



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF SW- Oasis

on 09/30/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Failed
1.03 Incident Reporting	Limited
1.04 Training Requirements	Failed
1.05 Analyzing and Reporting Information	Limited
1.06 Client Transportation	Failed
1.07 Outreach Services	No rating

Percent of indicators rated Satisfactory:16.67%
Percent of indicators rated Limited:33.33%
Percent of indicators rated Failed:50.00%

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:42.86%
Percent of indicators rated Limited:14.29%
Percent of indicators rated Failed:42.86%

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	Failed
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory:60.00%
Percent of indicators rated Limited:40.00%
Percent of indicators rated Failed:0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory:52.00%
Percent of indicators rated Limited:20.00%
Percent of indicators rated Failed:28.00%

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, Consultant-FORERONT LLC/FNYFS

Keith Carr, Consultant, FOREFRONT LLC/FNYFS

Balwin Davis, Chief Compliance Officer, Miami Bridge Youth and Family Services



Quality Improvement Review

LSF SW- Oasis - 09/30/2015

Lead Reviewer: Keith Carr

Shad Rennick, Program Director, Sarasota YMCA

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 2 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 0 Food Service Personnel | 9 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 checked="" 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 | 3 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 17 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 7 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 4 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 10 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 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

- 9 Youth 12 Direct Care Staff 0 Other

Observations During Review

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

Comments

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

[Rating Narrative](#)

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency dedicated to helping all people. Its headquarters is located in Tampa, Florida. The agency has several different types of programs located throughout Florida. LSF was first accredited by the Council on Accreditation (COA) in 2004 and was recently re-accredited by COA through February 28, 2018.

The Southwest program, Lutheran Services Florida Southwest (LSF SW), is the Lead Case Management program in southwest Florida which is funded by the Florida Department of Children and Families, through the Children's Network, to provide Child Welfare services to children in Lee and Charlotte counties. Services provided under this contract include: protective supervision, foster care, and adoption services. LSF SW also provides Guardianship Services, providing protection to incapacitated individuals age 18 and over in DeSoto, Manatee, and Sarasota counties provides a variety of services for youth and families.

LSF SW is the designated Residential and Non-residential CINS/FINS provider for Lee, Charlotte, Collier, Hendry, and Glades Counties. The Oasis Youth Shelter is the residential program located in Fort Myers, Florida. The Non-Residential program is located in a separate building at the same site as the Residential Program.

LSF SW participates in the National Safe Place Program, a network of voluntary community sites such as Fire Stations, local businesses, and schools that partner 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 program currently has a network of over 200 Safe Place sites including county libraries, fire stations, Walgreens, Goodwill Stores, United Way Houses, Lee County Transportation, and other prominent businesses in the region.

In addition to the collaboration with Safe Place sites, 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 Program 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 the following positions: Vice President of Programs located in Tampa Florida; Executive Program Director located in Fort Myers; a Manager III (LCSW) who supervises Prevention/Intervention, Quality Assurance, and Residential and Non-Residential Counseling programs; a Residential Services Manager; a Youth Care Supervisor (YCS III); a Part time Registered Nurse, and a Senior Administrative Assistant. At the time of the QI visit, the following positions were vacant: Executive Director – Interim Director is the Southeast Program Director, two residential full time Counselor positions, a full time Youth Care Staff (YCS), and 6 temporary YCS positions.

The Executive Director's position was vacated three weeks prior to the QI visit. In the interim, the SE Director spends two days in Fort Myers, providing oversight and supervision of the program managers who are responsible for the CINS/FINS residential and non-residential programs as well as other programs operated by the provider in the Southwest Region. The program experienced a turnover of its management staff during the past year including the former Statewide Director of CINS/FINS, Vice President of Special Projects, and Statewide Quality Assurance Director. The latter is not shown as a current position on the organization chart.

Two internal changes include the promotion of two former Residential Counselors to the Manager III and Residential Manager positions resulting in the two counseling position vacancies.

The program has an Annual Training Plan for each staff and orientation training is provided to all new hires. However, it was evident that training of staff has not occurred regularly and core training topics were not completed for both new hires and in-service staff.

The program experienced a Moratorium of CINS/FINS Services and a Corrective Action as a result of an unscheduled visit in June 2015 in which several issues and concerns were observed regarding the safety and supervision of youth and condition of the shelter. A Corrective Action Plan was implemented by the provider but some items were still pending completion during the QI visit.

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.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

LSF Southwest has a policy and procedures (1.01-Background Screening of Employees and Volunteers) that was last approved September 25, 2015. The policy addresses the screening of all Department employees, contracted providers, grant recipient employees, volunteers, mentors, and interns. The agency's policy also requires background screening to be conducted prior to offering employment. 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 randomly thereafter.

A total of fifteen (17) background screening files for sixteen (16) staff and one (1) volunteer/intern was reviewed. All of the fifteen (15) new hires were screened and had an eligible screening result prior to their hire date. The one (1) staff eligible for a 5 year re-screening was rescreened prior to their 5-year anniversary date. Similarly, the one (1) program volunteer was background screened prior to providing service.

The provider submitted its Annual Affidavit of Compliance with Good Moral Character Standards on December 29, 2014 prior to the January 31st deadline.

There are no exceptions to this indicator as of the date of the QI visit.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency's Policy and Procedure, #1.02, approved September 25, 2015, addresses all of the requirements of the QI indicator. Staff is informed of the agency's Abuse Free policy during orientation via the Agency's Code of Conduct, the Agency's Policy and Procedures Manual, and Personnel Policies and Procedures. Staff acknowledges receipt of this information by signing an Acknowledgement Form which is maintained in their personnel file. New staff also signs an acknowledgement of receipt of the Abuse Reporting Requirement.

