       | <input type="checkbox"/> Telephone Logs                              |  |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 3 Youth | 5 Direct Care Staff | 0 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 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 type="checkbox"/> Medical Clinic                       | <input 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

No Probation Respite Cases were referred to the agency for review as a sample Indicator 3.07 Special Populations.

## Strengths and Innovative Approaches

### Rating Narrative

The agency conducts YCS II & Supervisor Training classes that will meet quarterly.

The agency exposes both residents and staff members to various international cultures through events, activities and and celebrations.

The agency has a staff member that is designated to deliver Life Skills to residents during their shelter stay. The agency specifically staffs a part time YCS to perform these duties. They also learn to comparison shop for various life expenses and how to fill out job and housing applications.

The resident participate in activities at the Crestview Teen Center on a weekly basis. At the Teen center, residents learn to participate in various activities such as dancing, cooking class, drama, painting.

The agency hosts Dozer the Therapy Dog. Dozer comes monthly to interact with the residents.

The agency also exposes residents to faith-based activities at local churches and bible study weekly.

Title X tutor that comes twice a week to work with the clients on academics. The tutor is a teacher one of the middles schools in Crestview.

Operation of the CATS group (an aftercare group) interacts with the younger children who come here for tutoring, tutoring them, playing games, etc.

The agency hosts a food program 6 days a week.

The agency has experienced an increase in community partners to present to their program to the staff at regular meetings.

The agency has provided services to nearly twenty (20) Domestic Violenc clients since the begining of the calendar year.

## 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 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 emergency youth shelter operates 24 hours a day, 365 days a year and serves a range of ten (10) 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 four (4) CINS/FINS 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 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.

### 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 thirteen (13) employee personnel files was completed. This review included seven (7) new employee records and six (6) 5-year rescreen records. One volunteer record was also reviewed. One of the 7 new employees resigned in the first 6 months of employment. All new employees were screened prior to their hire date and all 5 year rescreens were completed prior to the anniversary of each staff member's date of hire.

The Annual Affidavit for Background Screens was completed prior to the annual January 31<sup>st</sup> due date.

### 1.02 Provision of an Abuse Free Environment

Satisfactory  Limited  Failed

#### Rating Narrative

The policy manual contains procedures that comply with the requirements for the agency to adhere to the Abuse Free Environment indicator 1.02. The agency has a policy on the provision of an Abuse-Free Environment for staff members/employees that interact and provide direct care services under its CINS/FINS contract with the Florida Network of Youth and Family Services. This policy was last updated and signed by the agency on September 2014.

The facility has Abuse Registry telephone number signs posted throughout the facility and client rights are given at intake. At the time of this onsite QI program review, there does not appear to be any graffiti present throughout the facility.

A total of three (3) out of four (4) residents were surveyed onsite during the review. All 3 reported that they did know about the abuse hotline available for youth to report abuse at this shelter. None reported having made an attempt to call the abuse hotline. All 3 youth reported that adults here are respectful when talking with them and other youth. Two (2) report No. None of the youth surveyed reported having heard any adults threaten them or other youth. All 3 reported feeling safe at this shelter.

A total of five (5) Direct Care Staff members were surveyed online during the onsite program review. These staff were surveyed and asked in the past year, how have the working conditions been at this shelter? Four (4) reported Good and one (1) reported Very Good. All 5 employees stated that they have not observed a co-worker telling a youth that they could not call the Abuse Hotline. A total of 4 staff reported No that they have ever observed a co-worker using profanity. All 5 staff reported that they have never observed a co-worker using threats, intimidation, or humiliation when interacting with the youth. All staff reported how frequently room checks are conducted when a youth (non-suicidal) is placed in their room for sleeping or non-punishment reasons.

There is a clear Grievance policy in place and all youth according to the surveys are aware of the process. The youth have the ability to write grievance statements during their shelter stay. A grievance statement was found that was reported by a youth regarding a staff member and curse words being used in the shelter. An interview conducted with the Regional Director resulted in her reporting that there was a recent termination of a male staff due him using curse words toward a resident in the youth shelter. This staff member's behavior was reported by a resident in the aforementioned Grievance and this staff was terminated (03/30/2015).

