Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF - SW- Oasis

on 09/05/2012

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Interagency Agreements and Outreach	Satisfactory
1.06 Disaster Planning	Satisfactory
1.07 Analyzing and Reporting Information	Satisfactory

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

Standard 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	Limited
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Youth Room Assignment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Shelter Environment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Daily Programming	Satisfactory
3.06 Behavior Management Strategies	Satisfactory
3.07 Behavior Interventions	Satisfactory
3.08 Staffing and Youth Supervision	Satisfactory
3.09 Staff Secure Shelter	Satisfactory

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

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory:96.43%
Percent of indicators rated Limited:3.57%
Percent of indicators rated Failed:0.00%

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

Members

Marcia Tavares, Lead Reviewer-Forefront LLC Baldwin Davis, Chief Compliance Officer, Miami Bridge Youth and Family Services Paula Friedrich, Delinquency Prevention Specialist, DJJ Prevention Services Paul Hatto, Assistant Program Director, SMA Behavioral Healthcare Beach House

Persons Interviewed

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

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

0 Maintenance Personnel
2 Program Supervisors
0 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
- [x] 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
- [ ] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

3 Health Records
3 MH/SA Records
18 Personnel Records
5 Training Records/CORE
0 Youth Records (Closed)
6 Youth Records (Open)
2 Other

Surveys

3 Youth | 3 Direct Care Staff | 0 Other

Observations During Review

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

Following items not listed were also reviewed: Facility Manual Health Inspections Case Staffing Meeting Schedules and Minutes

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency dedicated to helping all people. Headquartered in Tampa, the Agency has more than 60 programs located throughout Florida. It's southwest program, Lutheran Services Florida - Oasis Youth Shelter, is a Children in Need of Services/Families in Need of Services (CINS/FINS) program located in Fort Myers, Florida. Lutheran Services Florida Southwest(LSF SW) is the designated CINS/FINS provider for Lee, Charlotte, Collier, Hendry, and Glades Counties. The Department of Juvenile Justice ontracts with a single source statewide provider, Florida Network of Youth and Family Services (FNYFS), to oversee all CINS/FINS programs. Consequently, LSF SW is subcontracted with the FNYFS to provide CINS/FINS services to prevent children living in the aforementioned counties from entering the juvenile justice and child welfare systems. In addition to providing CINS/FINS services, LSF SW also provides protective supervision, foster care and adoption services as the Lead Case Management Organization in Lee County. LSF SW also offers Guardianship Services providing protection to incapacitated people — mainly the frail elderly. 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. This consistent achievement demonstrates the organization’s commitment to maintaining the highest level of standards and provision of quality services to its consumers. LSF SW participates in the national Safe Place Program, a network of voluntary community sites such as Fire Stations, local businesses, and schools that partners with the agency to provide a safety net where youth in need of help can go for refuge. A designated staff is responsible for Safe Place site recruitment, training, and ongoing support as well as community and school presentations. The efforts of the program are evident by the more than 140 Safe Place signs displayed on county libraries, fire stations, and other prominent businesses in the region. The program also has numerous interagency agreements that are used to network with the surrounding communities,such as low-performing schools, community parks, and various designated neighborhoods in an effort to make agencies, youth, and families aware that services are available to address the needs of troubled youth and families.