During the tour of the facility, the posting of the abuse hotline number was observed throughout the facility in the lobby, dorm hallways, bedrooms, and common areas. Rights and responsibilities are posted in the individual youth's bedrooms and are signed by the youth and/or parent/guardian during intake. A total of 14 abuse calls were reported by the provider during the past 6 months. Abuse incidents are documented on the monthly incident tracking form. Two of the 14 were institutional but were unfounded. The two staff were suspended, pending investigation, and were re-instated by the agency as the investigation concluded the allegations were unfounded. However, one of the two incidents lacked information and/or documentation

about the investigation conducted and documentation validating the staff's return to work.

The provider has written procedures in place for youth grievances. Grievance forms are kept near the telephone in the dayroom but no grievance depository box was observed in the facility. A total of eleven grievances were reviewed. Nine of the grievances reported in September 2015 pertained to a new phone policy (4), new rules (3), and staff's behavior toward youth (2). Two other grievances were made due to use of profanity by staff and a second by youth complaining that the staff did not offer her alternative meals more suitable for her diabetic condition. None of the nine grievances submitted in September were documented on the correct form showing how management addressed/resolved the issue and/or the youth's acceptance of a resolution. It appears the correct form had not been used since March 2015. Per the Shelter Manager, the grievances were informally addressed with each of the youth, discussing their concerns.

Fifteen of the sixteen staff surveyed stated that working conditions at the shelter during the past years have been poor (9), fair (5), or very poor (1). Five of the staff surveyed reported having observed a co-worker using profanity when working with youth and three stated they observed staff using threat, intimidation, or humiliation when interacting with youth. Interviews with staff members indicate until recently the physical plant or workplace was in poor condition. Staff expressed that current physical improvements are needed and a good positive measure to move the program workplace right direction.

Exceptions:

During the tour, no grievance box was observed. Forms are available and youth give the grievances to staff or the manager. Per the QI Indicator, direct care staff should not handle the grievance documents completed by youth.

Two of the shelter staff were disciplined for misconduct; one of the two incidents was lacking information/documentation for internal investigation of the incident and basis for staff to return to work.

Nine of the eleven grievances reviewed were not documented on the correct form that documents staff debriefing and/or recommendations. Additionally, adequate efforts to address these grievances were not documented to show they were resolved: 4 were related to new phone policy, 3 regarding new rules, and 2 regarding staff's misconduct.

Fifteen of the sixteen staff surveys indicated fair-very poor working conditions at the shelter during past year.

Three of the nine youth surveyed stated they did not know about the abuse hotline. Three of the nine youth also indicated they were not aware of the grievance process. With regards to care provided, three youth reported it was very poor (1) or fair (2). Two youth also stated that staff was disrespectful toward them.

One youth grievance stated the program was aware of her medical (diabetic) condition but did not provide alternative food she requested.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a written Policy, 1.03, and procedures for the notification of reportable incidents to the Department's Central Communication Center (CCC) within the two (2) hour timeframe. Incident Report training is included on the provider's training plan for new staff during program orientation. The procedures address communication of incidents to the Executive Director daily as well as post-incident review by the Management team. Follow-up communication regarding tasks/special instructions required by the CCC was not included in the policy/procedure.

The provider's procedures require staff responding to the incidents/accidents to immediately notify their direct supervisor and/or management during daytime hours or supervisor/designee during evening or weekend hours. Any unusual incident is documented on the Incident Reporting Form by the witnessing staff member. Upon notification, determination is made by management regarding how to proceed. Additionally, the QA Specialist keeps track of the number and severity of incidents and provides a monthly report. Incident reports are maintained in a binder on a monthly basis by fiscal year. The Incident Reporting Hotline numbers are posted throughout the facility in each youth's bedroom, the day room and intake office.

During the review period, fourteen (14) of the incidents reported to the Central Communications Center (CCC) were accepted. Of the fourteen incidents reported to CCC, one (1) was related to medication error, two (2) for mental health/medical incident, three (3) for contraband, three (3) for absconds, one (1) for altercation, and three (3) for complaint against staff. None of the three incidents alleging complaint against staff provided documentation to show how management investigated these incidents and whether or not a disciplinary and/or corrective action was implemented. Five (5) of the fourteen (14) incidents were not reported within the two hour timeframe required.

Exceptions:

The provider's Incident Reporting policy and procedures (1.03) does not address a process for following up with the CCC regarding specific tasks/special instructions required by the CCC.

Per the provider's P&P, the Clinical Manager and Shelter Manager will keep a log and track the number and severity of incidents on a bi-weekly basis. However, this practice was not evident. Additionally, there was no evidence that the Shelter Manager and clinical team has a review process for all incidents to include identification of antecedents, assuring proper follow-up and after care are in place, and implementation of recommendations.

No written summary of staff de-briefing or Recommendations/Corrective Actions were documented on the incident report forms.

Follow-up of incident that occurred on June 2, 2015 was not provided to DJJ CCC as requested.

Five of fourteen CCC incidents were not reported during the required 2 hour timeframe.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a comprehensive written policy and procedures to address staff training and has developed an annual Training Plan to ensure staff receives the necessary training to successfully complete job requirements. The agency provided a copy of their Training Calendar for the 2015-2016 Fiscal Year which includes a monthly staff training schedule. The agency maintains an individual training file for each staff which includes supporting training documentation and attendance log.

