Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF SE- Lippman

on 02/11/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
1.05 Analyzing and Reporting Information	Satisfactory

Percent of indicators rated Satisfactory:80.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Psychosocial Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/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	Limited
3.07 Special Populations	Satisfactory

Percent of indicators rated Satisfactory:85.71%
Percent of indicators rated Limited:14.29%
Percent of indicators rated Failed:0.00%

Standard 4: Mental Health/Health Services	
4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	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:87.50%
Percent of indicators rated Limited:12.50%
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 and Consultant, Forefront LLC

Marie Boswell, Delinquency Prevention Specialist, Department of Juvenile Justice

Kelly Barnett, Residential Services Manager, CHS WaveCREST

Mark Olshansky, Residential Coordinator, Florida Keys Children's Shelter

Persons Interviewed

- [x] Program Director
- [ ] DJJ Monitor
- [x] 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
2 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [ ] Confinement Reports
- [x] Continuity of Operation Plan
- [ ] 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
- [ ] Telephone Logs
- [x] Vehicle Inspection Reports
- [x] Visitation Logs
- [x] Youth Handbook

3 Health Records
3 MH/SA Records
14 Personnel Records
7 Training Records/CORE
1 Youth Records (Closed)
8 Youth Records (Open)
0 Other

Surveys

2 Youth | 3 Direct Care Staff | 2 Other

Observations During Review

- [ ] Admissions
- [ ] Confinement
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals
- [ ] Medical Clinic
- [ ] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Program Activities
- [ ] Recreation
- [ ] Searches
- [ ] Security Video Tapes
- [ ] Sick Call
- [x] Social Skill Modeling by Staff
- [x] Staff Interactions with Youth
- [x] 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

The Lutheran Services Florida (LSF) Broward 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 is sub-contracted through the Florida Network of Youth and Family Services (Florida Network). 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 ages ten to seventeen 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, 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.

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. 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 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. A designated part time 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. Over the past year, Lutheran Services Florida SW has struck new partnerships with United Way and Goodwill. Walgreen's also agreed to make every southwest Florida stores Safe Place locations, making the pharmacy chain the first retailer to participate locally. The success of the Safe Place program in Fort Myers is due largely to its Coordinator, Kathy Houser, who will train her new counterpart in the Broward program and assist in expanding the program by reaching out to other businesses.

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 Broward 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 an Associate Vice President of Quality Management; a Statewide CINS/FINS Director; a Statewide Quality Assurance Manager and local QA Manager; a Residential Manager, a Clinical Supervisor (Counselor III) who is both a Licensed Clinical Social Worker (LCSW); and a Senior Administrative Assistant. At the time of the review, the program had one vacancy for a Youth Care position on its overnight shift.

The Statewide Director oversees the general operations of both the residential and the non-residential programs. The shelter program staff structure includes: a Program Manager, a Counselor II, a YCSIII supervisor, seven fulltime YCSI, and six temporary YCSI. In addition to the Clinical Supervisor, the non-residential component has three Counselor positions and a Lead Program Assistant.

The program has an Annual Training Plan for all staff and orientation training is provided to all new hires. 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.

LSF Broward maintains valuable interagency agreements with over thirty agencies that ensure a continuum of services for the youth and families. 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 coded areas as well as low performing schools.

The Florida Network acknowledged receipt of the program's Disaster Preparedness plan for FY 2013-2014. The Department of Children and Families has licensed Lippman Youth Shelter as a Child Caring Agency, with the current license in effect until June 27, 2014.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures that comply with the requirement 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. Proof of the fax submission of the Annual Affidavit of Compliance with Good Moral Character Standards, sent to DJJ on January 23, 2014 prior to the January 31st deadline, was provided.

A total of fourteen (14) personnel files were reviewed for five (5) new hires, two (2) five-year re-screened staff, and seven (7) interns. All of the five new hires were screened and received an eligible screening result prior to their hire dates. Similarly, the seven 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 two eligible five-year re-screenings during the review period. The 5-year re-screenings were submitted to DJJ Background Screening unit and the results were obtained prior to the employees' five year anniversary dates.

No exceptions noted.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures in place that address all elements of the indicator and 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. The program also has a detailed policy and procedures regarding the Provision of an Abuse Free Environment Child Abuse Reporting. Staff's responsibility and protocols for reporting child abuse are clearly outlined in the 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 and the YCS III 's office door as well as on a board in the resident hallway. 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.