Standard 1: Management Accountability

Overview

Narrative

LSF SW operates both the Oasis Youth Shelter (residential) and Non-Residential CINS/FINS Programs in Lee County, Florida and is the designated CINS/FINS provider for the surrounding counties namely Charlotte, Collier, Hendry, and Glades. The program has a management team that is comprised of a Vice President of Programs located in Tampa Florida; an Executive Program Director; a Residential Services Manager; a Clinical Manager; a licensed Clinical Supervisor (Counselor III) who is a Licensed Mental Health Counselor (LMHC); a Youth Care Supervisor (YCS III); and a Senior Administrative Assistant. At the time of the review, the program had one vacant Outreach Specialist position. The Executive Program Director oversees the activities of both the CINS/FINS residential and the non-residential programs as well as other programs operated by the provider in the Southwest Region. 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 Southwest maintains multiple interagency agreements with various community agencies that ensure a continuum of services for its youth and families. The program has an active outreach component with participation of all program staff who focus their outreach activities in designated high crime zip codes and low performing schools. The Florida Network acknowledged receipt of the program's Disaster Preparedness plan for FY 2011-2012; the current plan shows a revision date of August 27, 2012. The Department of Children and Families has licensed Oaisi Youth Shelter as a Child Caring Agency, with the current license in effect until January 31, 2013.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures that address the screening of all Department employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth. The policy requires the screening to be conducted prior to hiring an employee or volunteer which is conducted using Live Scan. In addition to the DJJ Background Screening, the provider also conducts driver's license screening at hire and annually thereafter, annual local municipality and county screenings, and a drug screening upon hire and at random. The provider submitted its Annual Affidavit of Compliance with Good Moral Character Standards on January 4, 2012 prior to the January 31st deadline. A total of eighteen (18) background screening files for thirteen (13) staff and five (5) volunteers/interns. All eleven (11) new hires were screened and had eligible screening results prior to hire date. Four (4) of the five (5) interns received an eligible background screening prior to start date. Additionally, two (2) staff eligible for 5 year re-screening were rescreened prior to their 5-year anniversary mark. One of the intern's background screening result was completed two days later than her official start date on 8/23/11.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Agency Policy and Procedure, 1.02, addresses all of the requirements of the indicator. New staff, upon hire, is informed of the agency's Code of Conduct that is included in both the Agency's Policy and Procedures and Personnel Policies and Procedures Manual. An acknowledgement of receipt signed by each staff is maintained in his/her personnel file. New staff also signs an acknowledgement of receipt of the Abuse Reporting Requirement. A verification of the completion of both of these acknowledgements was conducted during the personnel file review for two new employees. In practice, evidence of abuse reporting was observed in one of the files reviewed and noted in an internal incident report. Child Abuse Training was observed in all of the applicable files reviewed. An onsite observation concluded the postings of the abuse hotline number in the shelter in common areas. Rights and responsibilities are posted throughout the facility and are in the individual case files, signed by youth that they have been read. Three youth surveyed stated that they knew about the abuse hotline and location of the telephone number. The three youth surveyed indicated that they feel safe in the shelter. Similarly, the three staff surveyed said they have never witnessed another staff prohibit youth from calling the abuse hotline and have never observed staff using threat, intimidation, or humiliation when interacting with youth. Two of the three youth surveyed stated that adults in the shelter program are sometimes disrespectful and occasionally use profanity when speaking with youth. They also indicated that they sometimes hear staff threaten other youth. However, it appears that management was not aware of these incidents and none of the grievances reviewed during the review indicated maltreatment of youth, verbally or physically. Additionally, one of the three staff surveyed indicated that s/he has observed a co-worker using profanity when speaking with youth. One known abuse report was called in by the counselor on the 09/04/2012 but this was not indicated in the log book.

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. Staff receives training on this topic during program orientation. The procedures require staff responding to the incident to immediately notify their immediate 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 and determination is made by management regarding how to proceed. During the review period, the program reported twenty-three (23) incidents called in to the Central Communications Center (CCC). A review of the incidents was conducted along with a review of the provider's Incident Report Binder and program logbook. Incidents are recorded on an Incident Report Form and were documented and highlighted in the logbook. However, some exceptions occurred with regards to prompt reporting, documentation of incidents in Netmis, and maintenance of copies of reported incidences. Three of the twenty-three incidents reported during the review period were not reported to CCC within the 2-hour timeframe required. Also, copies of four of the incidents reported were not found in the Incident Reporting Binder. Additionally, four of the reportable incidents were not documented in Netmis as required.