A review of seven training files for four first year and three in-service staff was conducted to assess compliance with the indicator.

Exceptions:

It was evident that the program lacked a systemic process for providing and documenting orientation training as this was not observed in three of the four new hire training files. There is no clearly defined list or evidence of Program Orientation training topics that is consistently provided to all new staff. Job specific training for new direct care staff was not evident in three of the four new hire training files.

None of the new hires were on target for completing the 80 hours required as follow:

- DOH 12/12/14 – 13.5 hours completed
- DOH 7/21/14- 18.5 hours completed
- DOH 11/3/14- 43.5 hours completed
- DOH 6/28/15 – 6 hours completed

The majority of mandatory training topics were not completed by 3 of the first year staff including topics such as Crisis Intervention, Personal Safety/Self Defense, Suicide Prevention, CINS Core, Mental Health/Substance Abuse, and Professional Ethics.

An in-service component for providing recommended training was not established by the program. Non-mandatory trainings are listed on the staff's training record but there isn't a clear list showing recommended topics.

None of the three in-service staff members were on target or had completed the 40 hours of annual training hours required.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record reviews, incidents, accidents, grievances, customer satisfaction, outcome data, and monthly review of Netmis data reports.

Peer record review is the responsibility of the agency's clinical staff. However, the program fails to demonstrate that peer record reviews have been conducted for the Residential Program as required by their P&P. There isn't a current Peer Record Committee in place.

The program collects and tracks data on incidents, accidents, and grievances on a spreadsheet on a monthly basis. The data is compiled by the agency's CQI Director into report that includes a summary of the incidents/accidents, grievances, and fire drills that occurred during the quarter, summary of case record reviews, reporting of performance measurements for the quarter, number and types of training provided to staff, and satisfaction surveys completed; however currently, there isn't an active committee that reviews or analyzes the reports to make recommendations and implement corrective actions based on the findings.

The program's Administrative Assistant reviews the NetMis data reports monthly and communicates deficiencies to the appropriate manager.

Consumer satisfaction data is included in the quarterly QIC Reports. Monthly reporting of Customer Satisfaction data is evident via observation of the database; however, no companion (aggregate report) was conducted by the program. Findings are reviewed by management and communicated to staff at staff meetings.

Although the Pyxis Med Station is installed and staff have been trained, the provider has not gone live with the Pyxis Med Station; consequently, there are no reviews of the Knowledge Portal.

Exceptions:

The program fails to demonstrate that peer record reviews have been conducted monthly or Residential files as required by their P&P. There isn't a current Peer Record Committee in place.

The QA Specialist collects and tracks data on incidents, accidents, and grievances on a spreadsheet on a monthly basis; however, there isn't an active committee that reviews or analyzes the reports to make recommendations and implement corrective actions based on the findings.

Monthly reporting of Customer Satisfaction data is evident via observation of the database; however, no companion (aggregate report) was conducted by the program.

Although the Pyxis med station is installed and staff has been trained, the provider has not gone live with the Pyxis Med Station; consequently, there are no reviews of the Knowledge Portal.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has developed a Client Transportation Policy that provides for and gives authority for agency approved drivers of agency owned vehicles or approved private vehicles. Evidence of group insurance coverage was provided at the time of the visit with coverage to include an umbrella policy.

Agency policy states that staff driving records are checked on an annual basis and staff with poor driving records would be excluded. However an employee's file noted instances of poor driving records and the employee is still allowed to drive the agency vehicle. Agency employees submit license at time of hire and driving records are checked for the previous three years.

Exception:

The transportation log documentation was checked and the agency has a log but it does not conform to LSF-SW or the QI indicator. Apart from mileage, name and initials, the log does not include time, number of passengers, purpose of the travel, and location. Current practice fails to indicate that staff are not to transport youth one-to-one without consultation and approval from the program director that youth history, employee history and circumstance of travel justify such risk.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure that addresses the standard. It differentiates between policy, procedure and practice. The program keeps a binder on interagency agreements between other providers. These providers include the School System, mental health providers, Juvenile Assessment Center and Law Enforcement.

A review of the Agendas for the DJJ Advisory Board Meeting indicates that there have been two meetings since August 2014. Those dates were August 20, 2014 and February 11, 2015. There are no meeting minutes for these two meetings and no documentation that staff attended these meetings. The Interim Regional Director indicated that he believes these meetings have been discontinued.

This Indicator is not being scored for this QI review.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Lutheran Services Southwest provides residential and non-residential services to youth ages 6 - 17. The Oasis Youth Shelter residential facility is located in Ft. Myers. The non-residential services provide services to four counties: Charlotte, Collier, Glades and Lee County. The Non-Residential program is under the direct supervision of a Manager III who supervises the clinical team comprised of 6 Counselors (1 Counselor III, 3 Counselor II, and 2 Counselor I). The Non-Residential program is divided into two components: clinical and prevention/intervention. Prevention/Intervention is comprised of 4 Counselor I positions. Referrals for services are received from parents, school, counselors, the court system, etc. Services provided include individual, family and group counseling along with case management services. Case management services include life skills, social skills and referrals for services upon the youth's return to the home. Youth also receive referrals for substance abuse and mental health services.

A CINS/FINS screening is conducted on each youth prior to their entry into the facility to determine if they are appropriate for the program. Trained staff are available to determine the needs of the family and youth. A needs assessment is then conducted on each youth to ascertain what services they will need to be provided. 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. After completion of the needs assessment a case/service plan is created to address these issues. 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.