The two youth surveyed stated that they knew about the abuse hotline but one of the youth was unaware of the location of the telephone number. Both youth surveyed 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.

The three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never heard observed staff using threat, intimidation, humiliation, or profanity when interacting with youth.

A log is maintained for all calls made to the Abuse Hotline. However, copies of seven of eleven abuse reports made in the past six months were not placed in the provider's binder and one of calls made was not logged on the call log. The shelter counselor provided the Reviewer with copies of the missing reports during the visit. Also, records of the abuse hotline calls were not being documented in the logbook as required by the provider's policy.

In reviewing the Abuse Call binder, reviewer observed documentation of 11 abuse calls that were reported to the Abuse Hotline; however, 7 of the reported calls were not filled out on the provider's abuse reporting form nor filed in the binder. In addition, one of the calls (1/9/14) reported to the Abuse Hotline was not logged on the provider's Abuse Call Log. In addition, records of the abuse hotline calls were not being documented in the logbook as required by the provider's policy. The two youth surveyed stated that they knew about the abuse hotline but one of the youth was unaware of the location of the telephone number.

According to the program manager, there was only one youth grievance in the past six months. The youth complained about not being able to watch television shows that have profanity, yet staff uses profanity a lot. None of the current youth survey acknowledged hearing staff use profanity. Observation of the grievance box onsite revealed a broken lock which renders the submitted grievance forms insecure, non-confidential, and subject to scrutiny or removal by anyone.The box was replaced during the QI review with a locked box.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a written Policy, 1.03, 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. Upon notification, determination is made by management regarding how to proceed. Staff is also required to document the incident in the log book. Additionally, the Safety Committee reviews and tracks the number and severity of incidents during their monthly meetings and provides a monthly report to management.

During the review period, two (2) of the incidents reported to the Central Communications Center (CCC) were accepted. Both incidents were related to theft of staff and youth's personal property, credit card, and clothing, respectively. One of the two incidents was reported outside of the two hour timeframe.

A review of the provider's documentation of the incidents was conducted along with a review of the DJJ CCC incident reports. Neither of the two incidents were documented on the provider's Incident Report Form or logged on the program's CCC Incident Report Log. Also, it appears that staff were using two different Incident Report Forms, one of which does not include detailed information about the CCC call and/or corrective action and follow-up.

Both incidents indicated CCC staff awaiting information from the Program Director; no follow-up by the PD was reflected in the CCC reports.

Exceptions:

One of the two incidents was reported outside of the two hour timeframe.

A review of the provider's internal documentation of the reported CCC incidents was compared with the reports generated by the Department's CCC office. Upon initial review, neither of the two incidents reported to CCC by the provider and noted above were documented on the provider's Incident Report Form or logged on the program's CCC Incident Report Log at the time of review. Also, it appears that staff were using two different Incident Report Forms, one of which does not include detailed information about the CCC call and/or corrective action and follow-up. The provider located one of the incidents during the visit.

Both incidents indicated CCC staff was awaiting information from the Program Director; no follow-up by the PD was documented in the CCC reports. The PD, upon notification by the Reviewer, submitted the requested information via email to CCC.

Several medication errors identified during the review were not called into the CCC as required. The PD was advised to report these errors to CCC immediately.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The program has a comprehensive written policy and procedures to address staff training and has developed an annual Training Plan to ensure staff receives the necessary training to successfully complete job requirements. The agency provided a copy of their Annual Training Plan for the 2013-2014 Fiscal Year which includes a monthly staff training schedule for March - December 2014. The Training Plan for FY 2013-2014 was submitted via email to the Florida Network on 9/9/13.

The agency maintains an individual training file for each staff which includes a 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.

Two of the four first year staff had exceeded the 80 hours of training required and the remaining two were on target for completing the required hours. Orientation training was provided and documented for all four staff; however, two staff did not receive the Title IVE training and did not have proof of CPR/First Aid certificates in the files. A review of the program's training calendar shows the scheduling of both training topics within the upcoming four months.

A total of three in-service staff training files were reviewed for one part time and two fulltime residential staff. In general, staff is non-compliant in completing the 40 hours of training required annually for direct care staff in a DCF licensed shelter. All three staff had current CPR/First Aid certification in their files. Fire Safety training was completed by one of the three staff and the remaining two staff had time to complete the training during their current training year.