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 provides an Annual Training Plan for the 2012-2013 Fiscal Year which includes a monthly staff training schedule. The agency maintains an individual training file for each staff which includes a tracking form, supporting training documentation, and attendance log. A review of five training files for three first year and two in-service staff was conducted to assess compliance with the indicator. Two of the three first year staff had completed or was on target for completing the 80 hours of training required. One of the two in-service staff is on target for completing the 24 training hours required and the other had exceeded the requirement and had completed 39.75 hours of training. One of the first year staff had only completed 62.5 of the 80 hours of annual training required during the first year of employment. Additionally, four of the five training files reviewed were missing some of the core training topics required by the Florida Network for first year and inservice staff such as Cultural Competency, Signs and Symptons of Mental Health and Substance, Suicide Prevention, and Crisis Intervention.

1.05 Interagency Agreements and Outreach

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program builds strong community partnerships and collaboration to ensure youth and families receive proper/appropriate services. As such, the program has a centrally located binder that holds all its Memorandum of Agreements (MOUs) and Interagency Agreements. Fifteen such agreements were evidenced in place with prevention/intervention programs, universities, substance abuse and mental health providers, and other services. All of the agreements reviewed were current and/or showed an ongoing renewal process. Although community outreach is a shared responsibility, the program has a designated staff person who is responsible for Community Outreach Activities. The Outreach position was vacant during the visit but the responsibilities were temporarily being conducted by the Nonresidential Program Manager. The Outreach staff coordinates the Safe Place Program and is responsible for recruiting of Safe Place sites, conducting presentations, and assists with the establishment of interagency agreements as well as any community partnership and collaboration. LSF Southwest also participates in the national Safe Place Program and maintains an outreach presentation log and outreach statistics on a monthly basis. The program conducts volunteer recruitment and currently has three Interns from local Universities. At the time of the onsite review, the program was not able to provide evidence of the outreach activities that were conducted during the review period. It appears that there is a gap in the documentation of these activities in Netmis and internally since the position became vacant in July 2012.

1.06 Disaster Planning

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a comprehensive policy and Procedures as well as an Emergency Plan that contain the following elements of the indicator: 1) required types of emergency situations (except for terrorist acts); 2) procedures to follow in a severe weather warning; 3) necessary equipment and secure transportation; 4) conditions under which evacuation would occur; 5) Identification of specific evacuation facilities; 6) procedures to bring necessary food and; and 7) notification procedures to the Florida Network. The procedures were reviewed and approved by the Executive Director, Residential and Non-Residential Managers on August 27, 2012. Employees are trained in emergency procedures during their orientation training and the majority of training files reviewed showed that staff had received Fire Safety and Emergency Preparedness training. Emergency episodic and fire drills are conducted by the program and are documented on a log and corresponding reports that provide details of each drill including an analysis and critique. Both types of drills were reviewed for the review period. Fire drills were conducted by staff at least monthly basis and more frequently during some months. Quarterly episodic drills were also conducted quarterly by the first and second shifts. The program participates in the Universal Agreement for Emergency Disaster Shelter with the Florida Network Member Agencies. The provider's Emergency Plan is missing procedures for Terrorist Acts. In addition, evacuation facilities are listed in the Emergency Plan but not

consistently noted or referenced in the provider's policies and procedures. Some deficiencies were noticed in the completion of fire drills and quarterly episodic drills as follows: 1)the fire drill evacuation times exceeded the two minutes recommended in four of the fourteen drills reviewed; 2) the fire safety forms completed after each drill were oftentimes incomplete and were missing information about the inspection of the fire extinguishers and name of staff inspector; 3) the third shift has not completed a quarterly episodic drill since January 2012.