File reviews conducted during the audit indicate that intake, screening, needs assessments, and case service plans are being completed in a timely manner and are addressing the needs of the youth. Individual sessions are being held with residential staff, but contact and cooperation with families is an issue. Non-residential staff are having family sessions, but residential counselors are not completing family sessions. With the promotion of some clinical staff to management positions the lack of supervisory reviews is evident. Weekly case reviews are not currently being conducted. Clinical staff are addressing case service delivery during their individual sessions, but there is not supervisory review of that process occurring until the 30 day case plan review. The Program Director seems to be disgruntled and has made it known that some things are not occurring and that she would like for things to change. While there seems to be a lack of Management oversight the clinical staff seems to be addressing the identified needs of the youth in individual sessions.

LSF SW coordinates the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. A case plan is created with the youth and family through recommendations through the case staffing committee. The case staffing committee may include representatives from the school district, DJJ or CINS/FINS provider, State Attorney's Office, Mental Health and Substance Abuse organizations, law enforcement and DCF. Aftercare and discharge planning are also addressed prior to the youth's release. The Case Staffing Committee meets at a minimum six times monthly and 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

Policy and Procedure addressed all aspects of the standard. The policy was well written and contained sections that incorporated information pertaining to policy, procedure, and practice. The program has centralized intake services that are available twenty-four hours, seven days a week. Initial screenings are occurring within seven days of referral. Cases are screened for crisis information and youth with elevated risk are being counseled.

Non-residential files contained sign off sheets for available services options, a parent/guardian brochure and possible actions occurring through involvement in CINS/FINS services. However, residential files did not contain any documentation of those notifications.

A total of ten files were reviewed for this standard. All four non-residential files contained appropriate information while all six residential files did not contain documentation of CINS/FINS information being provided.

Exception:

Residential files did not contain any documentation for available services options, a parent/guardian brochure and possible actions occurring through involvement in CINS/FINS services

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

The agency's Policy and Procedures addressed all aspects of indicator 2.02. The policy was well written and contained sections that incorporated information pertaining to policy, procedure and practice.

Needs assessments are being completed or initiated within seventy-two hours for residential clients or within two to three face-to-face contacts following the initial intake for non-residential youth. Needs assessments are completed by Bachelor's or Masters level staff and signed by a supervisor. Youth indicating suicide risk are being assessed by a licensed clinical staff. The credentials for the Licensed Clinical Social Worker staff was reviewed onsite and observed to be valid.

Nine files were reviewed for this standard. All three non-residential files had needs assessments completed within the timeframe. Of the six residential files that were reviewed, five had the assessment completed within 72 hours of admission.

Exception:

One of the residential files was out of compliance of completion of the needs assessment within the 72 hours required.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy and procedures addressed all aspects of the indicator 2.03. The policy was well written and contained sections that incorporated information pertaining to policy, procedure and practice.

Case service plans are being completed within seven days of the completion of the needs assessments and contain information gathered during screening, intake and assessment. Goals have been identified with the appropriate responsibilities and target and completed dates documented.

Exceptions:

Four of the nine case service plans reviewed were not signed by the parent/guardian. Two residential files did not have thirty day reviews completed. Case reviews are not currently occurring on a weekly basis due to staffing vacancies. In discussion with staff this has been occurring for about the last two to three months. However, in reviewing closed cases, the case reviews had been occurring prior to the vacancies.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy and procedures addressed all aspects of indicator 2.04. The policy was well written and contained sections that incorporated information pertaining to policy, procedure and practice.

Clinical staff are acting in the role of case manager. A review of the case files indicate that the clinical staff are providing counseling services as well as case management. Within individual sessions the clinical staff are monitoring progress and coordinating referrals for services. Services provided are documented in the progress notes.

Of the nine files reviewed, all three non-residential files had family participation.

Exception:

The six residential files reviewed showed limited participation in services from the families.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

The requirements for indicator 2.05 were addressed by the agency's Policy and Procedure. The policy was well written and contained sections that incorporated information pertaining to policy, procedure and practice.

Youth are receiving individual sessions from the clinical staff. Counseling services are based upon the needs assessment as well as the case service plan. Case notes do document the youth's progress and services provided.

Family counseling services are not being provided to residential clients on a regular basis. Of the six residential files reviewed, only one had a family session. Individual sessions are occurring on a regular basis, but clinical staff needs to make sure they are within seven days as discussed on the case service plan. Some are occurring just outside of a week.

Exceptions:

Case reviews have not been held on a weekly basis for approximately the last two to three months according to staff. The internal process that ensures clinical reviews of case records is not occurring due to staff vacancies. Service Plan reviews are occurring within the thirty day review period, but with weekly case reviews not taking place there is no review process occurring on regular basis.

Documentation of groups attended is not in the youth files. They are kept in a separate binder. There is a schedule of groups five days per week, but the group sign in sheets do not correlate with what is being provided. Groups are not being held the minimum of five days per week. From 7/1/15 through 9/30/15, there were only two weeks where there were five groups held during that week. The Good Behavior Game during daily activities was documented twenty-three times during that time period. These groups did not address any specific topics, but seemed to entail staff supervising youth during their daily activities. Even if the Good Behavior Game was utilized to address group counseling there would still be six of fourteen weeks that would not meet the criteria.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy and procedures addressed all aspects of indicator 2.06. The policy was well written and contained sections that incorporated information pertaining to policy, procedure and practice.