Exceptions:

Two of the new hires did not receive the Title IVE training and did not have proof of CPR/First Aid certificates in the files.

All three in-service staff training files reviewed were not on target for completing the 40 hours of required training. One staff had just finished his training year and had completed only 12 hours for the year. The other two staff had completed 4 hours and 9.75 hours in 5 and 8 months, respectively.

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 that includes detailed procedures to collect, review, and report various sources of information to identify patterns and trends.

The agency delineates specific responsibilities for Program Directors, Managers, Supervisors, and staff in their service areas to ensure they are meeting compliance standards. The agency-wide CQI Steering Committee is responsible for coordinating the Regional CQI Councils who directly oversee the activities of five CQI Teams made up of regional staff. The five CQI Teams are as follows: 1) Incidents, Accidents, Grievance, and Safety; 2) Consumer Stakeholder Surveys; 3) Performance Measurement; 4) Case Review; and 5) Program Implementation.

In practice, the program's CQI program includes many 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 clinical staff at least monthly. Upon completion of each record review, a Peer Review Report is aggregated summarizing the results and a copy of the report is provided to the program supervisor to address deficiencies. Program supervisors ensure appropriate follow-up is taken by their staff and responded to in a timely manner. An onsite review of Peer Record reviews verified that case record reviews were conducted on a monthly basis.

The program's Safety Team is made up of staff from the Residential and Non-residential program and is responsible for reviewing incidents and accidents, performing safety checks and fire drills, and making recommendations to management. Per document review, the committee met three times (July, September, November) during the last six months which is more frequent than the quarterly meetings stated in the agency's CQI Plan. The team reviews incident reports, emergency and fire drills, facility safety checklist, vehicle inspection checklists for the preceding quarter. Meeting minutes of the aforementioned meetings meetings were reviewed and included a summary of the findings, attendance sheet, and supporting documentation.

Per the provider's P&P, consumer grievances are reviewed along with the Program Improvement/Performance Team. The team last met on 8/7/2013; however, grievances were not being discussed or included on the team meeting agenda.

The CQI Plan shows a separate committee, Performance Measurement Team, to review statistical performance data and outcome measures. However, the program has one committee that combines the function of the Program Improvement and Performance Measurement Team. The outcomes data incorporates requirements of the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. The provider's Senior Administrative Assistant reviews Netmis data on a weekly basis and displays monthly program outcomes on a board in the copy room. A report of the outcomes is provided to management during bi-weekly meetings but formal agendas are not maintained.

Exceptions:

Per the provider's P&P, consumer grievances are reviewed along with the Program Improvement/Performance Team and meetings are to be held quarterly. The team last met on 8/7/2013 and

grievances were not being discussed or included in the team meetings as required.

The CQI Plan shows a separate committee, Performance Measurement Team, to review statistical performance data and outcome measures. However, the program has one committee that combines the function of the Program Improvement and Performance Measurement Team and not all CQI activities are conducted nor required meetings are held. The focus of the Performance Team needs to be consistent with the guidelines of the agency's CQI Plan which includes a review of statistical performance data and outcome measures.

The provider has a Consumer Stakeholder Survey Team that reviews consumer surveys and report on their findings. The team's last meeting report was in July 2013. There is no evidence of an annual review of consumer satisfaction data or quarterly meetings.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

LSF Southeast is contracted to provide both shelter and non-residential services for youth and their families in Broward County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and each day of the year. Trained staff are available at each program site to determine the needs of the family and youth. Upon referral, a screening for eligibility is conducted and the screening is the initiation of the assessment process. Information regarding the youths' presenting problems, living situation, etc. is collected. When a case is open on a youth the program will assign a counselor/case manager to develop a case plan with the youth and family. Upon intake into either program (residential shelter or non-residential services), a more thorough assessment is completed. After all assessments are completed, the assigned counselor develops a case services plan with the family during the initial family session. If the assessment indicates the need for a referral to a more intensive or specialized service such as substance abuse or mental health treatment, the counselor makes the necessary referral for service. After the development of the case service plan, the counselor works with the family to implement the plan. Counselors document progress towards completion of the service plan goals.

The Broward Family Center coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee meets monthly and files the CINS Petition with the court, as recommended by the CSC.