One (1) youth surveyed reported Yes to hearing adults use curse words when speaking with you or other youth. The yes response was listed as an un identified Youth Care Worker. One (1) staff member surveyed reported Yes that they had observed a co-worker using profanity when speaking to youth.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a current policy and procedure in place that meets the requirements for the Incident Reporting indicator. This review covered a time period of October 1, 2014- April 1, 2015 during which time fifteen (15) reports were accepted by the CCC. Of the fifteen accepted reports, seven (7) were program disruptions all of which involved youth bringing contraband into the shelter and six (6) were complaints against staff due to medication error. The remaining two (2) reports were 1 youth behavior and 1 youth medical incident.

There are Two (2) of the 15 reports did not get called in within the designated 2 hour time frame.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The Agencies training files are very well organized and easy to read. There were six (6) training files reviewed for first year training requirements and of the 6, all exceeded the required 80 hours for training. Of the 6 files reviewed, 3 were missing their CINS/FINS Core training, but 2 of those are still in their first year and have some time to receive it. Three (3) of the six (6) are missing Title IV-E training and two of them are in their first year. Three of the 6 were also missing their Fire Safety Training and two are in the first year and have time.

The reviewer assessed 6 training files for continuing training hours. Of the 6 files reviewed, all 6 exceeded the required 24 hours that the Florida Network requires. One of the files was missing Crisis Intervention Training and Suicide Prevention Training, but still had time to receive them before the end of their training year. One file was missing Universal Precautions and Cultural Competency, but again had some time to get it before the end of the year. The last file that was reviewed was missing Suicide Prevention, Signs and Symptoms, and Cultural Competency. This last file had not received the training before the end of their training/hire date. Overall, the agency does a very good job at keeping tracking of the trainings and offering a broad range of trainings for its employees.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The agency's analyzing and reporting data policy is current and satisfies the requirement for the indicator. The policy indicates that the program will collect and review several sources of information to identify patterns and trends including; quarterly case record reviews, quarterly review of incidents accidents & grievances, annual review of customer satisfaction data, annual review of outcome data and monthly review of NETMIS data reports. The agency has Continuous Quality Improvement (CQI) teams that regularly review data then report the trends, strengths and weakness to management and their individual programs so that improvement plans can be implemented.

The quarterly Continuous Quality Improvement report (CQI) is comprehensive in the fact that it captures the review of multiple areas including program outcomes, inspections, fire drills, clinical trainings, new hire & shelter trainings, staffing vacancies, case records, incident reports, accidents, grievances, satisfaction surveys, and numbers of individuals served. However, the agency doesn't have a system in place that documents the dissemination of the improvement plans nor the implementation or success of the plans.

## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Lutheran Services of Florida-NW Hope House provides non residential and residential services to youth in Escambia, Walton, Santa Rosa and Okaloosa County. According to the agency's organizational chart, these services are delivered through non-residential staff members located at each respective site. The non-residential staff members across both Crestview and Pensacola locations include a Licensed Clinical Director, a Counselor III and six (6) Counselor II and two (2) Counselor I 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.

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. Youth are provided a broad ranging of youth development, counseling and reunification services with their families. 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. In addition to counseling services, LSF also operates the Teen Court program in house for Santa Rosa and Okaloosa County. The teen court program allows first time offenders to be tried by a jury of their peers and satisfy the requirement of the court without being adjudicated into the juvenile justice system.

Referrals are provided through a variety of sources including Law Enforcement, school personnel and family members. Services are available 24 hours a day 7 days a week. Counselors are on a on call rotation to ensure that this expectation is met. Onsite counselors complete intakes and assist the youth when needed. Counselors follow up on referrals and complete intakes within 24 hours of the youth being admitted into shelter. After the intake is complete a case plan is created with the client, counselor, and parent. Additional referrals to outside resources are provided when needed. Counselors provide residential clients with individual, family and group counseling. After the youth are discharged from shelter, they are provided with a referral for non residential counseling services that are provided for an average of 12 weeks.

