



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF NW- Currie House

on 01/10/2018

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 3: Shelter Care

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

Percent of indicators rated Satisfactory:87.50%
Percent of indicators rated Limited:12.50%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory:92.59%
Percent of indicators rated Limited:7.41%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

Satisfactory Compliance	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.
Not Applicable	Does not apply.

Review Team

Members

Keith Carr, Lead Reviewer, FNYFS/FOREFRONT LLC

Krissy Botzong, PQI/Training Director, Anchorage Children's Home

Lea Herring, Regional Monitor, Department of Juvenile Justice

Karen Boulding, Statewide Training Coordinator, Florida Network of Youth and Family Services

Teresa Clove, Executive Director, Thaise Educational and Exposure Tours

Persons Interviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Chief Operating Officer |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Program Director | <input type="checkbox"/> Program Manager |
| <input type="checkbox"/> Program Coordinator | <input checked="" type="checkbox"/> Direct- Care Full time | <input type="checkbox"/> Direct-Care Part Time |
| <input type="checkbox"/> Direct-Care On- Call | <input type="checkbox"/> Volunteer | <input checked="" type="checkbox"/> Intern |
| <input checked="" type="checkbox"/> Clinical Director | <input checked="" type="checkbox"/> Counselor Licensed | <input checked="" type="checkbox"/> Counselor Non- Licensed |
| <input checked="" type="checkbox"/> Case Manager | <input type="checkbox"/> Advocate | <input checked="" type="checkbox"/> Human Resources |
| <input checked="" type="checkbox"/> Nurse | | |
| 3 Case Managers | 0 Maintenance Personnel | 2 Clinical Staff |
| 1 Program Supervisors | 0 Food Service Personnel | 1 Other |
| 1 Health Care Staff | | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 6 # Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 5 # MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 19 # Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 8 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 6 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> Telephone Logs | 6 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

6 Youth 5 Direct Care Staff

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 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 checked="" type="checkbox"/> Discharge | <input checked="" type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input checked="" type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <input checked="" 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

The agency reported that it does not have examples of special populations that include child profiles of Probation Respite, Staff Secure and Minor Sex Trafficking.

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida is a human services organization that serves children and families, adults and the elderly, refugees and immigrants, victims of natural disasters and victims of human trafficking. Lutheran Services Florida Northwest (LSF NW) Currie House is contracted by the Florida Network of Youth and Family Services to specifically provide children in need of services/families in need of services (CINS/FINS) in the Northwest region of the Florida Panhandle. Their goal is to help adolescents live healthier lives and remain out of the juvenile justice system through prevention and intervention activities. They provide these prevention and intervention activities through residential and non-residential programs.

Since the last quality improvement review in 2017, LSF NW Currie House has had many highlights. They include:

- Reduced medication errors.
- Filled seven positions since August (including a life skills coach).
- Started using the NoteActive Logbook in the Spring.
- Annual hurricane drill and real Hurricane Nate.
- Reaccreditation through COA.
- Long-time program supervisor retired. Her position was eliminated and responsibilities were redistributed across three staff members.
- Awarded HHS again after losing it last year.
- New, very professional LSF sign, new laptop for training, additional camera and lighting for the parking lot.
- Non-res groups have continued to increase in number and schools despite new background screening hurdles. Currently in 6 schools, using pre and post- tests, and getting feedback from teachers.
- Back to school bash with Currie and HOPE House clients happened.
- Dozier Therapy Dog visits occur once a month.
- Provided the Power of Service Award 2017 for recognition of excellent service to the community, including a \$2,500 check.
- Shelter youth helped interview a couple of staff members.
- Shelter youth prepared for and practiced job interviewing, including dressing for the part!

Standard 1: Management Accountability

Overview

Narrative

The agency is led by Beth Deck, Regional Director. The agency provides both Residential and Non-Residential CINS/FINS services for youth and their families in Escambia and Santa Rosa Counties. This youth shelter operates 24 hours a day, 365 days a year and serves a range of six (6) youth up to a maximum of twelve (12) CINS/FINS shelter beds. At the time of this onsite Quality Improvement (QI) review, the Currie House residential program was caring for eight (8) CINS/FINS youth. The agency promotes its broad range of service offerings to those youth and families in need through Outreach efforts in their immediate service region. The agency has several interagency agreements with local community stakeholders and partners. These local area stakeholders and partners include local schools, law enforcement, United Way, local area businesses, faith-based organizations, medical partners, homeless shelters, and various other community-based organizations.