Case staffing meetings are held on a regular basis in the four counties served. Notification to committee members is occurring through a yearly calendar sent out as well as individual case staffing meetings notifications.

In all three files reviewed, the program initiated the staffing and notification was provided to the families. Representatives from other agencies were present at the meetings. The parents were provided written reports outlining the recommendations of the committee within the required timeframe; one was mailed to the parent who was not at the meeting. In two of the three cases there was court action necessary and the counselor did provide a summary to court and work with the court on the interventions. Of the two completed one was a revision and the other was a new plan that was created after the committee met and during a new intake. That youth had been in services before and the court date was a carryover from the previous service provided.

Exception:

In one of the three files a new or revised plan for services was not completed. In speaking with supervisory staff they indicated that they are in the process of training staff in completing a new or revised plan upon completion of the case staffing committee recommendations and that staff are now revising plans.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Policy and Procedures reviewed addressed all aspects of indicator 2.07. The policy was well written and contained sections that incorporated information pertaining to policy, procedure and practice.

The policy did address the revision of the standard indicating that files are to be transported or locked in an opaque container that is marked confidential. Files are marked confidential and are kept in a neat and orderly manner. An opaque locked container marked confidential was observed onsite.

Standard 3: Shelter Care

Overview

Rating Narrative

The Oasis Youth Shelter is licensed by the Department of Children and Families (DCF) as a twenty-two bed Child Caring Agency through January 31, 2016. The facility is also licensed to provide children's substance abuse services for Prevention Level 1 and Outpatient Treatment.

The shelter provides short-term respite residential services to youth ages 6-17 in the Department of Juvenile Justice (DJJ) CINS/FINS program as well as for youth from the Department of Children and Families DCF. The CINS/FINS youth typically do not currently have any 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 the clients, parents or guardians. This shelter is designated by the Florida Network to provide staff secure services, Domestic Violence (DV) respite, Probation Respite, and Domestic Minor Sex Trafficking. The program had not served youth meeting the criteria for the latter three services during the review program.

The shelter program management team is comprised of a Residential Services Manager and a Youth Care Supervisor (YCSIII). Each shift also has a YCSII who is the designated team leader. An organization chart dated 9/18/15 shows a total of twenty-eight Youth Care positions in the shelter program (including 1 YCS III and 3 YCS II), seven of which were vacant during the review namely 1 FT YCS and six Temporary Relief YCS. There are also three residential counseling positions.

LSF-SW Oasis shelter building includes a large day room, 6 x girls' and boys' sleeping rooms, kitchen, laundry, staff offices and a secured internal courtyard area. During the Quality Improvement review, the shelter was found to be in improved condition prior to its state before a corrective active plan was imposed in June 2015; some facility improvements are currently in place at this time. The furnishings are in adequate condition and the rooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 bathrooms, one for each gender; the female bathroom was currently under reconstruction at time of site review visit. The bathrooms floors are tiled and the plumbing appeared functional. The sleeping rooms houses four (4) youth each. The sleeping room is equipped with two metal bunk beds and each youth has an individual bed, bed coverings and pillows. The windows are fitted with blinds for privacy for the youth.

In addition, the youth have access to a recreational games, volley ball court, and basketball. This youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services and other special populations.

The Direct Care workers are responsible for completing all applicable admission paperwork conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the staff as they are yet to get a RN as required by the 2015 CINS/FINS contract, a position that has been paid for since July 2015. Staff maintains inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administers first aid when needed, and coordinates all offsite appointments to medical providers. First aid kits are located in several locations throughout the facility, to include the medication office and kitchen. All medications are stored in a locked cabinet in the Medical Office.

Oversight of clinical services is provided by Clinical Manager. The program has policies and procedures in place for its Shelter Care programming. The Shelter Environment, Program Orientation, Youth Room Assignment, Log Books, and Behavior Management Strategies policy and procedure are all adequately written and more recently updated to reflect the Florida Network's standards. However, in moving forward, the actual practice of the policies and procedures will make for program improvements for the youth served, staff, and the physical plant ensuring achievement and an environment that's conducive to growth.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency's policies and the implemented procedures are in compliance with the mandated guidelines. The agency is on a corrective action plan (CAP) to address issues of concern that were identified back in June 2015. The agency has current DCF license valid through January 2016. A review of the 06/05/2014 Health Inspection shows that the shelter had a satisfactory inspection after several corrective action points were addressed. There is no current annual Residential Shelter Inspection and one was not provided on site. The Shelter Director called the DOH to seek this document or to arrange for an inspection visit.

The agency has a Disaster Plan that requires updating to include current chain of command; it did not meet the specific DJJ policy as required to be part of the Universal Agreement. The Disaster Plans were not observed to be accessible within the facility for ease of reference.

The shelter has up-to-date inspections for fire equipment, sprinkler and alarm systems, as well as this reviewer saw no signs of insect or termite infestation. The grounds of the shelter seemed well cared for and the building was recently painted and had a new replacement roof.

The male bathroom and shower was clean; the girl's bathroom was currently under reconstruction during the QI visit. The furniture in the shelter all seems to be in adequate repair. This reviewer did not notice any readily observable graffiti. The sleeping dorms were clean and each youth had his/her own bed, pillow, linens, etc. The shelter seemed to have adequate lighting and each youth had his/her own locked locker in their bedroom. The windows have blinds with strings which pose a safety hazard. The laundry was cluttered with all types of items and had one dryer and one washing machine that were both working but dated. Though not a standard requirement, it is a challenge to have only one appliance for 22 youth, in keeping with licensing.

