Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF SE- Lippman

on 01/14/2015

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	Limited
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:60.00%
Percent of indicators rated Limited:40.00%
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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory:100.00%
Percent of indicators rated Limited:0.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:91.67%
Percent of indicators rated Limited:8.33%
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

Marcia Tavares, Lead Reviewer, Forefront LLC

Baldwin Davis, Chief QI Officer, Miami Bridge Youth and Family Services

Ben Kemmer, Co-CEO, Florida Keys Children's Shelter

Joseph Hernandez, Clinical Program Supervisor, CHS WaveCREST

Gabriel Medina, Monitor, Department of Juvenile Justice

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [ ] DHA or designee
- [ ] DMHA or designee

0 Case Managers
2 Clinical Staff
1 Food Service Personnel
0 Health Care Staff

0 Maintenance Personnel
2 Program Supervisors
1 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [x] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [ ] Escape Notification/Logs
- [ ] Exposure Control Plan
- [x] Fire Drill Log
- [x] Fire Inspection Report
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Logbooks
- [x] Medical and Mental Health Alerts
- [ ] PAR Reports
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Sick Call Logs
- [x] Supplemental Contracts
- [x] Table of Organization
- [x] Telephone Logs
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

3 Health Records
3 MH/SA Records
16 Personnel Records
7 Training Records/CORE
3 Youth Records (Closed)
9 Youth Records (Open)
0 Other

Surveys

3 Youth | 3 Direct Care Staff | 3 Other

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida Inc. was accredited by the Council on Accreditation (COA) in 2005 and has been continuously re-accredited by COA since its accreditation.The theme for the agency's FY 2014-2017 Strategic Plan is: Growing and Responding to Change. This theme is a response to the agency's significant growth and opportunities which necessitated a review of organizational structures, management systems, and personnel needs. Though the changes presented challenges to the administrative infrastructure, LSF has positioned itself to be pragmatic, nimble, flexible, scalable, affordable, accountable, and visible.

The Lutheran Services Florida (LSF) Southeast is a Children In Need of Services/Families In Need of Services (CINS/FINS) program that provides residential and non-residential services to youth in Broward County. The program operates the Lippman Youth Shelter, located in the City of Oakland Park, Florida. The shelter provides twenty-four hours, seven days per week, crisis emergency services for youth under 18 years of age that do not have any current open cases of delinquency or dependency in Broward County. The Administrative Office and the Non-Residential Program, also known as Broward Family Center, is located on the second floor of the Lakes Medical Center Building at 4185 North State Road 7 in Lauderdale Lakes.

The southeast region is under the leadership of Gregg Miller, Program Director, who reports to new Statewide Director for CINS/FINS, Shannon Martin. In addition to Ms. Martin, the agency has a Statewide QA Manager, Larry Barnhill, who is responsible for Quality Improvement and Contract Monitoring oversight. The offices for Ms. Martin and Mr. Barnhill are located in Fort Myers, Florida at the Southwest CINS/FINS program site.

LSF Broward is a current member of the National Safe Place Program, a network of voluntary community sites where youth in need of help can go for safe refuge. Although the agency doesn't have direct funding for this Outreach Program, the provider has continued to partner with local businesses and schools to help youth in trouble. Designated staff is responsible for Safe Place site recruitment, training, and ongoing support as well as community and school presentations. As a result of outreach efforts, the program maintains over 100 Safe Place Sites in Broward County. Lutheran Services Florida has initiated new partnerships with United Way, Goodwill, and Walgreens on the SW Coast and the agency desires to continue these relationships in Broward County to expand the Network of businesses involved in the Safe Place Program.

As the first and longest serving provider for CINS/FINS Services in Broward County, LSF Southeast has developed and maintained several interagency agreements and Memorandums of Agreement (MOUs) with over thirty agencies that ensure a continuum of services for the youth and families, including schools, mental health, and substance abuse providers. The program has an Outreach Targeting Plan and a strong outreach component with participation of all program staff and emphasis on the designated high crime zip code areas as well as low performing schools. Its current community-based staff is comprised of a Licensed Clinical Supervisor and four counseling/case-management staff.

In addition to the CINS/FINS program, LSF Broward also serves the transitional age-group of at risk youth ages 17-21 years who are transitioning into adulthood. Through its partnership with Broward County "Second Chance" Program, LSF Broward is now also able to provide case management services to this population. The Second Chance program provides housing-focused case management and one year of housing and utility subsidy for these older youth, enabling them to learn how to budget, to save money, to locate and utilize community resources, and to put into practice the real-world life skills they are learning.