1.07 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, outcome data, and monthly review of Netmis data reports. The agency's clinical staff conducts peer reviews of all active client files on a monthly basis. Reports are generated and reviewed by the Non-Residential and Residential Service Managers. In additions, the Non-Residential Clinical manager conducts case supervision on a montly basis with all non-residential Counselors and Case Managers and any issues identified from the peer reviews are addressed. Monthly staff meetings are held for all program staff and during these meetings, all incident reports, grievances, and accidents are reviewed. The Non-Residential Manager prepares a Quarterly QIC Report which includes an analysis of incidents, accidents, and grievances. Consumer satisfaction data will be included in the QIC Reports, effective the first quarter of the current fiscal year. Findings are regularly reviewed by management and communicated to staff and stakeholders. Strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process. No exceptions noted.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Oasis Youth Shelter provides an array of prevention services for youth ages ten to seventeen years of age and their families who meet the criteria for CINS/FINS services. Referrals may come from the youth, parents/guardians, schools, law enforcement, or other community organizations. The program provides centralized intake and screening twenty-four hours per day, seven days per week, each day of the year. Trained staff are available to determine the needs of the family and youth. The youth and family participate in a face-to-face session in order for the staff to assess their individual needs and develop an individualized plan of services to accomplish specified goals. Residential counseling services, including individual, family, and group therapy, are provided. In addition, case management and substance abuse prevention services are also offered in non-residential settings. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, financial assistance, housing assistance, and educational assistance. LSF SW cordinates 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 can also recommend a CINS Petition be filed to court-order participation with treatment services.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency provided their policy and procedure that include the requirements of the indicator including: services being accessible 24 hours a day, seven days a week; conducting initial screening for eligibility within seven calendar days of referral; and provision to the youth and parent/ guardian of the service options, rights and responsibilities parent brochure, grievance procedures, rules and regulations of the shelter, and emergency procedures which are included in the handbook. For this review six (6) youth files – three residential files and three non-residential files were randomly selected. Of the six files reviewed, all six had their eligibility screening completed within the required 7-calendar days. Also, all of the six files documented that youth and parents received in writing information pertaining to the available service options, the rights and responsibilities of youth and their parents/guardians, the parent brochure, grievance procedures, the possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication). No exceptions noted.

2.02 Psychosocial Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures which includes the requirements that the assessment be initiated (or attempted) within 72 hours of admission and completed within two to three face-to-face contacts or updated if the most recent psychosocial assessment is more than 6 months old. Three of three residential files reviewed all documented that the psychosocial assessments were all initiated within 72 hours of the youth's admission. All of the assessments were completed within 2-3 face-to-face contacts after the initial intake. All assessments reviewed were completed by a Bachelor or Masters level staff member and included dated signature to indicate a supervisory review upon completion. Only one of the youth files reviewed identified the youth with an elevated risk of suicide as a result of the psychosocial assessment and the referrals for an Assessment of Suicide Risk for that youth was completed by a licensed mental health professional (LMHC) as required by the indicator and the agency policy and procedure. No exceptions noted.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The written agency policy and procedure for Case Service Plans requires that the plan be developed within seven (7) working days of the completion of the psychosocial assessment. The policy requires reviews to be conducted every 30 days for the first three months and every 6 months thereafter for progress in achieving goals and for making any necessary revision to the service plan, if indicated which is in compliance with the requirements of the indicator. Of the six files reviewed, all six files documented that the case/service plan was developed within 7 working days of the psychosocial assessment being completed. The review documented that all of the six youth files demonstrated reviews for progress every 30 days for the first three months. There were two instances when the 30-day reviews could not take place. The first instance occurred when the youth was in secure detention at the time the 30 day review was due. The second instance included documentation demonstrating that the youth was an active runaway at the time the 30 day review was due. None of the files reviewed were old enough to have required a six month review. No exceptions noted.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures which includes the requirements that each youth be assigned a counselor/case manager to follow the youth's case and ensure delivery of services through either direct provision or referral. The indicator and the policy both require case management to include establishing referral needs and coordinating referrals to services based on the assessment of the youth's problems and needs, coordinating the service plan implementation, monitoring the progress in services, providing support for the family, monitoring any out-of-home placement if necessary, referring to the case staffing committee as needed, recommending and pursuing judicial intervention in selected cases, accompanying youth and parents to court hearings and related appointments, if applicable, referral to additional services, providing continued case monitoring, and review of court orders and case termination with follow up. Fo the files reviewed 100% included documentation to indicate that the counselor established referral needs to services based upon the youths assessment, had coordinated service plan implementation, provided monitoring of the youth's/family's progress in services, provided support for the family. Monitoring of out-of-home placement was documented including the current status of one youth currently in process to be moved to an out-of-county shelter to best meet the needs of the youth. Referrals to the case staffing committee were documented in the three non-residential files reviewed. The files reviewed indicated that the counselor accompanies the youth and parent or guardian to court hearing and related appointments and referrals for additional services were made when indicated. None of the files included case termination as all the youth are still receiving services. No exceptions noted.