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2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

The provider

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 six files reviewed reflected eligibility screenings within seven days of the referral. All six files reviewed contained rights and responsibilities, grievance procedures, available service options and information on case staffing committee and CINS petition process.

Three residential files have a receipt of the client handbook in the file. All three non-residential files have case notes that document that the parent/guardians brochure was given and reviewed.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedure that meets the requirements of the standard.

A total of six files, three residential and three non-residential, were reviewed. All six files had a completed Psychosocial Assessment completed and maintained in the file. Forms were signed by a Bachelor's or Master's level staff. The assessments were completed thoroughly, duing the appropriate time frames, and signed by a supervisor.

One residential file did not meet the 72 hour requirement for the completion of the psychosocial assessment. The intake date was 1/24/2014 and the assessment was completed on the 1/28/2014.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedure in place.

A total of six files, three residential and three non-residential, were reviewed. The six files reviewed showed evidence of the service plan being developed within seven working days following the completion of the psychosocial assessment. The files showed the same date for the assessment and the service plan.

All six service plans identified needs and goals, type, frequency, location of service, persons responsible, target dates for completion, and signature of youth, parent, counselor, and supervisor.

Two youth were surveyed and indicated that they did understand the goals they were currently working on. Five of the files reviewed showed substance abuse by youth and three files reviewed contained mental health. All six files show individualized goals.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy and procedure in place that appear to address the requirements of the indicator.

A total of six files reviewed showed evidence of assigned case manager/counselor. Two youth were interviewed and confirmed they did have a counselor assigned.

All six files showed monitoring of the youth/family's progress in services. Non-residential files contained appropriate referrals for substance abuse and mental health. Two non-residential files have documentation showing that the youth was monitored when out of the home. Two non-residential files also contained referrals for a case staffing.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a written policy and procedure in place.

Three residential files were reviewed and all contained individual/family counseling goal on the service plan. Two files contained group documentation and one file was missing group counseling; however, the youth was out of the shelter when group had taken place. All three shelter files addressed the presenting problems on both the psychosocial assessment and the service plan. The three shelter files have case notes on counseling services that have were provided.

The policy did not have a clear procedure in place for a on-going internal process that would ensure clinical reviews of the case record. The clinical supervisor interviewed explained that supervision takes place on an as needed basis. A binder was produced to show supervision of case files.

Three non-residential files were reviewed and the presenting problems were provided on the psychosocial assessment and in the service plan. All three youth had substance abuse problems. All three non-residential files reviewed had a peer review sheet in the front of the file demonstrating that the file was selected and reviewed by the provider's Peer Review Team.

One residential file was missing a 30 day service plan update/review and the next update/review was due during the visit on 2/11/2014, but was not yet completed. The youth has been in shelter since 12/11/2013.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has written policy and procedure in place that meets the indicator.

The program's Case Staffing Committee consists of the following members: LFS clinical supervisor, program counselor, school board member, mental health representative, and CINS Attorney.

Two files were reviewed and contained all the required documentation. The files contained notification of the case staffing meeting to the parent/guardian and committee members five days prior to the meeting. Both files had documentation provided to the guardian of the revisions of the case plan. When interviewing the clinical supervisor it was stated that the committee members meet monthly on the third Wednesday of each month.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has a policy and procedure in place.

A total of six files reviewed for three residential and three non-residential cases. Five files were marked confidential, and all six were neat and orderly. All six files were organized according to the file checklist for each program. All of the files are stored in a secured file room.

One residential file had a few documents that were poorly copied in which signature lines were cut off at the end of the page. Also, a few files have copies that appear to be duplicated over and over, resulting in poor quality forms.

One closed non-residential file was not marked confidential.

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 6/27/14, 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 not designated by the Florida Network to provide staff secure services and is not licensed under Chapter 397.

Clinical services are supervised by a licensed LCSW 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 LCSW. 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 behavior management system seems to work effectively. The Reviewer was impressed with the incentives used to motivate youth and the way these incentives are used ie: the youth with the highest number of points at the end of the week chooses a top shelf incentive. In addition there is a board that staff use to write and highlight POSITIVE behaviors youth are engaging in.