Standard 1: Management Accountability

Overview

Narrative

LSF Southeast operates both the Lippman Youth Shelter (residential) and Broward Family Center (non-residential) CINS/FINS Program in Broward County. The program has a management team that is comprised of a Statewide CINS/FINS Director; a Statewide Quality Assurance Manager; a Program Director; a Shelter Services Manager; a Licensed Mental Health Counselor who is the Clinical Supervisor (Counselor III); and a Senior Administrative Assistant. At the time of the review, the program had two fulltime Youth Care positions vacant.

The Program Director oversees the general operations of LSF Southeast programs. The shelter program staff structure includes: a Program Manager, a Master's level Counselor II, a Youth Care Supervisor (YCS III), nine fulltime YCS I, one YCS II, and ten temporary YCS I. In addition to the Clinical Supervisor, the non-residential component has four Counselor positions and a Lead Program Assistant.

The program has an Annual Training Plan for FY 2014-2015. Each year a copy of the plan is submitted to the Florida Network for approval; the last submission date was February 2014. The plan includes mandatory training for all staff including orientation training for new hires and an in-service component. Employees receive ongoing training from the program's local providers and the Florida Network. Each employee has a separate training file that contains a training plan and supporting documentation for training received. Annual training is tracked according to the employee's date of hire.

The agency currently has a Disaster Preparedness plan for FY 2014-2015. A copy of the previous plan was submitted to Florida Network for approval in February 2014. The Department of Children and Families has licensed Lippman Youth Shelter as a Child Caring Agency, with the current license in effect until June 28, 2015.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Policy and Procedures, #1.01 "Background Screening of Employees and Volunteers," approved 1/7/15, that comply with the requirements for background screening of all Department of Juvenile Justice employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth. The screening is required to be conducted prior to the hiring an employee or volunteer and is conducted using Live Scan. In addition to the DJJ Background Screening, the provider also conducts driver's license screening for new hires, quarterly driver's license screening for existing staff, annual local municipality and county screenings, and a drug screening upon hire as well as randomly thereafter.

A total of sixteen (16) personnel files were reviewed for twelve (12) new hires, one (1) five-year re-screened staff, and three (3) interns. All of the twelve new hires were screened and received an eligible screening result prior to their hire dates. Similarly, the three interns utilized by the provider during the review period were background screened and eligible screening results were obtained prior to their volunteer start dates.

The provider had one eligible five-year re-screening during the review period. The 5-year re-screenings was submitted to DJJ Background Screening unit and the result was obtained prior to the employee's five year anniversary dates.

Proof of the faxed submission of the Annual Affidavit of Compliance with Good Moral Character Standards was provided with evidence showing it was sent to DJJ on January 6, 2015 prior to the January 31st deadline.

No exceptions were noted to this indicator as of the time of the QI Visit.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Policy and Procedures, #1.02 "Provision of an Abuse Free Environment" approved 1/7/15, that include procedures for: 1) enforcing a code of conduct regarding staff's behavioral expectations, 2) mandating the reporting of all allegations/suspected abuse to the abuse hotline, and 3) requiring management to take immediate actions to address incidents of physical and/or psychological abuse or staff's failure to adhere to the agency's behavioral policy.

Upon hire, staff receives a copy of the agency's Personnel Policies and Procedures Manual that includes a description of its behavioral expectations and code of conduct in Section 12 of the manual. An acknowledgement of receipt is signed by the employee and a copy is maintained in the employee's personnel file. Staff's responsibility and protocols for reporting child abuse are clearly outlined in the program's

procedures. Corporal punishment is prohibited and shelter staff is required to sign a Corporal Punishment Acknowledgement statement indicating receipt and knowledge of the policy.

The Abuse Hotline telephone number is visibly posted in the shelter on a door in the counseling hallway, the YCS III 's office, and throughout the facility in hallways as well as posted in each youth's bedroom. In addition, the abuse hotline phone number is listed in the Resident Handbook that is reviewed with youth and parents during admission. Also included in the handbook are the youth's rights, information on the grievance process, and behavioral expectations. The youth and parent/guardian sign the orientation checklist acknowledging receipt of the handbook and their understanding of the information provided during orientation. This form was located in the three files that were reviewed.

