



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF SE- Lippman

on 01/13/2016

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 | Limited |
| 1.06 Client Transportation | Satisfactory |
| 1.07 Outreach Services | No rating |

Percent of indicators rated Satisfactory: 66.67%
 Percent of indicators rated Limited: 33.33%
 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 | Limited |
| 3.05 Behavior Management Strategies | Satisfactory |
| 3.06 Staffing and Youth Supervision | Limited |
| 3.07 Special Populations | Satisfactory |

Percent of indicators rated Satisfactory: 71.43%
 Percent of indicators rated Limited: 28.57%
 Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

| | |
|---|--------------|
| 2.01 Screening and Intake | Satisfactory |
| 2.02 Needs Assessment | Satisfactory |
| 2.03 Case/Service Plan | Satisfactory |
| 2.04 Case Management and Service Delivery | Satisfactory |
| 2.05 Counseling Services | Satisfactory |
| 2.06 Adjudication/Petition Process | Satisfactory |
| 2.07 Youth Records | Satisfactory |

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

Standard 4: Mental Health/Health Services

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

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: 80.00%
 Percent of indicators rated Limited: 20.00%
 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

Gabriel Medina, Monitor, Department of Juvenile Justice

Tiffany Martin, Project Manager, Florida Network of Youth and Family Services

Kelly Barnett, Residential Supervisor, Children's Home Society WaveCrest

Joan Jordan, Clinical Director, Children's Home Society West Palm Beach

Lashonda Chavis, Director of Admissions, Miami Bridge

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 5 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 3 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 2 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 10 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 9 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 10 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 10 Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 1 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 3 Other |
|---------|---------------------|---------|

Observations During Review

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

Comments

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

[Rating Narrative](#)

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency whose mission is to bring healing, help, and hope to all people in need regardless of religious affiliation, age or national origin. Headquartered in Tampa, the agency has more than 60 programs located throughout Florida. Since its establishment in 1982, LSF has helped nearly 900,000 children and families. Program services include: Child Care Food Program, Head Start and Early Head Start, Foster Care and Adoptions Case Management, Youth Shelters and Family Crisis Counseling Programs, Guardianship Program, Housing, Employment, Refugee and Immigration Programs, Ryan White AIDS Program, and Disaster Response Programs for victims of tornadoes, hurricanes, floods and other natural disasters. ?

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 prevailing 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. 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. As a result of partnering with Safe Place, the program maintains over 100 Safe Place Sites in Broward County.

As part of its outreach efforts 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 CINS/FINS program has a management team that is comprised of: an Executive 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 three vacant positions: one fulltime Youth Care staff and 2 part time relief Youth Care positions.

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 five temporary YCS I. In addition to the Clinical Supervisor, the non-residential component has five Counselor positions and a Lead Program Assistant.

The program has an Annual Training Plan for FY 2015-2016. Each year a copy of the plan is submitted to the Florida Network for approval. 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.

LSF Broward maintains several 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 Department of Children and Families has licensed Lippman Youth Shelter as a Child Caring Agency, with the current license in effect until June 28, 2016.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a Policy and Procedures (#1.01 "Background Screening of Employees and Volunteers") that was last revised on 9/18/15. The policy and procedures 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 of 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 ten (10) personnel files were reviewed for five (5) new hires, two (2) five-year re-screened staff, and three (3) interns. All of the five 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 two eligible five-year re-screenings during the review period. The 5-year re-screenings was submitted to DJJ Background Screening unit and the result was obtained prior to the employees' 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, 2016 prior to the January 31st deadline.

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 9/18/15) that includes procedures for: 1) ensuring a code of conduct that prohibits physical abuse, profanity, threats or intimidation, and neglect; 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.

During agency orientation, staff receives a copy of the agency's Personnel Policies and Procedures Manual that includes a description of its expectation in Integrity in Service Delivery. An acknowledgement of receipt is signed by the employee and a copy is maintained in the employee's personnel file. In addition, new staff sign the Staff/Volunteer Code of Conduct in agreement with the rules. Staff's responsibility and protocol 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 in the lobby, office hallway, the YCS III's office, and 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.