LSF also conducts case staffing committee meetings for families and youth who are not successful or are resistant to counseling services. The court or family may request a case staffing committee which is made up of representatives from the school board, Department of Juvenile Justice, DJJ Cins/Fins agency, mental health agency, Department of Children and Families, the youth, family members, and any other individual that the family deems appropriate. The committee may request a petition if no progress is made or the family does not agree to participate in services.

Lutheran Services Florida Northwest (LSF-NW) delivers a broad range of services including Centralized Intake services.

### 2.01 Screening and Intake

Satisfactory  Limited  Failed

#### Rating Narrative

The LSF-NW Hope House program has CINS/FINS specific policies and procedures that address screening and intake practices and protocol. The agency's policies and procedures cover the requirements of the Screening and Intake indicator. A random sample of both active and closed eight (8) in the last six (6) months were selected to determine the agency's adherence to the requirements of this indicator. Of these client cases, five (5) of the cases were residential and three (3) of the cases were non-residential with two (2) open cases and six (6) closed cases.

All cases contained eligibility screening within 7- calendar days of referral. All cases had evidence of receiving available service options, notification of rights and responsibilities of youth and parents/guardians, and confirmation for receiving the parent brochure. All of the screenings were completed and signed by the counselor and supervisor by the time re frame.

One file did not have a parent signature for the parent/guardian brochure however the counselor documented that the parent refused to sign the brochure.

### 2.02 Needs Assessment

Satisfactory  Limited  Failed

#### Rating Narrative

LSF program has CINS/FINS specific policies and procedures that address assessment practices and protocol. The policies and procedures cover the requirements of the indicator. A selection of 8 cases were reviewed. 5 of the cases were residential and 3 of the cases were non residential with 2 of the cases being open and 6 of the cases closed.

All files were initiated and needs assessments completed within 2 to 3 face to face contacts. All assessments were completed by master's level counselors and were reviewed and signed by a supervisor. Of the 8 files reviewed, 1 file was identified as an elevated risk for suicide. The youth was sent to a local Baker Act facility. Upon her return an additional suicide risk assessment was completed.

No exceptions were found for this indicator.

### 2.03 Case/Service Plan

Satisfactory  Limited  Failed

#### Rating Narrative



The LSF-NW Hope House program has CINS/FINS specific policies and procedures that address case/service plan practices and protocol. The policies and procedures cover the requirements of the indicator. A selection of 8 cases were reviewed. 5 of the cases were residential and 3 of the cases were non residential with 2 of the cases being open and 6 of the cases closed.

All case plans were developed within the timeframe of completing the Needs assessment. All case plans were individualized to the client's specific issues. Signatures from the counselor and supervisor were completed on all files.

In general, the case plans reviewed included individualized need(s) and goal(s) identified by the Psychosocial Assessment. The reviewer found progress documented by counselor and parent (if available) every 30 days for the first three months and

There were exceptions noted for this indicator. On one of the files the client did not sign the case plan. The signature of the parent was missing on the case plans for two files however there was documentation in one file that indicated the counselor was unable to reach the parent for her signature. Out of the 8 files, 1 of the files was not due for a 30 day review. For two of the files there were no notes that indicated that the case plan was reviewed and revised for 30 days or thereafter.

## 2.04 Case Management and Service Delivery

Satisfactory  Limited  Failed

### Rating Narrative

The LSF-NW Hope House program has CINS/FINS specific policies and procedures that address case management and service delivery practices and protocol. The current policy addresses the requirements of the indicator. A selection of eight (8) cases were reviewed. Five (5) of the cases were residential and three (3) of the cases were non residential with 2 of the cases being open and 6 of the cases closed.

A case manager was assigned to all files. Counselors coordinated services and provided support for families in all case files. Out of the 8 files, three (3) were in need of additional services. Provided was a substance abuse referral for one file, a referral for non residential counseling for another file and assistance to a local baker act facility for the third file.