Five youth grievances that occurred during the review period were reviewed. The five grievances were related to staff's behavior toward youth either verbally or physically; two youth were upset about staff shaking them to wake them up, one alleged staff called him/her names, and two alleged staff refused to allow telephone contact with her Case Worker and sister. Ironically, none of the staff surveyed have heard a co-worker using profanity, threats, intimidation, or humiliation when interacting with youth. All of the grievances were addressed by the Residential Manager; however, four of the five were not signed by the youth indicating that a satisfactory resolution was reached.

The three youth surveyed stated that they knew about the abuse hotline and were aware of the location of the telephone number. The three youth also indicated that they feel safe in the shelter and feel that the adults are respectful when talking to youth. None of the youth reported hearing staff threaten them or other youth. Similarly, the three staff surveyed stated that working conditions at the shelter were good or very good.

1.03 Incident Reporting

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a written Policy, 1.03, Incident Reporting, and procedures for the notification of reportable incidents to the Department's Central Communication Center (CCC) within the two (2) hour timeframe. Incident Report training is included on the provider's training plan for new staff during program orientation.

The provider's procedures require staff responding to the incidents/accidents to immediately notify their direct supervisor during daytime hours or supervisor/designee during evening or weekend hours. Any unusual incident is documented on the Incident Reporting Form by the witnessing staff member. However, per the Program Director, as of October 2014, incidents are required to be documented on the Lutheran Services Florida Incident Report Form and a copy must be faxed to the Statewide Director of QA and Compliance. This protocol was not found in the provider's current Policy # 1.03. Upon notification, determination is made by management at the program level regarding how to proceed. Staff is also required to document the incident in the log book. Additionally, the Safety Committee is required to review and track the number and severity of incidents during their monthly meetings and provides a monthly report to management.

A total of forty-nine (49) internal incidents were reported by the provider for the period July 2014-January 2015. Four (4) of these incidents were reported to CCC and are classified as follows: runaway, contraband, physical altercation, and self-injurious behavior. A review of the provider's documentation of the incidents was conducted along with a review of the DJJ CCC incident reports. It was evident that two of the four incidents were reported during the 2 hour timeframe.

Exception:

The date and time reported to CCC for two of the four incidents was not documented on the new Incident Reporting Form implemented by the provider in October 2014. A review of the program logbook was conducted in order to ascertain the reporting time for the two incidents missing this information. One of the two incidents was not documented in the program logbook as required by the provider's policy and procedure. The new Incident Reporting Form is missing critical information to be documented such as: notification to reporting agencies, date and time reported, client program status, and follow-up component. Follow-up is important especially in medically related incidents. This information was lacking in four additional incidents reviewed, dated 10/19/14, 10/23/14, and two on 10/24/14, that did not meet the reporting criteria. Upon review, the incident dated 10/19/14 resulted in the youth having a torn ligament as documented in the program logbook. However, this was not called in to CCC.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a comprehensive written policy and procedures to ensure staff receives the necessary training to successfully complete their job requirements. The policy was revised on 08/28/2014 to take into account changes that occurred with CINS/FINS standards of that previous month, July 2014. With that, the agency has a thorough and impressive training plan for 2014- 2015.

The agency maintains an individual training file for each staff which should include a manually written tracking form, supporting training documentation, and annual training requirement. A review of seven training files for four first year and three in-service staff was conducted to assess compliance with the indicator.

None of the four first year staff randomly selected had reached their required 80 hours of training and whilst the first year was still incomplete for three of the four staff, one staff had just over a month to complete his first year training but only 27 training hours were documented. Two of the remaining three first year staff were not on track to complete their required hours and had completed 10 and 23 hours to date with seven and six months remaining, respectively, in their current training year. None of the four staff had completed the mandatory PREA. Basic orientation training was provided and documented for all four staff; however, three staff still did not receive the Title IVE training and both training topics (PREA and Title IVE) were not included on the agency's annual training calendar that shows the scheduling of relevant training topics. There was no evidence of First Aid training or certification for three staff and files did not have proof of CPR certificates for two staff.

A total of three in-service staff training files were reviewed for residential staff. In general, all three files showed that staff were not compliant in completing the 40 hours of training required annually for direct care staff in a DCF licensed shelter. In their past year, all three staff combined completed only 34.25 hours among them. Two staff had current CPR/First Aid certification in their files but there was no evidence on file to show CPR or First Aid for the other staff. Fire Safety training was completed by two of the three staff and the remaining staff has five months to complete the training during their current training year.