Youth appear to be comfortable with staff and staff seem to be interacting with youth in a respectful manner and seem to be modeling appropriate social skills. Youth have access to fresh fruit during the day.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Health fire safety policies seem to comply with standards. A review was made of documentation showing that inspections are being conducted of the fire safety equipment such as extinguishers and emergency lights. Health inspections were also conducted in the food service area.

The shelter seems to be maintaining regularly scheduled inspections of health and safety equipment. In addition, the shelter has two first aid kits easily accessible to staff in the shelter and a knife for life in the common area. First aid kits, seat belt cutters and fire extinguishers are located in each van. The shelter has current CCA licensing and Health Department inspections for group care facilities and food service. Fire and emergency drills are done regularly by the program, at a minimal, once per month.

Policies regarding furnishings seem well documented and compliant with standards. A review was made of documentation regarding furnishings as well as observation during a tour of the shelter to inspect furnishings. All of the furnishings seem to be in good repair.

Policies regarding pest control seem to be well documented and compliant with standards. A review of pest control records was made as well as a walk through the shelter to look for signs of insects or other pest. The shelter seems to be pest free as no signs of insects or other pest were observed.

Policies regarding maintenance seem well documented and compliant with standards. A walk around the grounds was made to review landscaping and maintenance. Shelter grounds seem to be well landscaped and maintained.

Policies regarding bathroom/shower areas seem to be well documented and compliant with standards. A walk through the shelter to inspect bathrooms/showers was conducted.

A review was made of policies and the residential handbook as well as a walk through the shelter to look for graffiti. See exceptions.

A review of the policies was made as well as an inspection of all the bedding. The shelter seems to be following its policies regarding beds and bedding. Each of the beds seems to have clean linens, plastic coverings for the mattresses, pillows, blankets and comforters. Each youth has a closet with a working lock to allow storage of personal belongings by youth. The shelter seems to have adequate lighting in each of the rooms.

A review of youth activities in policy manuals was made as well as a review of youth schedules and calendars. This reviewer also spoke with direct care staff about youth activities. The shelter seems to be providing activities and structure for youth in order to minimize idle time for youth. The shelter also seems to be providing daily physical activity for youth.

A review of daily programming schedules was made as well as talking with direct care staff about daily programming and activities. An inspection was made of items used for daily activities such as games, books etc. The shelter seems to be providing daily educational and recreational structure in order to minimize idle time for youth. The shelter seems to offer youth the opportunity to participate in faith based activities.

The Shelter seems to be posting required schedules for weekdays and weekends. The schedules are posted on a board in the youth lounge. Based on interviews with the staff, they seem to be familiar with the programming and schedules.

Exceptions:

The bathroom for room #3 seems to have mold around the toilet. Documentation, from a plumbing service dated 12/18/13, shows that attempts had been made to deal with mold and per the plumber, what appears to be mold may in fact be another sort of build-up. Mold was also found behind some toilets and in one shower stall. Staff removed the mold on 2/11/2014 after it was pointed out by the Reviewer.

Three of the bathrooms, for rooms 3, 5 and 7 have broken toilet paper holders and the toilet paper is being stored on the back of the toilets. Holders should be repaired or replaced so the toilet paper can be held/used more sanitarily.

Room #10 has a broken floor tile at the entrance to the bathroom. This tile should either be replaced or glued down to prevent youth from slipping and falling.

Eight of the beds had graffiti carved into the headboards. Staff sanded down the graffiti on 2/11/2014 after the graffiti was pointed out.

Several showers had soap build up that were removed by staff during the QI review on 2/11/2014.

A corner of one of the ceiling light fixtures in the common area was broken and should be repaired/replaced.

The exterior lawn has an unusual amount bees flying around the lawn which poses a threat to youth and/or staff using the grounds.

The fire drill reports for November 2013 are not included with the other reports; however, log book entries indicate that drills had been conducted.

The program vans seem to be in need of cleaning.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policies and procedures for orientation are clearly written and are in compliance with standards.

A review of three client files was conducted. Each file clearly showed that youth had been oriented via a residential handbook and/or verbal instruction in disciplinary actions, grievance procedures, emergency/disaster procedures, contraband rules, facility map, room assignment, daily activities and the abuse hotline. The page containing facility map was missing from the client handbook. It is recommended that the facility layout map be printed and included on page 4 of the residential handbook.