Only one (1) file was recommended for a case staffing committee. The counselor followed through with scheduling the committee and notifying all parties involved. That counselor also attended court hearings for the youth.

There are documented exceptions for this indicator. Out of 8 files, 2 were open and not applicable for case closure and follow up while 3 files had documentation of follow ups and 3 had no documentation of follow up after case closure.

## 2.05 Counseling Services

Satisfactory  Limited  Failed

### Rating Narrative

The LSF-NW Hope House program has CINS/FINS specific policies and procedures that address case management and service delivery practices and protocol. The current policy addresses the requirements of the indicator. A selection of eight (8) cases were reviewed. Five (5) of the cases were residential and three (3) of the cases were non residential with 2 of the cases being open and six (6) of the cases closed.

All of the files contained documentation that showed counseling services were provided in accordance to the case plan. Individual, family and group counseling were offered. The youth's presenting problems were addressed in the needs assessment and case plan in all 8 case files reviewed. Case notes for counseling services were located in all 8 files.

The supervisor explained that clinical staffings are held every Monday. Counselors take that time for discussing case plans, client progress, and to plan on-going services for the clients. This is the internal process that ensures review of case records and staff performance.

There are exceptions documented for this indicator. The Florida Network and LSF policy indicate that group counseling must be held a minimum of 5 times a week. The group log book and the 8 files reviewed lacked consistent documentation to confirm on-going group sessions being held 5 times a week. A total of 4 of the 8 files reviewed did not have documentation of case plan reviews.

## 2.06 Adjudication/Petition Process

Satisfactory  Limited  Failed

### Rating Narrative

LSF-NW Hope House program has CINS/FINS specific policies and procedures that address adjudication and petition practices and protocol. The policies and procedures cover the requirements of the indicator. A selection of 8 cases were reviewed. Five (5) of the cases were residential and 3 of the cases were non residential with 2 of the cases being open and 6 of the cases closed.

Of the 8 files reviewed, only 1 case was referred for a case staffing committee. Time frames for scheduling, notifying participants, and holding the staffing were all met. Attendees included the CINS/FINS provider, parents, and the yth. Representatives from the school board, state attorney's office, and substance abuse facility were invited however they did not attend the case staffing committee meeting. A written report was provided to the parent the day of the meeting. A new case plan was not needed being that the yth had entered the shelter a few days prior to the meeting and the case plan was in accordance with the committee's recommendations.

Case staffing committee meetings are held on an as needed basis. Counselors work closely with the juvenile and truancy court.

An exception is noted for this indicator. An additional court hearing was held on 10/10/2014 for the youth. There was no documentation of a written summary review for the court on the yth's progress and futher recommendations which is required according to the Florida Network and LSF policy.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The program satisfies the requirements for the Youth Records indicator. Youth records reviewed were marked as confidential and located in a secure room only accessible to staff and locked in a file cabinet.

There are two (2) record files for each active residential client. One is a clinical file and the other contains intake assessment and all other information. Each section is appropriately divided. Although, it is not easily readable when looking to correspond to different stay dates. For example, if a client has entered and has been discharged two or three times, the same forms are grouped together. It takes some time to get familiarized to the file to understand the differentiation of the different residential stay dates.

All closed files are combined to one file that also reads as confidential and appropriately organized.

There were not exception 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 ten (10) 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 including DJJ/CINS/FINS and FFN/DCF. At the time of this QI program review, there are a total of four (4) 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 of the facility. Each sleeping room is 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 monitoring office position on the second level between the resident bedrooms. At the time of this onsite program review, all beds, and bathrooms are clean. Linens appear clean and washed and refreshed every 5-7 days. All kitchen areas were clean and food preparation, storage and disposal practice are satisfactory. All common areas are neat and orderly. In addition, all safety equipment is in place and operational.

The agency operates an highly active and well received food donation program for the local community. The agency also enjoys many local partnerships with the Harvest Ministries, USDA, Salvation Army and others. The agency also conducts daily mentoring and youth development programming through their CAST Program.