The published and circulated annual training calendar does not necessarily match the needs of some of the individual staff training requirements and some key training are missing i.e. Title IV-E, PREA. All files are incompletely documented for training, combined with training hours that are not tallied, and generally, all files lack organization.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, and outcome data. In addition, there is a comprehensive Continuous Quality Improvement Plan (2014) that includes detailed procedures to collect, review, and report various sources of information to identify patterns and trends. The agency allocates specific responsibilities for Program Directors, Managers, Supervisors, and staff in their service areas to ensure they are meeting compliance standards.

In practice, the program's CQI program includes various activities that are conducted by all staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented. Quarterly case record reviews are conducted by the program's clinical staff at least monthly and these reports were submitted on site and verified at the QI Review. Peer Review Reports are aggregated summarizing the deficiencies only. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner.

Per the provider's Policy & Procedure, incidents, accidents and grievances are reviewed at team meetings but none of the minutes and agendas, 1/12/15, 11/19/14, 9/4/14, 8/1/14 and 7/6/14 that were produced showed these as being presented or discussed.

The CQI Report shows separate functional committees reviewed statistical performance data and outcome measures on the previous two quarterly reports that were presented to the QI Review Team. The outcomes data incorporates requirements of the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. The provider's Clinical Supervisor reviews Netmis data on a weekly basis. Reviews and communication with other key staff was conducted by way of emails sent to staff and verified onsite during the QI review.

Exception:

Contrary to agency Policy, there are no presentations and discussions of incidents, grievances and accidents at staff meetings.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services Florida Southeast is contracted with the Florida Network of youth and family services to provide both non-residential CINS/FINS and shelter services for youth and their families in Broward County. The program is designed to provide centralized intake and screening services twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. Staff have been trained to evaluate the needs of youth and their families and make recommendations based on what services are most appropriate at the time of contact. Residential shelter services include, but are not limited to: case management, individual, family, and group counseling services. Referral services begin when the youth are admitted into shelter. Direct care staff is responsible for completing progress notes documenting the development of youth while in shelter, group counseling focused on a youths daily highs and lows experienced throughout the day, and providing daily supervision.

The program appears to have a competent centralized intake procedure in place. All staff interviewed appear to have a wealth of experience helping youth and their families work through crisis situations. Documentation reviewed contained detailed background information pertaining to a youth's level of functioning in the home, school, and community. Staff and supervisors appear to be proficient in gathering pertinent information, knowledge of motivational interviewing, and crisis counseling/intervention.

The non-residential component of Lutheran Services consists of four (4) non-residential counselors, all of which are funded by the Florida Network, and a clinical supervisor. The non-residential program currently has one (1) vacancy. Non-residential counselors are tasked with providing family counseling and case management services that link youth and families with services in the surrounding community. At the time of the visit of the quality improvement program review, Lippman Youth Shelter had eleven (11) clients in care and the non-residential program had seventy (70) open cases.

Lutheran Services coordinates Case Staffing Committee meetings in which a statutorily-mandated committee makes recommendations for treatment plans for youth that are runaway, ungovernable, truant, and lock out/homeless when other services have proven unsuccessful or per request from parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedure. The policy and procedures appear to be compliant with the standard.

A total of six files, three residential and three non-residential files, were reviewed. All of the residential and non-residential files reviewed were screened for eligibility within appropriate timeframes.

Youth and parents/guardians were all informed of their rights and responsibilities, grievance procedures and available service options in all of the six files reviewed. This was evidenced in the residential and non-residential files by the confidentiality agreement form, grievance procedure declaration form, and consumer handbook receipt acknowledgement form.

No exceptions were found while reviewing this standard.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedure. The policy and procedures appear to be compliant with the standard.

A total of six files, three residential and three non-residential files, were reviewed. All of the residential files reviewed had Needs Assessments initiated within 72 hours of admission. Addendum pages were not necessary in any of the residential files reviewed as all needs assessments were originals.

All of the non-residential files reviewed had needs assessments completed within the program standard of 2 to 3 face to face contacts. Each residential and non-residential file reviewed had a needs assessment that was completed by a Master's level Intern, Master's level staff or

Bachelor's level staff and were review/signed by a licensed Clinical Supervisor.