During the review period, none of the direct care staff were written up or disciplined for any incident abuse, neglect, and/or excessive use of force.

The four staff surveyed stated that working conditions at the shelter were good or very good. None of the four staff reported hearing or observing a co-worker using profanity, intimidation, or humiliation when interacting with youth.

Exceptions

Two of the three youth surveyed said they did not know about the grievance process. Two written grievances that occurred during the review period were reviewed. The two grievances were submitted on the same date and were related to staff not feeding them when they returned from running away. However, the grievances were noted as resolved by the youth prior to being noted as being resolved by the Residential Manager.

Two of the three youth surveyed indicated they did not know about the abuse hotline and were unaware of the location of the telephone number. One of the three youth also indicated that adults were not respectful when talking to youth and did not provide a response for feeling safe in the shelter. None of the youth reported hearing staff threaten them or other youth.

Indicator 1.02 stipulates Direct Care workers should not handle the complaint/grievance document submitted by youth; however, the agency's policy and procedures allow staff persons to handle grievances completed by youth.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a written Policy and Procedures (#1.03), revised 9/18/15 for 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 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.

Incidents are documented on an agency incident reporting form that captures pertinent information including date, time, location; client status; participants/witnesses; individuals notified; corrective action and follow up; and signatures of individuals who reviewed the incident. An Incident Reporting Cover Sheet that summarizes the incident is attached to the Incident Report Form and emailed/faxed to Agency's Statewide Director of QQA and Compliance for data entry.

A total of eighty-nine internal incidents were reported by the provider for the period January 14, 2015-January 15, 2016. Thirteen of these incidents were accepted by CCC as reportable. Of the thirteen reportable incidents, six were classified as contraband, four as absconds, one as miscellaneous, and two as youth on youth sexual abuse. Nine of the thirteen CCC incidents were reported within the 2 hour timeframe required.

Exception

Four of the thirteen CCC reportable incidents were reported outside the two hour time-frame required.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures to ensure staff receive the necessary training to successfully complete their job duties/requirements. The policy was revised on 9/18/2015 and has an updated training plan as of 1/7/2016 which includes a training calendar with scheduled dates. The agency maintains an individual training file for each staff which includes manually written training logs, supporting training certificates, sign in sheets, and agendas for each training attended.

A review of nine training files (three clinical, three new hire staff, and three in-service staff) was conducted to assess the compliance with the indicator. All three new hire training files have reached more than eighty (80) required hours, but were missing the required trainings for Personal Safety and Self Defense, and Title IVE Procedures. Out of the three files, there was one

training file that did not receive the required training for Signs and Symptoms of Mental Health and Substance abuse, CPR/First Aid, Human trafficking identification and Domestic Minor Sex trafficking.

For the in-service employee training files, all did not receive the required Fire Safety equipment training; two training files did not have the required Crisis Intervention skills training; and one did not have the required Suicide Prevention training. Out of the three in-service training files, one completed the forty (40) hours required and two training files indicated employees had ample time until their anniversary date to gain the required forty hours.

A review of three clinical training/personnel files was conducted. Out of the three, there was only one staff member that completed the non-licensed mental health clinical staff training in Assessment of Suicide Risk. The agency's policy states if there is a suicide risk screening, the following professionals shall assess the youth within twenty-four hours—a licensed mental health professional or a non-licensed mental health professional under the supervision of a licensed mental health/social worker. Also, the mental health professional's license number was missing from the non-licensed mental health clinical staff person's training in the assessment of suicide risk.

Exceptions

Three of three new hire training files were missing the mandatory required training for Personal Safety and Self Defense training and Title IVE training. One employee was missing the training for Signs and Symptoms of Mental Health and Substance abuse and CPR/First Aid training

All three in-service staff files reviewed did not have the mandatory training for Fire Safety Equipment training.