The facility is a very clean and well kept that shows the Management and staff take pride in there program.

### 3.01 Shelter Envonment

Satisfactory  Limited  Failed

#### Rating Narrative

The facility is clean and well maintained. The reviewer observed that the program's management, staff and youth are invested in and take pride in the program. The youth are offered a variety of activities during their stay that helps keep them active and involved. These activities are designed to provide each youth with the opportunity to mature physically, mentally and socially through exposure to positive role models, competition, peer influence and leadership. There is limited down time. Staff engage residents on an on-going and consistent basis, even during down time. .

No exceptions are documented for this indicator.

### 3.02 Program Orientation

Satisfactory  Limited  Failed

#### Rating Narrative

The facility has a very clear Orientation program setup and the staff members spend time with the youth during intake. Youth are introduced and provide orientatation in a very welcoming and respectful manner. Staff members interact with the youth during intake to help the youth feel more emotionally and physically safe, thus reducing safety and security risks and increasing responsiveness to treatment.

The staff use the CINS/FINS admission Data form, as well as general agency forms to determine the appropriate placement of the youth in a room. Any youth that have alerts show up during the intake process have their information is placed on the alert board in the YDS office. Alert notification stickers are also placed on the youth charts. The information is aslo documented in the pass down log and shared with the oncoming staff. A very well prepared youth handbook is shared with the youth at intake that answers all general questions that residents may have.

There are no exceptions noted for this indicator.

### 3.03 Youth Room Assignment

Satisfactory  Limited  Failed

#### Rating Narrative

The facility uses the CINS/FINS admission data form, as well as agency generated forms to determine the youth's history, status, and exposure to trauma when deciding where a youth will be placed in the facility. Youth are required to sign a contract when they enter the facility that explains to them all the expectations that the facility has for the youth and the youth's rights and responsibilities during their stay at the shelter. If during the intake process an alert shows up for Suicide, Mentall Health, Substance Abuse, Physical Health or a security risk factors, it is documented in the youth's chart, the program log, alret board in the YDS office and stickers are placed on the youth's chart.

There are no exceptions in this area.

### 3.04 Log Books

Satisfactory

Limited

Failed

#### Rating Narrative

The facility uses a bound book with numbered pages as per contractual requires. All the entries are clear and legible. Non-erasable ink is used when making the entries. The program Director and Lead YDS make entries on a weekly bases and those entries are in a different color ink so that it is easy for everyone to see. When staff arrive on shelter they review the logbook and make entries to reflect that accordingly. Entries that pertain to security or safety issues are highlighted in different colors and those colors are defined in the front of the logbook making it easy for some from the outside to pick it up find things in the book.

The review did not find any exceptions in this area.

### 3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has a very well organized behavior management system (BMS) plan that they have modeled after the Behavior Management System operated by Boys Town Program. The agency's BMS system is comprised of a points program that the youth have a chance to earn points and through earning points they gain privileges and the ability to shop in the Achievement store. The youth sit down with the staff every night to count up there points and see if they reached thier daily goals and have privilgdes for the next day. Youth are trained on the program during thier intake process and it is also explained in the Client Handbook provide during the program orientation process.

Staff members are trained on the system during thier intake process and retrained on a yearly bases. The staff supervisors are also trained on how to monitor and manage the staff running the program. Monthly staff meetings are held and in which the BMS is discussed to get feedback from the staff and recommendations or changes are made. Six (6) staff training files were reviewed and all staff had evidence that they received the initial training during there orientation and those staff that have been here more than a year do have evidence of re-trained.

The agency is a hands-off facility that does not use any behavior intervention techniques even though the staff are trained on it. If a youth begins to act out he/she loses point in the BMS and if those behaviors escalate law enforcement is called to address the issue. Room restrictions are never used as a disciplinary technique, but youth are offered an opportunity to have some alone time away from the group but still in the visual site of the staff.

There are no exceptions documented fo rthis indicator.