There were no youth identified with an elevated risk of suicide as a result of the Needs Assessments completed for all residential and non-residential files reviewed.

No exceptions were found while reviewing this standard.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedure. The policy and procedures appear to be compliant with the standard.

A total of six files, three residential and three non-residential files, were reviewed. Case service plan signatures were present in the 3 residential files and 3 nonresidential files reviewed. If a signature was not present in a case service plan for a residential or non-residential file, documentation was present in the progress notes recording what had occurred causing its omission.

All reviewed service plans contained treatment goals that were individualized to each youth in addition to being quantifiable. Residential and nonresidential service plans also consistently incorporated identified concerns during needs assessment development.

All of the residential files reviewed had case/service plans that were reviewed for progress/amended within required timeframes, with one (1) exception. The review for progress/ revisions of case/service plans by counselor and parent every thirty days for the first three months and every 6 months thereafter were present in all six (6) residential files reviewed.

One exception was found while reviewing this standard. One out of the three residential files reviewed did not have an open service plan. This client is an open CINS/FINS Non Residential client that has been receiving services for approximately 8 months. A 30 day update was made to the initial service plan dated for 11/17/14 during the site visit. This brings the file into compliance with CINS/FINS Standard 2.03.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedure. The policy and procedures appear to be compliant with the standard.

A total of six files, three residential and three non-residential files, were reviewed. All residential and non-residential files reviewed addressed need for referrals, when applicable, coordination of referrals made, when applicable, and coordination of service plan implementations and evidence of family support. This was evidenced by the case/service plans in residential and non-residential files reviewed as well as progress notes

Three (3) of the six (6) non-residential files reviewed and one (1) of the three (3) residential files reviewed were court ordered. 30 and 60 day follow up forms were completed in all of the residential and non-residential files reviewed.

All closed residential and non-residential files reviewed did not contain a 180 day follow up form after discharge as this in no longer the current standard that has been established by Florida Network.

No exceptions were found while reviewing this standard.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

All residential and non-residential files reviewed received counseling services in accordance with case/service plans located within each files. This was evidenced in the progress notes located in both the residential and non-residential files. The progress notes are located in both the residential and non-residential files showed strong evidence of counseling services being provided for youth while in shelter and in the community. Signatures by the clinical supervisor in residential and non-residential files show evidence that clinical reviews of files are ongoing and staff performance is regularly being monitored.

Group counseling is administered on a daily basis by the direct care staff and focuses on a youth's daily highs and lows experienced throughout the day. This also includes a daily goal identified by youth during session.

The aftercare recommendations that were reviewed in all residential files showed a strong emphasis on an integrated continuum of care that exists within Lutheran Services. There were several instances of referrals being made directly to Lutheran Services CINS/FINS non-residential services to provide in home counseling/case management as part of aftercare planning prior to discharge. Non-residential files contained multiple referrals to community partners in the area providing mental health and substance abuse counseling services.

No exceptions were found while reviewing this standard.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Three (3) of the six (6) non-residential files reviewed were designated to be staffed by the case staffing committee.

The parent/guardian and case staffing committee were given written/verbal notice within appropriate timeframes in all three files. This was evidenced by documentation of verbal contacts located in the progress notes and copies of written correspondence located in court documentation section. Copies of written documentation include, but are not limited to, documented phone contacts and emails.

The case staffing committee members in all three non-residential files reviewed included a combination of school district officials, DJJ and CINS/FINS providers (Lutheran Services). Additional case staffing committee members identified were representatives from the local Juvenile Assessment Center. There were revisions/updates made to the service plans of all three non-residential files reviewed after the completion of all case staffing held.

No exceptions were found while reviewing this standard.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

All residential and non-residential youth records reviewed were marked "confidential" and are only accessible to program staff. The open residential files are housed in a locked filing cabinet located in the Lippman Youth Shelter counseling office. This room is locked and only accessible to program staff. All closed residential files are housed in a locked file room that is located within the Lutheran Services Florida Southeast Administrative Office. This room is also only accessible to program staff.

All open and closed nonresidential files are located within a locked file room within the Lutheran Services Florida Southeast Administrative Office Building. The file room remains locked at all times and is only accessible to program staff.

No exceptions were found while reviewing this standard.