The orientation is documented on an Orientation Checklist and is conducted by the intake staff. The shelter seems to follow program orientation policies. In addition, alerts are clearly documented and placed on the covers of client files using color coded dots.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The policy and procedures for room assignments seem to be well documented and in compliance with standards.

This reviewer looked at three client files for intake and psychosocial assessment information relevant to the assignment of rooms for youth. In addition this reviewer spoke with shelter staff about how rooms are assigned to youth and what things such as medical needs, history of violence etc. are taken into consideration when initially assigning rooms.

The shelter seems to assign rooms to youth based on information gathered by staff at time of intake and observations of youth by staff subsequent to the initial intake. The room assignment is documented on the second page of the Intake Assessment form. All three files reviewed showed the room and bed to which youth were assigned.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Policies and procedures regarding log books seem to be well documented and in compliance with standards.

This reviewer read three weeks of a log book for consistency and periodic pages throughout four other log books. The log book seemed to address safety/security issues, incidents involving

youth/staff, supervisor reviews, residential counts and visitation/home visits. The Shelter seems to be following policy and procedures for log book entries. In addition, entries are made in ink and are legible.

With the exception of the below noted log book dates, errors seem to be routinely struck through using a single line; however they are not consistently dated or initialed:

- On 9/26/2013, 3 separate entries are scribbled out.
- On 10/14/2013, a 3 line entry written at 10:25pm was scribbled out.
- On 10/15/2013, a note written at 9:15am was scribbled out.

Rating Narrative

Policies and procedures regarding behavior management strategies are well documented and in compliance with standards.

This reviewer read agency policies regarding behavior management and reviewed supporting documentation used by staff such as the point cards and other check lists used to monitor behaviors. Staff seemed familiar with the purpose and application of the behavior management system and seemed to view the system as a motivational tool.

The shelter implements a weekly meeting in which youth are recognized for earning points and have the opportunity to receive incentives based on the number of points they earn. Supervisors review point cards and give verbal feedback to staff if they are applying too many consequences i.e. losing points and losing access to television. Log book entries reflect supervisor's feedback of behavior management strategies.

The shelter seems to be effectively applying the behavior management system with positive results. During the facility tour, the Reviewers observed the point store which is located in the Counselor's office. The items are stored in a glass encased cabinet that clearly displays numerous attractive products from which the youth can select such as watches, accessories, shoes, cosmetics, games, posters, and other youth friendly donated items.

3.06 Staffing and Youth Supervision

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Policies and procedures regarding staffing and supervision seem to be well documented and comply with standards.

This reviewer read agency policies regarding staffing and spoke with direct care staff and supervisors about staffing. Staffing schedules from August 2013 through February 2014 along with corresponding youth census were reviewed. Staff schedules are kept in a binder available to all staff and are also posted 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 interviewed are aware of the minimal staff to youth ratios and the staff schedules show a minimal of 2 staff predominantly scheduled on each shift with additional coverage from Interns and Counseling staff when the census is higher. 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. There are 16 functioning surveillance cameras located in the shelter and recordings are kept for 30 days.

Exception:

Indicator 3.06 requires at least one staff on duty the same gender as the youth in the program. Male and female staffing was not observed for multiple days during each week, particularly on the 3-11 p.m. shift. The provider regularly scheduled 2 female staff on various shifts consistently throughout the review period, even when the census included male youth.

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 does not maintain a holdover or overtime roster and does not have contingent or relief staff to assist with additional coverage as required.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The provider has written policy and procedure in place for providing services to special populations. The procedures were consistent with the requirement of the indicator.

Lippman Youth Shelter is not designated as a Staff Secure Shelter by the Florida Network. The program does have a current contract with the Florida Network to provide Domestic Violence Respite (DVR) Services effective through June 30, 2014.

All three DVR youth files that were reviewed 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. All three files showed that the youth were pick up within four hours of referral.

Two files show evidence that the service plan reflects goals focused on aggression management and family coping skills. One file was only opened for less the 24 hours; however, all other requirements were met. One file has evidence showing the transition to CINS/FINS. The Residential Manager has documentation for one of the files where the youth was in a DVR bed for 14 days and needed extra approval for the last 7 days of shelter stay.

Exception

Although the shelter is not a Staff Secure program, the program has a detailed policy and procedure for serving staff secure youth. The provider should change its policy to reflect the practice of the shelter.