In two of the three clinical files reviewed, staff were not trained for the Assessment of Suicide Risk.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures, #1.05 – Analyzing and Reporting Information, that was last reviewed 9/18/15. In addition, there is a comprehensive Continuous Quality Improvement Plan (2015) that includes detailed procedures to collect, review, and reports various sources of information to identify patterns and trends. Per the procedures, findings are reviewed by management and communicated to staff and stakeholders.

Quarterly Case Record Reviews

The provider maintains a binder with monthly case record reviews that are conducted for non-residential case files. A total of 101 cases were reviewed between July and December 2015. Documentation included the checklists used during the peer record review, documenting deficiencies. A report is generated for each review. The residential program does weekly case staffing but does not participate in the Peer Record Review.

Quarterly Review of Incidents, Accidents, and Grievances

Data regarding the number of incidents/accidents and grievances is entered into the agency's database that captures a variety of data for all of the programs statewide. A copy of the data entered for the review period was reviewed. Per the provider's procedures, incidents/accidents and grievances will be reviewed at staff meetings. A review of the agendas for monthly staff meetings held since August 2015 for the Non-Residential program did not provide evidence of these reviews.

Customer Satisfaction Data

The programs collect customer satisfaction survey data and enter the number completed each month into the agency database. However, there is no quarterly QIC report of the customer satisfaction surveys completed as required by the providers policy and procedures.

Outcome Data

Florida Network Outcome's data is entered, tracked and documented in the agency's database. The data was reviewed onsite for the period July-November 2015. There is no evidence of this information being shared with program staff per the provider's policy and procedures.

Netmis Data Review

Monthly review of Netmis Data is required by Indicator 1.05. The provider does not demonstrate that this data is reviewed by staff and if any actions are implemented to address any deficiencies.

Quarterly Review of Knowledge Portal

The Shelter Manager reviews the medication inventory and discrepancies on a daily basis but was not aware of the Knowledge Portal. Hence, quarterly reviews of Pyxis Med-Station Reports since implementing the medication system in September 2015 were not conducted.

Exceptions:

The residential program does weekly case staffing but does not participate in the Peer Record Review.

There was no evidence of quarterly reviews of incidents, accidents, and grievances as required by the indicator. Contrary to the agency's policy, there are no presentations and discussions of incidents, grievances and accidents at staff meetings.

There is no quarterly QIC report of the customer satisfaction surveys completed as required by the providers policy and procedures or an annual review as required by the indicator.

Although the agency captures outcomes data in a database, there is no evidence of this information being shared with program staff per the provider's policy and procedures.

No evidence of practice was provided to demonstrate the review of Netmis data by staff on a monthly basis.

Quarterly reviews of Pyxis Med-Station Reports since implementing the medication system in September 2015 were not conducted.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a Policy and Procedures (#1.06 "Client Transportation") for the agency transportation policy. It was revised and approved on 9/18/2015. The procedure of the policy addresses the following: 1) Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle; 2) Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy; 3) Third party is an approved volunteer, intern, agency staff, or other youth; and 4) Documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location. This standard was created in fiscal year 2015-2016. A review of two vehicle transportation logs was conducted for the white minivan and blue van. Agency practice shows employees are on an insurance list. The agency does conduct driver's license checks/screenings, but does not specify if employees are approved drivers and if all employees are on the list.

According to guidelines on Indicator 1.06, if a driver is transporting a single client in a vehicle, there has to be evidence of a supervisor being aware prior to transportation and consent is to be documented accordingly. The agency practice (according to Shelter Manager III) is that staff calls or texts notifying supervisor in order to get consent, but it is not documented anywhere in the log book or transportation log. Agency has a vehicle transportation log which includes date, number of staff, driver or staff name, number of youth, activity and location, time out and time in, mileage start/end, and cleanliness/maintenance comments. But staff didn't start using new vehicle transportation log until December 2015 instead of when indicator became effective in July 2015. Agency policy does not specify or include exceptions if a third party is not available or present in the vehicle while transporting.