2.05 Counseling Services

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The written agency policy and procedures adheres to the requirements of the indicator in that it requires provision of individual and family counseling, and group counseling in shelter at least five days per week. The policy also requires non-residential program's provision of community-based services in the youth's home, a community location, or the provider's office. The agency policy and procedure adheres to the indicator by including the requirements for counseling services as detailed in the indicator. Six of six files reviewed documented that the youth had received counseling services in accordance with the case service plan for that youth. Both individual and family counseling were documented in the files. In the case of one youth documented to be poorly engaging in the services, the file demonstrated that the counselor made attempts to provide individual counseling in excess of the frequency prescribed by the plan in an effort to engage the youth. Six of six files reviewed documented that the youth's presenting problems were addressed in the psychosocial assessment, the initial case service plan, and reviews; case notes were maintained for all counseling services provided. Documentation also supported the on-going clinical review of case records and staff performance. Group counseling was noted to take place on Tuesdays through Saturdays (inclusive). In a review of group sign in sheets dated from March 1, 2012 through September 5, 2012, it was noted that there were 16 dates where groups were not held thereby providing fewer than the minimum five days per week of group counseling sessions. The sign in sheet log maintained documentation to explain that the group sessions of these dates were not held due to the counselor attending training or conferences (five instances), the counselor being out or out sick (four instances), the office being closed (one instance), because of agency holiday (two instances), and three dates were no notation was made to indicate why group was not provided. There was no documentation included to show efforts of other staff members being arranged to provide the group counseling in the place of the counselor.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures which includes the requirements of the indicator. The three Non-Residential files reviewed documented that the Counselor or the TURN Committee initiated the staffing rather than it being requested by the parent. Two of the three files documented that the notifications were sent to the family and staffing committee at least 5 working days prior to the staffing. Documentation of case staffing in all three files indicates that the local school district and DJJ and the CINS/FINS provider were in attendance at the staffing. One of the three files documented that the notification was sent to the family and staffing committee on February 29, 2012 when the staffing was also scheduled for February 29, 2012. This was believed to be a typographical error on the date of the letter sent to the family and the staffing committee members but no other documentation to disprove this was available. The indicator does not specifically stipulate which representatives are required to be present at the case staffing. The agency policy and procedure for this indicator exceed the indicator in that it states that the Case Staffing Committee includes specific representatives "as required by Florida Statute", including a representative of the state attorney and the alternative sanctions coordinator. The documentation of case staffing did not include attendance by any representative of the state attorney or the alternative sanctions coordinator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The indicator requires that the program maintain confidential records for each youth that are maintained in a near and orderly manner, are marked "confidential" and kept in a secure room or locked in a file cabinet. The client files reviewed were neat and orderly, each following the same order and table of contents included at the front of each section of the file. Client files are kept in a locked file cabinet located in a secure room. One of the six files reviewed was not marked “confidential” on the outside of the file.