The procedure and the practice for DVR services appear to be duplicated in the provider's Policy and Procedure Manual and a reference was made to another agency, the Oasis Shelter instead of Lippman Youth Shelter. Additionally, the policy did not state the procedure or practice for documenting the change in status from domestic violence to CINS/FINS.

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 Agency has written policy and procedures for Healthcare Admission Screening.

The program performs a preliminary physical health screening for each youth at the time of admissions to the shelter and documents the screening on the second page of the CINS/FINS Intake Assessment. The screening is conducted by the YCS staff and includes: current medications; existing medical conditions; allergies; recent injuries/illness; presence of pain or other distress; observation for illness, injury, physical distress, difficulty moving etc; and observation for scars, tattoos, or other skin markings. The agency demonstrated that they are in compliance with the indicator in the three residential files reviewed. Two of the youth were noted as taking medication for acute/chronic medical conditions with the condition being diabetes for one youth. The youth noted as having allergies had a nutritional alert documented in the kitchen. All of the alerts were appropriately communicated to staff and were documented in the youth's files.

While the program documents all medical referrals in the program log book, medical referrals are not documented on a daily emergency medical log as indicated in the QI indicator. The program did provide an instance where a youth required emergency medical care. In review of the program log book, it is documented that the program contacted the parent to arrange for the parent to come take the youth for emergency medical treatment. However, the parent did not come which resulted in the youth waiting two (2) days before the program called for emergency medical services for this youth. It is suggested that the program review its policy and procedure for consideration of inclusion of procedures for emergency medical care when parents do not respond in reasonable timeframe, for example, within 24 hours of notification depending on type of illness and need for emergency services.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a Suicide Prevention Plan revised on 1/31/13 that contained all the elements required. Youth admitted to the program are initially screened using the CINS/FINS Intake Form. If a youth answers "yes" to any of the six questions pertaining to suicide risk on the CINS/FINS Intake form, they are immediately placed under sight and sound supervision until an Assessment of Suicide Risk is performed by the licensed staff or a Master's level counselor under the supervision of the licensed Clinical Supervisor. 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 two applicable case files revealed the youth were assessed as suicide risks and were immediately placed under sight and sound supervision until an Assessment of Suicide Risk was performed by the licensed staff or a Master's level counselor under the supervision of the licensed Clinical Supervisor. The case files also provided documentation indicating that a licensed clinician removed the youth from sight and sound. However, in reviewing the "Alert System Precautions-Observation Log", behavioral observations of youth placed on sight and sound is not compliant with the agency's policy that those observations are to be documented every 10 minutes. Review of the log document observations ranging from 11 to 15 minutes. The program completed safety plans for youth as needed and observation logs were completed as required.

In reviewing the log book, sight and sound ("SS") is noted by many youth entries. Staff advised that those entries pertain to youth awaiting Intake Screening who are automatically placed on "SS" until they are assessed by staff.

It is suggested that the agency develop another terminology for those youth who have not yet been assessed and are being closely monitored until completion of the Intake Assessment. Placing a youth on official sight and sound requires a lot more than what is currently provided to those youth placed on agency referenced sight and sound. Screening and Intake policy would need to be updated to include this process.

4.03 Medications

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

Program has written policy and procedures for Medications that are consistent with the requirement of the indicator.

A review was conducted of the medication storage, access, disposal, and administration/distribution of medications process. All medication is stored in a locked room in a locked cabinet. Narcotics and controlled medications are stored in a locked box for each youth and are kept in a locked cabinet in a locked office which is inaccessible to youth. It was observed that there was an empty prescription bottle and asthma medication stored in the medication storage of two youth that are no longer in the facility.

Although there are no medications requiring refrigeration stored at the time of this review, there is a refrigerator with a lock for storing of the medication. The locked refrigerator is kept in a locked room which is inaccessible to youth.

The program utilizes the Controlled Medication Inventory Record to record Shift to shift counts for controlled substances. Shift to shift counts are conducted and documented on the controlled Medication Inventory Record for each of the youth on controlled medication. However, in some instances, the documented "Actual Time of Count" is not done at the time of the shift change. The "Actual Time of Count" ranges from five (5) minutes to five (5) hours into the shift. The initials of the staff conducting the Medication count and/or the incoming shift leader verifying medication count is not always documented for all medication counts. On January 26, 2014, it appears there was no count conducted as no staff signatures were noted on the inventory form. Over-the-counter medications that are accessed regularly are inventoried weekly and a perpetual inventory is maintained. At the time of this review, there are no syringes sharps stored at the program.