Standard 3: Shelter Care

Overview

Rating Narrative

LSF Southeast operates its residential program, Lippman Youth Shelter, at 221 NW 43 Court, in the City of Oakland Park in Broward County, FL. The shelter is a twenty bed facility, licensed by DCF through 6/28/15, that provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program. The contract to provide services to youth from the Department of Children and Families (DCF) was terminated by Lutheran Services a couple years ago. At the time of the quality improvement review, the shelter was providing services to six DJJ youth. The shelter is designated by the Florida Network to provide staff secure, domestic violence respite, and probation respite services to youth.

The program has adequate space for all activities and is equipped with 20 cameras in and around the outside of the building. The Lippman Youth Shelter has one dormitory; half of the wing is for male clients and the other half for females and a separate individual room for clients with special alerts. These areas are separated by a large common area used for watching television, groups and other activities. The facility was constructed in the 1970s and is showing its age. The dormitory, kitchen, restrooms and common areas were clean during the tour of the facility. Youth are assigned closets that lock to store their personal belongings. Beds are lettered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities.

Clinical services are supervised by a licensed LMHC Supervisor. Services provided include individual, group and/or family counseling, and any other applicable intervention required. The youth admitted to the program are screened using the Network Management Information System (NETMIS) Youth Screening Form, the CINS/FINS Intake Form, and a brief FAM (Family) General Scale. If a youth answers “yes” to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form or if the staff member’s observations of the youth’s behavior would indicate any area of concern, an Assessment of Suicide Risk (ASR) is completed. The ASR is completed by either licensed professional or a non-licensed counselor under the direct supervision of the LMHC. A medical and mental health alert system is in place and the shelter staff that administers medications have been trained in the distribution of medication.

The Shelter behavior management system seems to work effectively. The program offers a myriad of incentives to motivate youth. Youth with the highest number of points at the end of the week chooses a top shelf incentive.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses the elements of this indicator 3.01. The policies are reviewed and signed annually. LSF Southeast operates its residential program, Lippman Youth Shelter, at 221 NW 43 Court, in the City of Oakland Park in Broward County, FL. The shelter facility is licensed by DCF for 20 beds through 6/2015. The shelter has one wing half of the wing is for male clients and the other half for females and a separate individual room for clients with special alerts. These areas are separated by a large common area used for watching television, groups and other activities. The dormitory, kitchen, restrooms and common areas were clean during the tour of the facility. Youth are assigned closets that lock to store their personal belongings. Beds are lettered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities.

The facility was constructed in the 1970s and is showing its age. All health, safety and fire inspections are current and rated satisfactory. During our tour of the facility we found all fire safety equipment properly tagged and dated. All furnishings were in good repair and the grounds and landscaping are well maintained. Bedding, linens, towels and laundry equipment were all found to be sufficient. During the first day of this review we found one youth actively engaged in orientation activities. Daily schedules are posted in the facility offering time for education, recreation, meals, social skills, faith-based activities and other services.

One exception was noted during this site visit. The area behind the washer and dryers was full of lint, dirt and a can of disinfectant spray. The reviewers also gave one recommendation. The interior walls of the shelter could use a fresh coat of paint.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of standard 3.02. The policies are reviewed and signed on an annual basis.

Each youth admitted to the Lippman Youth Shelter receives a comprehensive client orientation upon admission to the facility. The staff conducting the orientation process completes a "Checklist for Orientation" form that covers 18 different areas related to program operations, services and schedules. Youth and parents also are provided a copy of the Lippman Youth Shelter Handbook and sign the receipt of orientation handbook form during the orientation process. Youth rights, emergency procedures and grievance process are reviewed with each youth at intake. All four files reviewed contained the receipt of orientation form signed by the youth and the parent as well as LYS staff. All of the forms are completed at intake and within 24hours of admittance.

Exception:

Room assignment section was not completed on the CINS/FINS intake form in one of four Residential files reviewed.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of standard 3.03. During the intake, assessment, and new client orientation process, youth are evaluated by the staff member doing the intake and are assigned to a room and bed based on various criteria, behaviors and/or characteristics gender, age, physical size, maturity level, history of physical or sexual aggression are among some of the many factors considered during the room assignment process. Youth on close watch or with risk associated behavioral concerns may be placed in a single room designated the special alert room. The boy's special alert room is closest to the staff's observation desk and the girl's special alert room is room 5. Overnight room checks occur every 15 minutes and are documented in the log book. Of the four residential client case files reviewed, three contained the room/bed assignment located in the client file.