### 3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

#### Rating Narrative

During the entrance interview this morning the CEO informed thre Review team that the Agency was down one full time staff member. During the review, the staff schedule was reviewed and all contractual requirements were met related to keeping a 1 to 6 ratio during the waking hours and a 1 to 12 ratio during the overnight.

The agency has done a very good job keeping one male and one female on shift at all times with some exceptions. A phone list is kept on all the staff and staff are called as needed for illnesses or emergencies. Overnight bed checks were reviewed in the Program Log and the Agency preforms bed checks every ten (10) minutes as opposed to every fifteen (15) minutes required by the Florida Network so this is diffently a best practice. The bed checks are done exactly every 10 minutes it would recommended that it be varied at times but will be hard to do with the checks every ten minutes.

The agency's bed checks are documented in writing as being don at exactly every 10 mintues.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has clear and precise policies and procedures when it comes to Special Populations. The Agency does have plans as a staff secured facility, however they have not had any staff secure referrals for over a year or more so. Therefore, no obersvations can be made in this area. The agency has also not recieved any probation Respite youth.

The agency has just started in January 2015 taking Domestic Violence respite youth again. This reviewer observed four (4) youth files in this area. Of the 4 youth files observed, two (2) of the youth stayed less than the fourteen (14) day period, but 2 of the youth stayed longer than the 14 day program. Clear documentation was present in the Youth Program Log and the Contact Sheet. All youth had documentation present of the Approval Letter from the Florida Network. All 4 youth files had a Case Plan that reflected anger management, family coping skills, or other intervention designed to reduce propensity for violence in the home.

There are no exceptions in this area.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

The agency provides screening, counseling and mental health assessment services. The agency has sixteen (16) 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 its agency in September 2014. 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 member that is a licensed clinician and 2 registered interns. This staff member is involved in the review of all residential clients that screen positive for suicide risk. The agency has nearly full complement of staff of both male and female staff members across all three (3) work shifts. The agency reported one vacancy. Agency training files indicate that direct care staff members received annual crisis intervention, first aid, CPR, suicide prevention and medication distribution training. The last medication training was conducted in September 2015. 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 program does perform a preliminary physical health screening for each youth at the time admission to the shelter. This is established by the Lutheran Services Florida- Northwest Youth and Families Services Policies and Procedures. The latest policy was approved by the regional director on 9/26/14. This indicator was measured by reviewing three closed and three open CINS/FINS residential files.

The files for each youth have two different areas where health is assessed—the LSF shelter intake assessment and the CINS/FINS intake form (physical health screening section) in section one of client folder. Both health screening forms for all files prove that condition of the client was assessed and signed verifying so by the interviewing youth care specialist on the same day the client entered the program. Both screening tools address allergies and existing medical conditions- medical and mental. Though there is one client file (closed) that had health assessment conducted two days after initial intake.

As in accordance with best practice, LSF's policy includes documentation of observation for presence of scars, tattoos, or other skin markings. This is also recognized on the shelter intake assessment. All files had this indicator noted and signed by the youth care specialist. In addition picture of client is also taken and have the potential to also identify any specific markings in the face and neck areas of client.

With the CINS/FINS Shelter Voluntary Placement Agreement, LSF NW's assures that the parent/guardian of the clients are fully aware of the position that they have to be able to provide a comprehensive service to the client. The parent/guardian is to initial next to each indication that the agency has requests to be agreed upon from cooperation with all the rules established by LSF to being actively involved in the coordination and scheduling of follow-up medical appointments. The program also documents all medication on a daily log for client. When appropriate, chronic medical conditions have a referral to ensure medical care by indication of the clinical file. There is no particular medical documentation protocol for chronic medical conditions, but process is discussed through counseling. In one case of a pregnant client, a case plan was put together to have follow-up with an agency for care. The client was discharged and was plan was noted as incomplete. There has been no follow-up since her latest intake on 3/12/15.

There is one client file that has been in the shelter on and off three times. And during all three (intakes) times, a health screening was conducted. Dividing the three different health assessments by dates would make the understanding of medical condition on each occasion easier.