On 12/17/2015, there was one staff who transported a client on a school run at 12pm and returned at 1:10pm, but there was no documentation regarding consent by supervisor giving the okay to transport youth. The program has in practice ways to keep clients safe while transporting a client of the opposite sex by having clients sit on rows in the vehicle.

Exceptions

The agency has no evidence that program supervisor was made aware when there was a single driver transporting a single client prior to transportation. No consent was documented in the log book or vehicle transportation log.

The agency has vehicle transportation log which includes date, number of staff, driver or staff name, number of youth, activity and location, time out and time in, mileage start/end, and cleanliness/maintenance comments, but staff did not start using the new vehicle transportation log until December 2015 when indicator became effective in July 2015. Staff should write their full name when completing the vehicle transportation log instead of first name only.

The agency does not maintain a list of approved drivers.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy (1.07 Outreach Services) and procedures for participating in local DJJ board council meetings and to advocate for effective use of CINS/FINS services to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services. The program policy also states to maintain written agreements with community partners that include services provided and a comprehensive referral process.

The program procedures require staff to attend a monthly DJJ Board Council Meeting and community outreach events to distribute written information about its role, programs, and services. The agency will diligently seek out opportunities to form collaborative partnerships and develop inter-agency agreements. According to the Executive Program Director, for over a year no employee has been designated to specifically attend all outreach events, but there are two staff members who attend monthly meetings.

In the program's binder for DJJ Board and Council Meetings, there were agendas but no minutes for the month of August 2015, September 2015, October 2015, and only minutes for month of June 2015. Program Inter-agency agreement (MOU) binder contains agreements with organizations in the areas of mental health services, safe place sites, substance abuse services, truancy services, other CINS/FINS services, educational services, employment services, and support services. Many of the MOU's term of agreements are expired (stemming back from 2011).

Exceptions

At time of the review, agency has not maintained minutes for each Circuit 17 Juvenile Justice Advisory Board meeting. In the binder, there were only minutes for the month of June 2015, and no representation from LSF-SE was present for meeting.

Update terms of agreements and expiration dates with some of the interagency agreements.

Agency should enter data on outreach events into the Netmis system.

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 functional centralized intake process in place. All staff interviewed appears to be knowledgeable in providing CINS/FINS services and helping youth and their families work through crisis situations. Documentation reviewed contained detailed background information pertaining to a youth's immediate needs and presenting problems. 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 five (5) non-residential counselors, all of which are funded by the Florida Network, and a clinical supervisor. There were no vacancies in the non-residential program as of the date of the onsite QI visit. Non-residential counselors are tasked with providing family counseling and case management services that link youth and families with services in the surrounding community.

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.

Standard 2 addresses clinical intervention and case management. Three residential files were reviewed: two open and one closed. One of them contained a completed suicide assessment and two had mental health issues. Three non-residential files were reviewed: two open and one closed. Two had mental health issues, but only one needed a complete suicide assessment. Two files indicated substance abuse issues.

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. Residential and non-residential intake processes mirror Standard 2.01. All youth are screened for eligibility and are offered screenings crisis counseling and information. Screenings are thorough and well documented. Their residential handbook was reviewed and is well written and organized. 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.

A total of six files, three residential and three non-residential files, were reviewed. All 6 files were well-organized, followed identical format, and documented placement given their residential/non-residential determination.

Exceptions

All six (3 residential and 3 non-residential) files did not have proof that CINS petition, case staffing, and adjudication process (DJJ brochure/handbook) were provided or discussed with clients and/or families.

One of the residential client files had missing data in certain areas (e.g., screening form, eligibility form, intake form, health care form).

Three residential clients did not have YCW intake notes.

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. Residential and non-residential needs assessments contained all the elements required by Standard 2.02.

All six files reviewed contained thorough and well-written needs assessments. They follow Florida Network policy and procedure. Residential needs assessments were initiated (and completed) within the required 72-hour timeframe. Non-residential needs assessments were also completed within the required timeframe. All six files had timely clinical director reviews. Two files contain well-documented suicide assessments by both the assigned therapist and the licensed therapist.