Standard 3: Shelter Care

Overview

Rating Narrative

Oasis Youth Shelter is a twenty-two bed facility that provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program and youth from the Department of Children and Families (DCF). The shelter provides short-term residential services for youth ages ten to seventeen, who do not have any current open cases of delinquency or dependency. With the exception of court-ordered CINS youth, the services are voluntary in nature and no fees are charged to clients for CINS/FINS services. At the time of the quality improvement review, the shelter was providing services to ten DJJ youth. The shelter is designated by the Florida Network to provide staff secure services but had not admitted a Staff Secure Youth during the review period. In addition, the shelter provides services to youth in the custody of the Department of Children and Families (DCF). The shelter program management team is comprised of the South West Regional Executive Director, a Residential Services Manager, and a Youth Care Supervisor. Each shift also has a YCSII who is the designated team leader. An organization chart dated 8/24/12 shows an additional twenty-four Youth Care positions in the shelter program, none of which was vacant during the review. There are also four residential counseling positions, one of which is occupied by the Licensed Mental Health Counselor (LMHC). Clinical services are supervised by the LMHC Counselor. Services provided include individual, group and/or family counseling, and any other applicable intervention required.

3.01 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency demonstrates practice of indicator 3.01 by way of documentation of this standard element. It has a written policy in place that sets out the expectation. These standard areas were deemed satisfactory based on the accurate and well recorded documentation reviewed in three residential client files. A suicide risk assessment is conducted at intake of client. The alert system is utilized on client file so that a risk assessment of client needs can be readily identified and youth placed appropriately. Allocation of youth to assigned beds was evidenced also by the client information board in the shelter day room. By way of interview with staff, it was evident that assignment of rooms and beds are also based on age of youth and any behavioral concerns at the time of placement. Alerts on the files that were added after intake did not and perhaps should have those action dates written on it also so that the new alerts are consistent with updated client status. One file had both words written on the red alert “Added” “Off”, with no indication of which occurred first or which was the current youth alert status.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency demonstrates practice of indicator 3.02 by way of accurate documentation of this indicator within the three case files that were reviewed. The agency has a written policy in place that sets out the expectation of this indicator and all three case files reviewed showed that the orientation process occurred within the specific timeframe, no later than 24 hours of admission. Signatures were in place to show that the orientation packet (handbook) was reviewed with the clients by staff in a timely way. The agency Orientation Handbook itself, covered all the relevant elements for that indicator. There are available grievance forms and there is a grievance box located centrally that all clients have access to should they chose to submit a grievance by that means or go to staff directly. Seven grievance reports were submitted for review to the team for the six month period and all were dealt with within the expected timeframe. Rights and responsibilities are part of the orientation handbook and it is posted throughout the facility and are in the individual case files, signed that they have been read. No exceptions noted.

3.03 Shelter Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

A general walkthrough was conducted initially by the review team as part of the audit orientation. The reviewer also conducted an independent inspection of the shelter facility. The facility appears satisfactory in appearance and provides a clean and safe environment for the clients and staff. Bedrooms were furnished with adequate bedding, numbered beds and individual drawers units. The day and dining room were adequately furnished with practical recreational objects for the clients use. Bathrooms are adequately laid out and functional and the laundry room has a workable industrial type washing machine and dryer. The kitchen was clean and tidy; all menus were posted as well as the Registered Dietician's license that is current. The refrigerator and freezer showed the recommended temperature and food was labeled and organized appropriately. All fire extinguishers that were checked were within the scheduled maintenance timeframe of May 2013 and were mounted safely. Egress plans, showing evacuation routes, were visible throughout. Emergency lights and signs were checked and were operational. The agency has on record, a current fire department violation letter/notice dated the 29th August 2012. A further inspection for corrective action is due on 12th September 2012. The following were noted by way of an audit inspection on the following items by the review team on Thursday,