All in all, the healthcare admission screening for each client provides information for current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, and observations of visible markings and illnesses/injuries. In addition, located on the CINS/FINS physical health screening, peer reviewer signature is inconsistent throughout the files.

### 4.02 Suicide Prevention

Satisfactory                       Limited                       Failed

#### Rating Narrative

The agency has an up to date Suicide Prevention Policy that specifically outlines the details of its suicide prevention process and all steps involved. The policy is called Suicide Prevention and is documented as last being improved in 2014 by the LSF-NW's Regional Director on September 26, 20014.

The agency has a written plan that details the program's suicide prevention and response procedures. The agency's current process requires that all residents admitted to the program be screened for any suicide risks. The agency executes this process on all residential and non-residential clients. Youth placed in the residential program are required to have a comprehensive shelter intake assessment completed by the Youth Care Specialist (YCS) that includes a mental health screening, suicide risk screening, and an initial substance use screening using the CINS/FINS Intake Form.

The agency lists Mental Health areas partners agencies include referring to NORTH-North Okaloosa Medical Center Emergency Room, SOUTH-Bridgeway and or Fort Walton Beach Medical Center and COPE for Baker Act Screening.

A sample size of five (5) client files with suicide risk were reviewed to determine their adherence to the requirements of this indicator. A review of the 5 client case files indicates that the agency met all of the general service delivery requirements for this indicator. All 5 cases also include evidence that each youth placed sight-and-sound supervision until assessed by their licensed professional or non-licensed counselor under the direct supervision of the licensed professional. Five out of 5 cases all contained signatures that verify date, detailed conversations and signatures of both the counselor and licensed clinician.

All 5 cases have evidence that each case has a completed suicide risk screening during the initial intake an screening process. The results from all 5 screenings confirm that they have been reviewed and signed by the supervisor and documented in the youth's case file. All 5 cases have documentation that each youth was placed on elevated supervision via sight and sound supervision unitle assessed by a licensed professional or non-licensed staff member under the direct supervision of the licensed professional. All suicide risk assessment screening results indicate and are documented that each youth was placed on the appropriate level of supervision. Documentation reviewed on all 5 cases revealed that the supervision level of each case was not changed until the non-licensed counselor under the supervision of a licensed clinician verified the results via consultation with the counselor.

Three (3) out of 5 youth files reviewed did not have evidence of documentation of placing youth on elevated supervision in the logbook.

The agency also provided evidence of current licenses in effect for the supervising clinician. The agency has one (1) licensed mental health counselor and two (2) registered Interns. Two (2) counselors provided evidence of being trained to administer suicide assessments under the supervision of the licensed clinician.

An exception is noted for this indicator. Three (3) out of 5 youth files reviewed did not have evidence of documentation of placing youth on elevated supervision in the program logbook.

#### 4.03 Medications

Satisfactory

Limited

Failed

##### Rating Narrative

The policy manual contains procedures that comply with the requirements for the agency to adhere to the Medication Distribution indicator 4.03. On site observation found that all medications in the shelter are stored in locked metal 4 drawer metal cabinet in the Youth Care Specialist area. This area is inaccessible to youth. All medication was stored behind a double locked cabinet in a locked 4-drawer metal cabinet. All Oral medications are stored in a separate plastic cosmetic box that is labeled with each client's name. Each medication is stored in its original packaging or bottle inside a client-specific each plastic box. 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 refrigerating medication. At the time of this onsite QI review, there was no medication that required refrigeration.

Controlled medications are locked in the 4-drawer metal cabinet behind two (2) locks that include the top to bottom exterior cabinet lock and an individual metal key controlled medication only lock box. At the time of this review, there were three (3) CINS/FINS youth that were on medication. The agency maintains a Medication Distribution Binder on each resident. 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 secured in the 4-drawer metal cabinet. The sharps include scissors, razors, finger nail cutters. The agency's are maintained 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 October 2014 to date (April 2014).

A review of 5 files (1 open and 4 closed) were reviewed to determine accuracy and completion. All general areas were documented as required related to medication distribution. A medication pass was observed by the reviewer. All medication distribution practices were followed as required.