In line with the policy and procedure, only the designated staff delineated in writing have access to secured medications. All designated staff have received training in the Agency's Medication Policy and Procedure and Medication Management.

Of the two (2) medication records reviewed, the records contained the required information, youth's name; youth's date of birth, allergies, medication side effects and/or precautions, picture of youth, staff initials medication record, youth initials medication record, full printed name, signature, and title of each staff member who initials a dosage and full printed name of signature of youth receiving medication.

However, medication errors were observed in the two youth medication records reviewed. In review of the medication distributed to one of the youth, staff did not comply with the prescribed dosage. Per the youth's prescription, the medication was to be administered two (2) times per day yet the medication record documented that youth was issued medication one (1) time per day. Staff advised that the mother requested that they reduce the number of times medication is administered to the youth but this instruction was not confirmed with the youth's Physician neither was a revised prescription obtained.

In another instance, the second youth's medication prescription required medication is administered every six (6) hours. Review of the Medication distribution record documents that the youth received the medication on the 7a.m.- 3 p.m. and 11 p.m.-7 a.m. only and, consequently did not receive it every six hours during the first full day of distribution (2/11/14).

A significant number of medication distribution records were inventory records were not accurately documented and/or not consistent with the medication distributed. On two separate days, the staff and youth initialed for receipt of Adderall medication under the Sertraline medication. On January 26th and 27th, due to the staff initialing in the wrong spot for the wrong medication, it appeared that the youth had taken Sertraline twice in one day and was not given the Adderall.

Additionally, the medication count inventory was not consistent with the medication distribution on January 28th for two different medications (Adderall and Sertraline). The distribution log showed where each medication was distributed once on that day, yet the corresponding inventory for each of the two medications indicates each pill was distributed twice in that day.

It is recommended that the program comply with their agency policy 4.03 for appropriate disposal of medication for youth discharged from the program.

It is recommended that shift to shift inventory counts of medication are conducted at the time of shift change for every shift, that the record is complete and accurate, and staff completing the counts consistently initials and document the times of the counts.

Agency is to ensure prescribed medication is appropriately administered to the youth as prescribed by the physician and that the Medication Distribution Record (MDR) accurately reflects the times prescribed medication is administered to each applicable youth. Any changes to administering dosage(s) of prescribed medication should be directed from the prescribing physician.

As a result of these medication errors observed during the QI visit, the provider was advised to notify CCC.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has written policy and procedures for the medical and mental health alert process to ensure that information concerning a youth's medical condition, allergies, common side effects, etc. is communicated to staff on a daily basis. The program has a medical alert system to communicate medical conditions and other health related issues between staff in the program. The alert system includes: posting of alerts on a board in the staff office, using a color-coded alert system, documentation of coded alerts on a "Shelter Alert System Sheet" maintained in the youth's individual case file, and flagging of the alert on the cover of the case file.

Three (3) files of youth in shelter placement were reviewed. Two of the youth had a medical or mental health condition and were appropriately placed on the respective alerts. The alert system included precautions concerning the medical/mental health conditions and review of the files document compliance with all the requirements of the indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Program has written policy and procedures to address Episodic Emergency Care. The provider has entered into interagency agreements with organizations to provide mental health and medical services.

During this review, the program advised that there was only one incident requiring emergency medical care during the review period. A review of the provider's procedures for emergency medical care revealed that the Program notified parents of the need for emergency medical services and parental notification is documented in the progress notes in the youth's file and in the program log book. In the case file reviewed, it was observed that the program delayed ensuring that the youth received emergency medical services. The program was aware of the need for medical services on 9/23/13 at 10:30am and notified the parent to transport the youth to the Doctor. However, the parent did not show up and EMS was not contacted by the provider until 1:00pm on 9/25/14. The program had not documented the incident on a Daily Emergency Medical/Dental Log but it was documented upon notification during the review. Verification of receipt of medical clearance, discharge instructions was included in the file.

Knife-for-Life and wire cutters are located in the Common Area in a locked "Break-panel" box; in both vans used to transport shelter youth. First aid kit/supplies are located in the Common Area, kitchen area and in both vans used to transport shelter youth.