Exception:

CINS/FINS Intake form questions on history of violence, sexually aggressive reactive behavior and staff observations was not completed in one file.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Policy Procedures related to the keeping of a bound log book. Log book entries that could impact the security and safety of the youth and/or program are highlighted. All entries are brief and legibly written in ink and include the date and time of the incident, event or activity, names of youth and staff involved, a brief statement providing pertinent information, and the name and signature of the person making the entry. All recording errors are struck through with a single line and the staff person must sign the correction and the use of whiteout is prohibited; The shelter manager or designee reviews the facility logbook every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow up are required and signs/dates the entry. The oncoming supervisor reviews the logbook to become aware of any unusual occurrences, problems, etc. and makes an entry signed and dated into the logbook indicating the dates reviewed to document the review. Direct care staff in the unit reviews the logbook and make an entry in the logbook and sign/date that they have reviewed it.

Exception:

The staff do document shift change and staff turnover but do not each specifically document that they have reviewed the log book for at least the previous two shifts. Staff should document “Staff Logbook Reviewed” and sign. Also, staff should use real-time when making logbook entries.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Policy and Procedures covering all elements of behavior management system and a detailed written description. The Behavioral Management System (BMS) being used by Lippman Youth Shelter is a positive reinforcement model that promotes and teaches acceptable behaviors by the youth. The system consists of three phases. Point logs are kept and a client has to accumulate points to advance to each phase (i.e. it takes 100 points to advance from Phase 1 to Phase 2, 200 points from Phase 2 to Phase3). An advancement in phases

means the client receives more incentives. The shelter maintains a cabinet filled with items for the clients to purchase with their earned points. It's equipped with clothing items, special hygiene items, and an assortment of items that the youth can use. In addition special outings are used an added reward/incentive within the behavior management system. Grievance reports are readily available to youth and a process is in place for supervisors to review all grievances with youth within 48 hours and with staff if applicable so that a resolution can be reached.

Exception:

No documentation that staff are oriented and trained in the theory and use of the BMS and evaluated in its use was provided during the review. Similarly, there was no documentation that supervisors are trained in its use and also monitor staff's use of the BMS. LYS staff did have verbal crisis intervention trainings documented although no physical intervention training was documented.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policies and procedures regarding staffing and supervision are documented and comply with the QI standards. The reviewer read agency policies regarding staffing and spoke with direct care staff and supervisors about their practice. Staffing schedules from July 2014 through January 2015 along with corresponding youth daily census were reviewed and showed to be consistently in staff/youth ratio as required by CINS/FINS standards. Staff schedules are kept in a binder available to all staff and are also posted on board in the YCS office.

Youth Care staff (YCS) are scheduled on three shifts: 7 a.m.-3 p.m., 3-11 p.m., and 11 p.m.-7 a.m. The staff and Shelter Manager interviewed are aware of the minimal staff to youth ratios and the staff schedules show a minimal of 2 staff scheduled on each shift with additional coverage when the census is higher or for some outings and recreational activities. When compared with the youth census for the period, the program was found to meet the requirement of 1 staff to 6 youth during wake time and 1:12 ratio during sleep time. Log book entries reflect that room checks are conducted every 15 minutes while youth are in their rooms. QI Indicator 3.06 also requires programs to maintain a holdover or overtime rotation roster for staff that may be accessed when additional coverage is needed. The provider maintains a holdover or overtime roster and has contingent or relief staff to assist with additional coverage as required. There are 20 functioning surveillance cameras located in the shelter; however, in checking the system, it did not demonstrate that recordings are kept for 30 days.

Exception:

Adequate working surveillance camera system is in place but recordings are only available for 21 days while the standards requires 30 days of recording to be available.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has written policy and procedure in place for providing services to special populations. The procedures were consistent with the requirement of the indicator that Lippman Youth Shelter is a designated Staff Secure Shelter by the Florida Network. The program does also have a current contract with the Florida Network to provide Domestic Violence Respite (DVR) Services.

During the QI visit, there was one current DVR youth in the shelter; however, that file was not reviewed since the client was admitted to the program within 24 hours of QI Review. Three closed files were reviewed and they contained documentation showing that the provider is consistent with all the general CINS/FINS program requirements. All three files were referred from the JAC/Detention center for domestic violence and showed that the youth were transported within four hours of referral and did not meet the criteria for secure detention.