September 6, 2012: 1) All bedrooms now have smoke detectors and bedrooms 1,2,5,6 were checked and were operable; 2) Two A/C filters were checked and they were found to be clean. Emergency light was repaired and now working; 3) Grease collection bowl is on order and expected within the next 7 days, but before the Fire Department re-inspection date; 4) Tape and plastic cup has since been removed from obstructing the fire sprinkler head; and 5) As indicated above, all fire extinguishers are hung appropriately. All the necessary DCF licenses and residential DOH Group Care Inspection certificates were in place. No exceptions noted.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a log book in place and provided the review team with completed log books for the past six months. Completion of the log book met all the basic requirements of the audit, notably the entries were in real time, errors were corrected as required by the standard and overnight bed checks were conducted at 10 minute intervals, above the standard requirement. All staff signed when an entry was made. During the review of the logbook, it was difficult to find weekly supervisor reviews of the log book and staff had to help to idnetify these reviews because the notations by the supervisor were not distinguishable. In addition, bed check entries merely stated, “All youth appear to be resting” rather than include more detail information of the names of the youth and their specific locations. Playback on the CCTV was not possible so the reviewer could not verify the logged bed check times against that task being completed by staff. No exceptions noted.

Rating Narrative

The agency has a structured programming component in place for all clients. Daily programming charts are posted in various areas within the shelter, notably in all bedrooms, day room, and hallways so that it is visible to clients, staff and visitors. Introduction to programming is introduced via the orientation packet. All youth are offered a variety of appropriate recreational activities throughout the day. These supplement individual sessions that are in place for the week. All sessions are documented appropriately with sign in sheets and details of discussion items. No exceptions noted.

3.06 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy in effect that drives their behavior modification strategy. This was reviewed and confirmed that they use the Boy's Town model of points system with which to increase and reward positive behaviors of clients. Oasis Youth Shelter uses a reward system that includes but is not limited to recreational outings and extra privileges on a daily and weekly basis. Upon admission, each youth receives a pre-loaded total of 200,000 points with the initial behavioral goal of following the shelter rules. Positive behaviors are rewarded by deducting up to 10,000 points daily, while negative behavior results in points being added and privileges being affected. Youth are given a point card to begin each day and positive and negative behaviors are tracked on the card throughout the day as behaviors are observed. If a youth has successfully reduced his or her points to zero and has received the appropriate rewards, a new card with 200,000 points is given to the youth to continue the process. By way of the standard requirement, it is the expectation that staff will be oriented in understanding this process and evaluated on their performance in utilizing the BMS. A sample of staff training files was reviewed. Of the five files reviewed, two Youth Care Specialist showed no recorded evidence of BMS training provided by the agency. In reviewing the BMS and its effect on staff Performance Evaluation, four program staff files were reviewed and none indicated that BMS was a part of their performance attainable goals.

3.07 Behavior Interventions

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a current policy in place that compliments their behavior modification strategy. All clients are required to have a behavior modification plan in place so that whenever negative behaviors are in place, it gives staff an understanding of how to deal with youth. All three files reviewed revealed all clients had a behavior management plan. The provider's policy and practice covers all areas of this particular indicator. No exceptions noted.

3.08 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for staffing and youth supervision and adopts its own staffing best practice where it provides a 4-4-3 staffing structure on a daily basis and at all times. This ensures that the agency meets its staffing ratio obligation at all times. Throughout the audit visit it was evident that staffing ratio was adequate and within the standard expectations. Staffing schedules are prepared a minimum of two weeks in advance and are posted in the Intake office and kept in a labeled binder for reference also. No exceptions noted.

3.09 Staff Secure Shelter

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has policy for this standard in place; however the agency has no recorded intake of staff secure client over the last year. Staff was interviewed and confirmed not having a recent staff secure youth in the program. If that were the case, the agency's policy provisions meet the requirement for accommodation, supervision, and services to staff secure youth. No exceptions noted.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

LSF SW 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 room 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 shelter manager and/or Youth Care Supervisor is 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 in the daily log, on the alert board, shift exchange forms, and in the youth files using a color coding system. 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 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