There seems to be some misunderstanding of roles and responsibilities in keeping the shelter clean and clutter free. One room where chemicals are kept locked in a closet was almost inaccessible as it was full of paint and other building chemicals and equipment which smelled quite toxic, even on the outside. The chemicals are inventoried and MSDS are available. While the bedrooms have all been recently painted and are fresh, bedroom 6 had graffiti on the ceiling, just over one bunk bed. Bunk beds are steel type and have some issues of safety where they could cut or scrape an individual; these areas of concern were visibly covered with tape. One ladder in room 6 needs to be removed immediately as it was partially broken and has become a safety hazard.

The kitchen was clean and tidy. Food items in the main fridge required proper arrangement and fridge to be cleaned. Labels were on food items; however, there was no evidence to Food Hygiene Service Inspection from the DOH nor was there a dietician's license available for verification. The Dietician's license via DOH online verification was subsequently made available on site. Sharps are kept locked in the kitchen and a count observed that these are checked daily by staff. In talking with staff it is apparent that there is no control on keys and so there is a safety and accountability issue at stake as keys are not signed in or out, nor are they accounted for in the log book. While surveillance cameras are operable, no one knows how to operate the system for review.

The agency's vehicle is kept locked. It was used on the morning of the site visit and was found to be very dirty with garbage strewn all over. There was no knife for life, flashlight or glass breaker, seat belt cutter or air bag deflator. The fire extinguisher did not have an inspection tag and the first aid kit had opened packets of items with some missing. A folder with confidential youth information was found on the floor under the first aid kit. The log was dirty, crumpled with water marks and partly torn; the documentation for the log does not meet current transportation policy requirement as previously cited.

The Shelter Manager disclosed that due to recent overhaul of shelter, the grievance box was removed and she is in the process of replacing. In the interim, forms are made available in the day room by the telephone for youth to complete and return to staff, this is not in compliance with CINS/FINS standards. Daily activity schedules are not posted and made readily available; however, there was a set weekly agency schedule that was posted at different locations.

The provider is striving to create a safe shelter environment and home-like ambiance for youth and staff. LSF-SW has taken some very necessary corrective action steps; however the following concerns remain:

- Emergency Fire drill – one is done in the past year, on 07/23/2015. Previous one was done in August 2014.
- Residential Group Care Inspection Report – none current in place, see main narrative
- Transportation Log - Van protocol not carried out in accordance with CINS/FINS standard (see main narrative) needs revising to take into account requirements such as purpose of travel, number of passengers etc.
- Food Hygiene Service – none in place, see main narrative.
- Security – see camera and shelter keys accountability and control in main narrative.
- Cords on blinds must be removed from windows or the blinds removed to meet DJJ specific standards.

Additional from CAP:

- Emergency light in lobby not working
- Outside camera pointed downwards (see above under security)
- Smoke detector needed in room 6
- Remove broken ladder on bed in room 6
- Need numbers need to be on all bedroom doors
- Ice machine still not working
- Fire signs to fix throughout
- Remove blind chords in rooms
- Put temporary cover over all electric sockets/outlets
- Fence at rear needs fixing
- Baseboard needed in kitchen, cover all area.
- Cover low positioned plug in outlet in boys bathroom
- Fix loose wire in shower area, alarm, security, unsure of use.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a clearly defined policy for providing program orientation to youth and family members. The youth is provided with a shelter handbook that highlights things such as contraband, how discipline works in the shelter, proper dress, access to medical/mental health care, visitation, banned items, mail and telephone, grievance procedures, behavior management system, and suicide prevention. This was evidenced in the 5 open and 4 closed shelter files reviewed, including those for special populations, DV Respite cases. Youth signatures were all present on orientation checklist form, stating that they received and reviewed this information with staff.

There is a designated Intake office where at the time of intake a youth meets with staff who provides both the client handbook and an explanation of the information stated above. After meeting with a staff, the youth then meets with other shelter staff who provides the next part of orientation to include taking the youth on a tour, introducing key staff and their functions, review emergency evacuation procedures, and identify all areas of the facility.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy for room/bed assignment is to assess the youth's needs at time of intake based on personal demographics such as gender and age and specific history and risk factors of the youth such as medical needs, mental health needs, and history of violence or sexual aggression. At the time of intake the youth meets with a member of the staff who does the intake and the assessment of the youth. In the event that the youth is admitted at night or other times clinical staff are not available, shelter staff will do the initial assessment and clinical staff will reassess as needed.

A review of six (6) individual residential youth case files found that, in all cases reviewed, the program completed a CINS/FINS Intake Assessment form that included all the required elements of the room assignment indicator. The facility has six separate moderately sized rooms for males and females with 4 beds in each room. Youth are assigned a bedroom and bed based on age, physical size and behavioral characteristics. Shelter staff interviewed seemed to have a working knowledge of how room assignments are made.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a clearly defined policy for log book documentation. This reviewer looked at log books dating for the past six months prior through the present. The log books met some of the requirements of the indicator. In most instances log book entries seem to be brief and concise, consistently showing the date and time of information shared.

Exceptions:

This reviewer did observe some unusual events from the review of the log book notes. Staff did not review entries from the previous two shifts and do not enter in the log book that they were on or leaving to go off duty. Overnight bed checks are not documented as conducted in real time. Staff doing the bed check is not documenting in the log book as only one person enters these, for all rooms, male and female. Because no one knows how to operate the camera playback, no bed check reviews could be done for this review; the Shelter Manager is not randomly reviewing the recordings as required. Entries or corrections have been etched out, not voided, initialed and dated as the standard requires.