Two of the three files reviewed provided evidence that the service plan reflects goals focused on aggression management and family coping skill as well as two files has evidence showing the transition to CINS/FINS. None of the files showed where the youth was in a DVR bed for up to 14 days needed extra approval.

All three files showed no evidence of prior approval for placement of youth for DVR. Prior approval is not required as LSF is located in one of the Domestic Violence Priority Areas.

Exception:

The procedure and the practice for DVR services appear to be duplicated in the provider's Policy and Procedure Manual. Additionally, the policy states the procedure and practice for documenting the change in status from domestic violence to CINS/FINS but two of the three files reviewed did not indicate this change.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The Lippman Youth Shelter has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room assignment, given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Supervisor and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on Alert System Form that is maintained in a binder and is accessible to all staff.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. Medications are stored in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures related to healthcare admission screening that ensure medical care for youth admitted with chronical medical conditions. The procedures reviewed also included a thorough referral process for follow-up medical care, as needed.

A review of three youth files randomly selected found that the program completed a preliminary healthcare screening in each case. Each screening completed included the current medication, existing medical condition, allergies, presence of pain or physical distress, observation for evidence of illness, injury and physical distress and the presence of scars, tattoos or other skin markings. In each case reviewed the parent/guardian was involved in the coordination and scheduling of the treatment required, and the applicable medical referrals were documented on the daily log.

No exceptions noted.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures for suicide assessment that were reviewed. The procedures included the monitoring process for all the supervision levels of suicide risk. The program's Assessment of Suicide Risk (ASR) is approved by the Florida Network. Interview with the Clinical Supervisor (Counselor III) indicated that if the youth is in imminent danger of suicide, the program contacts the Henderson Youth Emergency Services YES Team.

A review of three youth files randomly selected found that two youth were applicable for suicide risk screening, and in both cases the required screenings were timely completed during the youth's initial intake process by a licensed professional or the non-licensed counselor, under the direct clinical supervision of the licensed professional. None of the youth required to be placed in supervision as a result of the screenings reviewed.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written policy and procedure in place for medication management. Observation found that all the medications in the program are stored in a locked medicine cabinet located in the locked Youth Care Specialist room. Observation found that each applicable youth had a locked box that contained only his/her medication. Oral medications are not stored with injectable or topical medications. The program did not have any narcotics and/or controlled medications, syringes or sharps at the time of the review. The program had a list of ten staff members that participated in medication administration and are authorized to assist in the distribution of medication. The program had an Over the Counter medications log that was reviewed. There were four youth in prescribed medication at the time of the review. The program maintained current Medication Distribution Logs, without lapses in the receipt of the youth medication, for each youth in medication. The program policy indicated that the facility utilized Walgreens Pharmacy for prescriptions.

Exception:

There was no perpetual inventory in place in the program for Over the Counter medication, as required.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure for medical and mental health alert processes that was reviewed. Documentation reviewed found that the program staff conducting the preliminary screening identified any medical, dental or mental health issues and make the necessary arrangements for treatment or referrals. All the program staff are alerted of any medical/mental health condition through the Board Alert located in the Youth Care office, the Food Allergy Board located in the kitchen, and the alerts documented in each applicable youth record. The program had a coding system for medical/mental health/substance abuse alerts. When staff identifies "at risk" issues youth are place on One-to-One supervision, and only a clinician can remove youth from this supervision or transported youth to a community mental health facility, when applicable.

A review of three youth files randomly selected found that the youth were place on an alert and the alerts were appropriately documented on the alert board, in the youth's file. In addition, staff communication provided sufficient information to respond to the needs for emergency care for youth in the shelter.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a comprehensive process for the provision of emergency care that was reviewed. The program procedures reviewed covered off-site emergency services, parent/guardian notification, incident reporting to the Central Communication Center (CCC) and the Florida Network, and the daily log. Training documentation reviewed found that the program staff received training in emergency procedures and universal precautions. A tour of the program revealed that the program had knife-for-life and wire cutters located in the common area of the program, and First aid kits located in the common area and the dining area. The program also had a Monthly Emergency Drills log that was reviewed. The review of the program's incident reports and the program's logbooks confirmed that the program provided episodic care and emergency care services and transportation, as needed.

Exception:

The review of the emergency drills logbook indicated that although the program conducted several healthcare drills in different shifts, there was no any drill related to suicide prevention, as required. The program did not have a log for transportation of the youth in the cases of medical emergencies when youth is transported for treatment.