Exception

The Suicide Assessment form completed for one of the three non-residential youth was missing the Program Director's review signature.

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. LSF follows the case plan policy and procedure for Standard 2.03.

All reviewed service plans contained pertinent goals based on initial screenings, intakes, and needs assessments. Treatment goals were individualized to each youth in addition to being quantifiable. Residential and nonresidential service plans also consistently incorporated identified concerns during needs assessment development.

Two out of the three residential files reviewed contained service plans. The remaining file's service plan was not applicable as it was not due at the time of the review.

All three non-residential files contained service plans. All six service plans are hand-written in neat and legible script.

Exceptions

All six service plans lack a place for therapists to write in "Completion Date" for each goal when each is completed.

One of the Residential files did not have a service plan within the required 7 working days from the needs assessment. The intake was 11/18/15; however, the service plan was not implemented until 12/7/15 (13 business days).

One of the Non-residential file's service plan was created on 10/22/15. The 30-day review was to be on Saturday, 11/21/15, but was not completed until Monday, 11/23/15.

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

The two residential files with completed case management services contained all the Florida Network requirements for Standard 2.04. The referrals documented in the progress notes of one of the two files are appropriate and based on the needs of the client and involve family decision-making. All three non-residential files also contained the requirements to meet Standard 2.04.

Exception

No referrals were listed or provided in the service plan for one of the Residential youth. Referrals are only documented in the progress notes.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The provider has a written policy and procedure. The policy and procedures appear to be compliant with indicator 2.05.

All residential and non-residential files reviewed received counseling services in accordance with case/service plans located within each file. All six files have therapeutic interventions based on individual youth intakes and needs assessments. All six files follow their service plan goals. 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.

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 the session.

Exception

Two Residential files reviewed did not have any groups.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The program has policy and procedures for the Adjudication/Petition Process (approved 9/18/2015) that comply with requirements and outlined by the Florida Network policy and procedures manual for CINS/FINS. CINS cases require a case staffing committee meeting to review the case of any youth or family that the program determines is in need of services or treatment if youth/family is not in agreement with services or treatment; youth/family will not participate in services selected; and program receives written request from parent or any member of the committee. Agency has regular CINS case staffing which are called Truancy, Ungovernable, Runaway Network that are held on a monthly basis at 9am along with the peer review meetings.

There were three non-residential cases that were reviewed for this indicator. The reviewer observed a combination of committee members present at the CINS case staffing committee such as school district employees, DJJ representative, mental health representative, Counselor, Clinical Director, and parents. The program has documentation in all cases that parents and committee members are being notified no less than five days. 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 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. There were revisions/updates made to the service plans of all three files reviewed after the completion of all case staffing held.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Residential client records are locked in a secure room and secure file cabinet. All physical handling of both open and closed client files maintain strict confidentiality requirements. All three residential files are neat, clean, and well-organized.

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.

The residential facility and the administration office have opaque containers marked "confidential" that are used to transport files.

Exception

All three residential clients did not have "Confidential" marked on outside front cover of open client binders or the closed client manila folder.

Standard 3: Shelter Care

Overview

Rating Narrative

LSF Southeast operates its residential program, Lippman Youth Shelter, licensed by DCF through 6/28/2016. The shelter provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program. At the time of the review, the shelter was providing services to 12 DJJ youth. Lippman provides staff secure and domestic violence respite services to youth. The program has adequate space for all activities and is equipped with 23 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 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. 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 Youth Screening Form and the CINS/FINS Intake Form.

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 Environment

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 through 6/2016. LSF had made improvements to the shelter—including providing fresh paint and new living room furnishings.

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.

During our tour of the facility, reviewer found that all fire safety equipment were tagged and dated. Grounds are landscaped and well maintained. Bedding, linens, towels and laundry equipment were all found to be in good repair.