- Entries or corrections have been etched out, not voided, initialed and dated as the standard requires.
- Bed checks are inconsistently recorded in log book in real time.
- Staff do not document that they review entries from the previous two shifts and as such without that entry, it does not identify which staff is on duty and what time they come on and depart duty.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has developed a new Behavior Management Strategy (BMS) that is structured on a level system and dictated by resident behavior and rewards and incentives. This is in transition mode and consists of three (3) levels which entitles youth to certain privileges and rewards by meeting the criteria associated with the level. Residents can advance to a higher level when reaching these goals. As youth advance to a higher level, they can receive more privileges and opportunities in the shelter.

From speaking with staff, it appears that the previous system was not working so well and so the new system is still early work in progress to address this dire need of a workable BMS for the agency.

The agency clearly had issues pertaining to staff supervision and management of clients several months ago; hence, a corrective action plan was implemented some months ago. From general conversation with youth in the shelter, they did not currently voice any concerns or felt affected by the previous or current BMS that was in place. Staff also confirmed that a core group of clients that were apparently deviant to shelter structure and rules have since left and staff are regrouping to implement a better and more appropriate BMS.

Four staff training records had been reviewed and it showed where staff had recent training in behavior management strategies that they adopted from their Southeast program.

The agency employs a policy where physical intervention should not take place between staff and youth except in situations where physical interventions are required to prevent serious injury to youth or others. Interviews and surveys with staff and youth indicated that youth currently feel safe at the facility. Rules and consequences are included in the youth's orientation handbook and are prominently posted on the wall in the facility. Staff have also participated in the recent FN recommended Managing Aggressive Behavior (MAB) training.

Exception:

Management oversight of BMS was not properly enforced for some while since the last review and more recently during the past six month period. This is evident by log book entries of multiple and serious deviant behaviors and incident reports. A mixed population is served CMO/CINS that resulted in serious program disruption, partly due to an ineffective BMS. Training in the new policy development to address the issue only occurred a week ago, although this was identified three months ago.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency's policy and procedures fully address the requirements of the indicator.

While checking the log book in tandem with staffing schedule, it was noted that the agency maintains a minimum staffing ratio; however, for two nights of the week the agency has only male staff doing the third shift (overnight). By the same token, the afternoon shift on those two days included three female staff members. Not using the log book or any documentation for staff to sign in or out, leaves the shelter exposed to particular risks of accountability of staff and security and safety of both clients and staff. Staff schedules are done weekly and not circulated to individual staff members; however, these are posted in the Intake office for all staff to review.

Exception:

On reviewing the staff schedules, it showed two male staff only working overnight consistently on two days of the week. Consequently, the program does not meet male and female staffing guidelines during these shifts and does not provide evidence of any attempt made to find staff of equal gender as the agency policy suggest and per the QI indicator.

There is no hold over roster; however, the reviewer saw a list of on call staff and telephone numbers that was provided for staff to use.

The program's camera's playback is not accessed by staff and no playback is available since staff does not know how to operate system.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a recently revised and detailed policy 3.07 on Special Populations that address the general requirements for this indicator.

There is a defined process for receiving and addressing primary issues related to all special population groups: Staff Secure, Domestic Violence, Domestic Minor Sex Trafficking, and DJJ Respite referrals.

The agency has taken in a total of 12 DV client referrals over the past six months. No documents were in the three files reviewed to show that these were approved by the Florida Network prior to Intake. Staff however confirmed that the approvals were made and provided documentation on site to confirm this practice.

In all three files, the youth's stay did not exceed the 14 days allowed. One of the three youth transitioned to CINS/FINS and the youth's file included documentation of the intake and transition. Services provided to the three youth are consistent with those provided to CINS/FINS youth. In addition, all Domestic Violence client files reviewed did have evidence of a treatment plan that focused on aggression management and family coping skills or other associated violence reduction strategies.

The program did not serve any other special populations such as Staff Secure, Probation Respite or Domestic Minor Sex Trafficking during the review period.

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 Manager III (LCSW), Residential Manager and/or Youth Care Supervisor is notified immediately if risks and/alerts are present; 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 locked cabinet, and topical and/or injectable medications are stored separately from oral medication. The provider has installed the new Pyxis Medication System and has trained at least two Super Users but has not gone active to date. 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 Medication Distribution Log binder.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a recent policy that was reviewed and signed by Residential Manager on September 25, 2015 that describes the approach to executing the Healthcare and Admission Screening.

The agency has a description of the process. The current process requires that the agency perform a preliminary physical health screening at the time of admission to the shelter. The policy has been updated to include that if the agency has a Nurse, the Nurse will conduct the health screening. The agency utilizes several documents that identify and capture physical health issues such as medical conditions or current medications the client may be taking. The current forms used to capture healthcare information include the NETMIS screening form, 2 page CINS/FINS Intake Assessment, Oasis Healthcare Admission Screening form and Body Chart. The CINS/FINS Intake form and Oasis Healthcare Admission Screening form address all elements of the indicator: current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings.

The policy requires that all barriers to a resident receiving treatment for medical services be eliminated to ensure immediate access to medical services. The policy indicates that the agency will make arrangement for medical services as needed. The policy also requires that the agency employees receive general training in assessment of common health conditions and risks.