A review of 4 closed resident client files were reviewed to assess their adherence to the requirements for this indicator. All files included specific information that confirms medication verification; medication log documentation; medication alert and on-going documentation in in the program logbook. The reviewer also observed first shift YCS staff giving medication to a resident. The YCS excuted the count, documentation and distribution of medication as required with no expcetions.

The agnecy's practice for Medication Verification; Low Dose Alert; and Medication Disposal are in place and practiced on a consistent basis.

The agency has an up to date list of staff members that are approved to provide medication. recieved training from the DJJ Office of Health Services in September 2014. The agency recently developed a medication error follow up process to document their follow up on medication errors.

A total of six (6) medication errors were reported to the DJJ CCC in last 6 months. Medication errors included 4 medication missed times and 2 dosages discrepancies. Of these six (6) incidents, none of the 6 medication errors had evidence of the agency's documenting efforts to address root cause of medication errors. Two (2) of the medication error communications with the DJJ CCC state that the LSF-NW Management would follow up with corrective action and or remedial training efforts. Overall, the correction action or oversight and administrative follow up to address each specific medication error is not documented.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

The program follows written procedures that ensure information concerning a youth's medical condition, physical activity restrictions, allergies, common side effects of prescribed medications, food and medication contraindication, and other pertinent treatment information is effectively communicated to all staff through an alert system. This indicator was measured via the professional log, the communication board located in the youth care specialist office, the allergy board in the kitchen, the program log, client file, and the medication book.

The youth care specialist conducts the shelter intake and screens for medical, mental, and allergies conditions. This information is then

translated to the professional log, the communication board, allergy board, program log, client file, and medication book. Upon arrival of shift, personnel are to read the information and be well aware of any alerts. There is only one person that prepares the food for the clients. This person receives food allergy regarding an immediate residential client and prepares food accordingly. Alternative meals are provided to clients when there are food restrictions.

The dry erase board (communication board) identifies medications to be distributed to clients and are color coordinated by the number of medications to be given to the client. Types of medication to be distributed is also signified through the medication book. Different colored stickers (red, green, or orange) are placed on the client files representing a medical or behavior condition. Colored stickers are placed on the medication log to correspond with different times for the medication pass.

A review of six files, three closed and three open indicates that the procedures were being followed. Medication was distributed daily and documented appropriately. Medical precaution (includes common side effects) documentation is also contained in the medication book. This specifies that staff were fully knowledgeable about procedure needed to treat the client and communicate with other staff about client conditions.

Suicide risk alerts, mental health alerts, and medication alerts are programmatically recognized through different methods-- the professional log, the communication board located in the youth care specialist office, the allergy board in the kitchen, the program log, client file, and the medication book.

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There was an observation of no exceptions for this indicator.

#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

LSF does implement a policy and written procedure for episodic/emergency care. It does indicate the process for emergency situations including medical and dental emergencies; awareness of environmental stressors (includes checking weather daily report and preparation for weather e.g. water for hydration); and root cause analysis for severe incidents.

LSF has noted how to obtain off-site emergency services via the documentation of an emergency facility (North Okaloosa Medical Center) for emergency medical and dental care. After emergency call is made, appropriate persons are contacted including parent and guardians. Implementation of daily log is also conducted (called the Professional Log). Incident reporting to the CCC and the Florida Network is also performed appropriately. Three closed and three open cases were reviewed.

There are two knife-for-life and wire cutters located in the facility (in the upstairs youth care specialist office and the teen court office). They are both secured in a locked area. First aid kits were also recognized in the kitchen, upstairs youth care specialist office, downstairs youth care specialist office, and van. (LSF has two vans. One van is in the shop so no verification of first aid kits was made.) In addition, they exceed this indicator by having breathing barriers and bloodborne pathogen kits.

Reviewed through employee training files, all staff are trained on emergency medical procedures. First aid and CPR training are noted for all staff.

There was an observation of no exceptions for this indicator.