Daily schedules are posted in the facility offering time for education, recreation, meals, social skills, faith-based activities and other services. LSF is COA accredited through 02/28/2018. Fire drills and emergency drills are consistently conducted on each shift per month. The program has an Emergency Disaster Plan that has been approved by the Network and meets all the requirements of the standard.

Exceptions

Graffiti was found on the headboard of beds in rooms 4, 9 and 10. Room 2 had graffiti on the side of the dresser and the headboard of the bed.

Light covers in the dining room, staff bathroom and dayroom have cracked covers and the light fixture in the kitchen appears to be loose from the ceiling. In the dining room and hallway the light covers have dead insects inside of them.

Evacuation time for three of the nineteen fire drills completed exceeded two minutes to exit the shelter and on the fire drill reports the rating was good without any comment as to why the evacuation took over two minutes.

Cameras only record for 23 days, not the required 30 days. While on site, this was corrected by the video provider.

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 indicator 3.02. The policies are reviewed and signed on an annual basis.

Each youth admitted to the shelter receives a comprehensive client orientation upon admission to the facility. The staff conducting the orientation process completes a Checklist for Orientation that covers different areas of the program. All of the forms are completed at intake and within 24 hours of admission.

Youth and parents also are provided a copy of the 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 three files reviewed contained the receipt of orientation form signed by the youth and the parent as well as shelter staff.

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 indicator 3.03. The policies are reviewed and signed on an annual basis.

Three residential files were reviewed (two open and one closed). During the intake process, youth are evaluated by the staff member conducting the intake and are assigned a room based on history, status, exposure to trauma, behaviors and or gender, age, physical size, maturity level, history of physical or sexual aggression, susceptibility to victimization, medical, mental health, physical disabilities and suicide risk factors. Youth on close watch or with risk associated behavioral concerns may be placed in a single room designated for the special alert room.

Overnight room checks are conducted every 15 minutes and are documented in the log book. Of the three residential client case files reviewed, three contained the room/bed assignment located in the client file.

Exception

Two open files did not have the room assignment section completed on the CINS/FINS Intake Form. Shelter staff did complete the two room assignment sections on the CINS/FINS Intake Form during the review.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Policies and procedures regarding log books seem to be well-documented and in compliance with Standard 3.04. The policies are reviewed and signed on an annual basis.

The log book seems to address safety/security issues, incidents involving staff, supervisor reviews, residential counts and visitation/home visits. Entries are made in ink and are legible. Log book entries that could impact the security and safety of the youth and/or program are highlighted. The shelter manager or designee reviews the facility logbook every week.

Exceptions

Correction of errors are not consistently dated or initialed: On 7/18/2015, entries have write-overs. On 10/09/2015, a line entry was scribbled out along with other write-overs. Multiple logbook pages with dates and time of day (a.m./p.m.) was missing.

Supervisory reviews are conducted; however, they do not indicate corrections, follow-up and recommendations on a consistent basis.

Staff documents shift change but do not document consistently that they have reviewed the logbook. Current logbook shows some improvement with the staff documenting logbook reviews.

A number of pages in the logbooks did not have the month, day and year at the top of the page. This made it hard to know what date was being reviewed.

It was also observed that the staff secure logbook has scribbles and is missing staff signatures, dates and blank spaces/pages.

Logbook entries need to be documented in real time; documentation with consistent 15 minute entries did not appear to be realistic.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

A written policy is in place. Three staff members and three residents were interviewed.

Staff explains the Behavior Management System (BMS) to youth at intake. Residents also sign an acknowledgment that they received a resident handbook at intake which includes a detailed BMS outline. Youth also review forms that are posted in the shelter once they are admitted. BMS uses extra phone calls, extended bedtime, off-site movies twice per week (Friday Phase 3 and Tuesday Phase 2), prize closet, candy and an award ceremony at 5:30pm each Monday as incentives and rewards and to promote completion of the program. Manager maintains records for resident phase work as well.