There is a written policy and procedure in place to address the healthcare admission screening process. The procedures cover all seven bulleted items of the indicator. The CINS/FINS Intake form includes much of the healthcare screening information: health insurance information with doctor and dentist's contact names and numbers; any observable injuries, illnesses, or other health related issues, medication, dental or other health conditions/concerns; recent history (one year) of treatment or hospitalization(s); current treatment or medication for mental health disorder; current medications; any food, medication or general allergies; dietary restrictions; nutritional concerns or fitness issues; and presence of any scars or tattoos. The Oasis Healthcare Admission Form covers a number of overlapping health issues with more indepth information being gathered. Three youth files were reviewed for this indicator. All three files accurately captured the information required by the indicator on both the CINS/FINS Screening Form and the Oasis Healthcare Admissions Form. All three youth files had a healthcare screening completed the same day of admission. The program maintains a medical referral daily log for appointments. No exceptions noted.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a comprehensive policy and procedure written to address the indicator regarding suicide prevention. Three youth files were reviewed to determine compliance with the indicator. Two of the three files reviewed did not require sight and sound supervision. One youth was placed on sight and sound beginning 8/17/12. There was evidence of this in the logbook, on the shift change logs for every shift, and on the alert board (light blue dot). Youth was assessed by a licensed mental health professional on 8/17/12. It was determined that the youth would remain on sight and sound due to the fact that the youth stated the s/he would not notify staff if s/he felt like cutting her/himself. A follow-up was completed by the LMHC on 8/23/12 and youth continued to be on sight and sound. When a youth is on sight and sound for a long duration, it can be difficult to maintain five-minute checks. The youth placed on sight and sound was not assigned to a specific staff responsible for sight and sound observation on three days: 9/1/12, 9/5/12, and 9/6/12. The provider also did not provide consistent five-minute checks as required for the entire duration of sight and sound supervision.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy and procedure to address this indicator. The reviewer observed that medication is stored in a separate secure area that is inaccessible to youth. Oral medication is stored separately from topical or injectables. A secure refrigerator is available if needed. Narcotics/controlled substances were behind two locked doors. Shift-to-shift counts are conducted and documented for controlled subbstances. Designated staff are delineated in writing to have access to secured medication. This list is posted in the medication room. Syringes and sharps are secure and counted at least weekly. Records of CINS/FINS youth contain: youth's name, date of birth, allergies, medication side effects or

precaution, picture of youth, youth and staff initial, and full printed name, signature, and title of each staff member who initials a dosage. Three youth files were reviewed for medication records. All three files reviewed had accurate medication counts. All of the required information were completed and documented on the medication distribution form. The medication distribution records form does not include the youth's full printed name and signature. Additionally, no formal training is completed for staff members responsible for the distribution of medication.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy and procedure to address how medical and mental health alerts pertinent to the youth are conveyed to program staff. The program also uses a color coded system of alerts. The alerts are added to the youth's file, the alert board, allergy alert board, and entered into the alert binder and logbook. In practice, at the end of the intake process, the alerts are recorded and placed in all of the aforementioned places. Four youth files were reviewed. All of the files reviewed had a medical, mental health condition, or food allergy. All youth were placed on the program's alert system. Documentation in the shift change log provided evidence that staff are initialling to the fact that they reviewed the log book and alert board. Lead staff initials for medication review and this is done daily on each shift. No exceptions noted.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

There is a written policy and procedure in place to address when, where, and how staff obtains offsite emergency services. The parental notification element of the indicator was also addressed in the procedures. The program has a daily log that has been in place for a number of years. The procedure is very specific as to what treatment can be addressed at the Convenient Care and what treatment is appropriated at a hospital Emergency Room. The policy further defines who and how a youth can be transported. The provider's procedure covers parental notification procedues in depth and how and where to document the episode. Three youth files were reviewed and none required emergency care. A knife for life and wire cutters were accessible in three lcoations: medication room, Residential Services Manager office, and the file room. First aid kits/supplies are available in five location throughout the facility. No exception noted.