The policy requires that all parent/guardians complete Medical Treatment and Medication Consent Forms, authorizing the program allow immediate access to medical services and to be able to dispense proper medications to the youth. The procedures indicate that staff would contact the parent/legal guardian to obtain information and to notify in case medical treatment is needed. All contact with parent/guardian is to be written in the log book and/or client's file.

All medical referrals were documented on a daily log.

A review of eight (8) randomly selected charts indicated that the agency's procedure to address the health care admission process is being completed as required. All eight (8) files [five (5) open and three (3) closed files] reviewed contained documentation of the CINS/FINS Intake form that was completed the day of the youth's admission. The form addressed all elements of the indicator with the exception of observation of scars, marks or tattoos. All 8 files reviewed contained the required forms. The written policy does state procedures to address the referral process and follow-up medical care.

The CINS/FINS Intake form and Oasis Healthcare Admission Screening form addresses all elements of the indicator: current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, physical distress, difficulty moving, etc. and observation for presence of scars, tattoos, or other skin markings.

Exception:

The CINS/FINS Intake form and Oasis Healthcare Admission Screening form addresses all elements of the indicator with the exception of observation of scars, marks or tattoos.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The shelter had a written plan that outlined the suicide prevention and response procedures that was last reviewed and signed on September 25, 2015. The agency's policy requires that all youth officially determined eligible and admitted to the shelter be screened for suicidal risk by the six (6) suicide risk questions on the CINS/FINS Intake form. The agency's policy requires that suicide risk screening is included as part of the screening and intake process and if the youth answers "yes" to any of the 6 questions, the program will place the youth on suicide risk monitoring status (choice of 2 levels) and immediately refer the youth to a licensed mental health professional or a non-licensed mental health professional under the supervision of a licensed mental health professional within 24 hours. If the screening occurs between 5pm on Friday and 9am on Monday and there is not access to staff to conduct an assessment within 24 hours, the assessment must be completed the morning or the first business day.

The shelter utilizes two (2) levels of supervision: one to one supervision and constant sight and sound supervision. The policy does meet all the content requirements of the indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

All four (4) randomly selected files reviewed (1 open file and three closed files) contained documentation that indicated a suicide risk screening was completed during the initial intake and screening process. All 4 files contained documentation that indicated the suicide screening results were reviewed and signed by the licensed mental health professional. The agency does have a licensed clinical social worker with credentials are in effect until March 31, 2017. All applicable youth were placed on sight and sound supervision immediately. These residents remained on this status until they were assessed by the licensed professional or non-licensed staff under the direct supervision of the licensed professional. The supervision level was not changed or reduced until approved the licensed professional. Supportive documentation was reviewed to include precautionary observation logs and 5 and 10 minute checks.

Exceptions:

Exceptions include inconsistent documentation in the agency program log book. Agency documentation did not have consistent documentation of youth identified as being placed on suicide sight and sound status; youth identified as sight and sound on each shift; and when youth are stepped down or taken off suicide risk status.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. The program has a list delineated in writing of staff that are designated to have access to secured medications and limited access to controlled substances. All medications in the shelter are stored in a separate, secure area, which is inaccessible to youth. Oral medications are stored separately from topical medications.

The agency does have the automated Pyxis medication cart installed. The agency did have a minimum of 2 site-specific Super Users trained for the full use of the automated Pyxis medication care in June 2015.

Exceptions:

At the time of this review, the automated Pyxis medication cart is not being used by the agency although 2 Super Users were trained in June 2015.

The agency was provided resources to place a Registered Nurse. At the time of this onsite program review, the agency does not have a Registered Nurse hired.

The agency does have documentation of a medication error in the last six months.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written procedure to address medical and mental health alert process. The shelter maintained a large dry erase board with nine (9) domains that represent the status and condition of the youth.

Each domain includes a color coded dots to identify various medical/mental health conditions. The green dot indicates a mental health or substance abuse condition, blue dot indicates medical condition, light blue is sight and sound status, yellow is elevated supervision, orange is for allergies, Red is Medication, Light Green is Substance Abuse, Black is Mental Health, Dark Green is Physically Aggressive, and Pink is Chronic Runaway.

All fifteen (15) open files contained the appropriate color coded dots which were documented on the dry erase board and in the individual files. The dots are also placed on the spine of the resident shelter file for each client. Shift Exchange Information forms and log book entries were reviewed to indicate staff were provided sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment.

Exception:

Updating of the Alert Board and in real-time is delayed following a discharge or exit of a youth from the shelter. Also, 7 of the sixteen staff surveyed did not feel that medical/mental health alerts were communicated in the shelter effectively.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written procedure to address episodic/emergency care that was last reviewed on September 25, 2015.

At the time of this onsite QI program review, the agency had evidence of four (4) instances of emergency medical/dental care events in the last 6 months. Emergency episodic event included visits to offsite medical facilities such as the Emergency Room/Hospital for stomach aches, finger injury, infection, and asthma attack. There were three (3) episodic events within the last six (6) months. All 3 episodic events were documented on the episodic log and in the program log book. There was documentation for the parent/guardian notification requirement and obtaining off-site emergency services i.e. EMS or the police for Baker Acts.

Exceptions:

A review of eleven (11) staff member training files indicated one (1) on-going staff person was missing documentation for current CPR and First Aid certification. At the time of this review, the shelter had a first aid kit, wire cutters and a knife for life.

One of the four (4) emergency events found did not include documentation of parental notification in the log book per the agency policy.

Agency has evidence of only one drill in the last year. The agency policy requires that an emergency drill be conducted once per quarter. Documentation does not account for 3 additional emergency drills.