During the facility tour, there were certificates posted in bedrooms of current youth from most recent award ceremony. Program also utilizes positive reinforcement, verbal processing, switching out with staff and regrouping (coping skill) as preventive measures before providing a consequence. Consequences used include loss of privileges and early bed time. There is evidence that all staff are trained on practice of BMS including supervisors. BMS does provide constructive discipline through offering youth opportunities to process their behaviors.

Staff are provided feedback on BMS in staff meetings, performance review and informal impromptu coaching by shelter manager. Manager provides feedback when he directly observes staff interaction on the floor and after film review. Shelter manager additionally provides feedback when staff asks questions about implementation about BMS.

Exception

There is no protocol for providing feedback and evaluation of staff regarding their use of the BMS rewards and consequences.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

A written policy is in place to ensure safety and security of youth and staff.

Two staff members were interviewed regarding posting of schedule as well as holdover overtime roster.

Program maintains minimum staffing ratios as required by Florida Administrative Code, overnight work shifts maintain a minimum of two staff members present and maintain one staff member of each gender on shift. Staff schedule was seen posted in YCS III office, shelter manager office, and staff work area. Shelter manager and shift manager both are knowledgeable regarding staff/youth ratio.

Staff schedules were submitted for June 2015-December 2015 and were in compliance with scheduling procedures. Agency has a total of 23 cameras with one recently installed in the laundry room. At time of the review, there was also a representative from Tyco that advised Lippman Shelter Manager regarding saving information on an external hard drive. He additionally walked him through the process of saving video footage for up to 90 days. Film footage was reviewed for shift 12/26/15. At 12:45am, 1:00am, 5:30am and 9:30 am. There were no bed checks completed per film footage, however there was documentation stating they were conducted.

Exception

The following days were reviewed for consistency in bed-check documentation with the shelter's video recordings. During the review of the video recordings the Reviewer found that entries were falsified for the following dates reviewed: 12/27/15, 12/30/15, 12/31/15, 1/3/16 and 1/6/16. Due to the nature of the finding, the CCC report was called in by the Reviewer on 1/14/16 at 5:29pm and was accepted; the case number is 2016-00249.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

Agency has a written policy for special populations. Six staff members were interviewed regarding staff secure population.

Agency has had 2 cases for staff secure youth since last review. According to two YCS staff interviews, there is no evidence of there being a formal process of notification for staff to be made aware of who is assigned the staff secure youth. Staff states all persons on shift share responsibility. According to shelter manager and YCS III staff interviews, the process of notification for staff being assigned to youth is done through verbal notification from YCS III or team lead to YCS on shift. There is documentation that there is a log being maintained every 15 minutes regarding status and behavior of staff secure youth. Staff additionally does provide a written report for court proceedings regarding youth progress.

Agency does not serve Probation Respite or Domestic Minor Sex Trafficking populations. Two staff members were interviewed regarding Domestic Violence Respite and three files were reviewed. All three files included a face sheet or court file that document proof of charges for eligibility purposes. Agency staff was also knowledgeable regarding criteria for DV respite. One file reviewed was an intake that occurred the first day of review. That file doesn't currently contain a treatment plan due to recent intake. In two closed files that were reviewed, one did not contain a treatment plan while the other had a plan with one goal that did emphasize reducing the reoccurrence of violence in the home.

Exception

One file reviewed did not contain a treatment plan.

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 Pyxis Med-Station 4000 Medication Cabinet located in the medication room. Over-the-counter (OTC) medications are maintained in another locked cabinet located in the medication room and documented in the OTC medication log. 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 procedure reviewed on September 21, 2015 to ensure medical care for any youth admitted with chronic medical conditions that includes a thorough referral process and mechanism for necessary follow-up medical care as needed.

A review of four youth files randomly selected found that all had healthcare admission screenings documented on the CINS/FINS Intake Assessment Form and were timely completed. It includes the current medication, existing medical conditions, allergies, recent injuries or illnesses, and observation for evidence of injury, pain or physical distress. In each applicable case reviewed the youth was referred to ensure medical care, and the parent or legal guardian was involved in the coordination and scheduling of follow-up medical appointments.

4.02 Suicide Prevention

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a written suicide prevention plan that details the program's suicide prevention and response procedures. It was reviewed on September 21, 2015. The suicide risk assessment and response process continuously assesses and monitors a youth's level of risk for suicidal thoughts, threats, gestures and behavior. The program has a suicide response kit located at the staff station desk.

A review of four youth files randomly selected found that in each case the program completed a suicide risk screening during the initial intake and screening process (documented on the CINS/FINS Intake Assessment Form). In one applicable case, the program completed an Evaluation of Suicide Risk Among Adolescents form and the youth was not in any potential imminent danger. In another case youth was Baker-Acted when she returned from school since she was discovered trying to hurt herself, and displayed depressed and anxious feelings.

The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services. Training documentation reviewed indicated that the program staff completed training in suicide prevention and Knife-for-Life. The program has the National Suicide Prevention Life-Line available for each youth and posted in the facility. All staff surveyed indicated that they knew what to do when youth expresses suicide thoughts, and where the suicide response kit is located.

Exception

One CINS/FINS Intake Form completed does not include the youth's name, the name of the staff completing the form, and the date.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures that address the safe and secure storage, access, inventory, disposal, and administration/distribution of medications. It was revised on September 21, 2015. The program has a part-time licensed registered nurse (RN) that started on January 12, 2016. She distributes medications when she is on site. A tour of the program, staff interviews and documentation reviewed reveals that all medication in the shelter are securely stored in the locked medication room inaccessible to youth.

The program has a list of thirteen staff members currently employed that complete the required training and has been authorized to assist in the distribution of medication when the nurse is not on site. Youth medications are verified by the shift leader and a pharmacist at intake. Medications are stored in a Pyxis Med-Station 4000 Medication Cabinet located in the medication room. Over-the-counter (OTC) medications are maintained in another locked cabinet located in the medication room and documented in the OTC medication log.

Thirteen staff members are assigned as Super Users for the Med-Station. All staff surveyed indicated that they assist youth in the delivery of medication, and that they are informed of medication side effects and the medical alert system. Oral medications are stored separately from injectable and topical medications.

Narcotics and controlled medications are stored behind two locks and documented in the medication distribution log. A perpetual inventory with running balances is maintained. All the youth's Medication Distribution Logs (MDLs) reviewed, displays all the required information. The program has a small refrigerator which was used only to store medication that was empty at the time of the review. There were no syringes and sharps at the program during the time of the review. The program has a Medication Disposal Binder and a Medication Disposal Form, but shows no medication has been disposed since 2012.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure (reviewed on September 21, 2015) that ensure information concerning a youth's medical and mental health condition is effectively communicated to all staff through an alert system. Communication of the alerts included preliminary screening information, staff logbooks, medication distribution logs, case notes, and youth records information.

The program has a color code alert system. The program maintains a medical and mental health alert clipboard located in the intake office and one Food Allergy Board located in the kitchen. In addition, every alert is also documented on a label located in the cover of each applicable youth case file. All the program staff received training in the alert system. All staff surveyed indicated that they received training in common side effects of prescribed medications.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

There is a detailed written policy for episodic emergency care log.

Three staff members were interviewed for this indicator. All staff were knowledgeable about the location of first aid kits and submitted documentation of weekly first aid inventories. Knife for life and tweezers were located at the staff area. Both first aid kits were located and fully stocked—one in the common area near the bathroom and the other in the dining room.

Three youth files were reviewed for emergency care evidence. There was documentation that all three youth needed care. One youth had documentation that parent was not notified. Another youth was transported by local sheriff's office and there is no written documentation in youth file or logbook.

Exceptions

There is no evidence provided that there is a daily emergency log maintained within the shelter.

One staff has not had First Aid and CPR training.

One youth does not have documentation of parent notification.