1.01 Background Screening

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a written policy and procedure; “Background Screening” (1.01 YFS-PMM 2016 - 5.03), which addresses all the key elements for this indicator. This policy and procedure was last reviewed and signed by the Regional Director on September 29, 2017.

The program’s procedure requires all background screenings be completed prior to any offer of employment, granting of volunteer status, and/or before any direct contact or participation in agency activities. A five year rescreening of each active employee is completed after the date of the initial screening. An Annual Affidavit of Compliance with Level 2 Screening Standards is to be completed annually and sent to the Department’s Background Screening Unit by January 31st of each year.

Twenty-one staff personnel records were reviewed for initial background screenings prior to being hired by the program. Three staff records did not have a background screening completed prior to the date of hire due to on-line training that was authorized by NWR Family Safety Program Manager. After the interview with the Regional Director, she explained that three staff were authorized to start on-line training at home prior to any contact with youth. Despite the staff completing training and not having contact with the youth, the Department requires an approved background screening be complete prior to any action or employee function.

One staff had a background screening completed in March of 2016, with a hire date of May 7, 2017. The staff with the background screening complete over a year prior to his date of hire, was first an intern who received a background screening as required, and then hired on in May of 2017. This staff had no break in service with the provider and as a result, did not require another background screening. One staff personnel file was eligible for the five-year rescreening review and the screening was completed five days after the annual date of hire anniversary. Two Annual Affidavit of Compliance with Level 2 Screenings were reviewed for the last year, which included dates January 5, 2017, and January 3, 2018.

Exception:

Three staff records had background screenings complete after the date of hire.

1.02 Provision of an Abuse Free Environment

Satisfactory
 Limited
 Failed

Rating Narrative

The program has a written policy and procedure; “Provision of an Abuse Free Environment” (1.02 YFS-PMM 2016 - 5.02), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Regional Director on September 29, 2017.

The program’s policy outlines staff adherence to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation and youth are not to be deprived of basic needs. Any person who knows or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a person responsible for the child’s welfare, as defined by Florida Statute, reports such knowledge or suspicion to the Florida Abuse Hotline. The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Management takes immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.

Review of five randomly selected personnel files showed a signed employee code of conduct. In addition, each employee of the program is a mandatory reporter for any suspected abuse or neglect of any child, disabled adult, or elderly person under Florida Statute. Review of staff training records demonstrates that staff receive training in mandatory child abuse reporting. There were no abuse allegations made toward staff within the six-month review time. Calls made to the Florida Abuse Hotline on behalf of a youth’s allegation against non-staff are recorded in the individual youth record on an Abuse Registry Report form.

The program maintains a binder specifically for calls which meet reporting requirements under Florida Administrative Code 63F-11 Central Communications Center (CCC). This binder captures all other incidents pertaining to daily operations. None of the CCC reports for the six-month review period, were regarding abuse allegations against staff. The program has a grievance box located on the living unit of the program. Youth have unimpeded access to complete and submit a grievance as needed. There were no grievances completed for the six-month time frame reviewed.

There were no exceptions noted for this indicator.

1.03 Incident Reporting

Satisfactory Limited Failed

Rating Narrative

The program has a written policy and procedure; “Incident Reporting/Risk Management” (1.03 YFS-PMM 2010 - 5.01), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Regional Director on September 29, 2017.

The program policy states all reportable incidents involving CINS/FINS clients are verbally reported to Department of Juvenile Justice, Office of Inspector General, and Central Communication Center (CCC) within two (2) hours of knowledge of the incident. The policy outlines incidents that are labeled as reportable incidents—that includes definitions of each kind of incident.

Review of the eleven Central Communications Center (CCC) reports were reviewed from the Department’s Juvenile Justice Information System (JJIS) and the providers log of internal incidents. One report documented as a failure to report because it was reported outside the two-hour required timeframe, but no follow-up for staff corrective action could be observed. One internal incident was reviewed regarding medication error from a parent not providing the youth's prescription medication to the facility. This incident involves a youth not receiving their medication, which requires a CCC report. The program called CCC regarding this incident during the annual compliance review, but it was not accepted by the CCC operator.

Another internal incident reviewed regarding a youth's aggressive behavior. The CCC included law enforcement being called and reported the youth be arrested as a result. However, no arrest was

completed. The CCC report was initiated, but not necessary without a youth arrest. All internal incident reports did not have any program supervisors' or director's signatures signifying review of the programs incident reports.

Exceptions:

One incident was not reported to the Department's Central Communication Center (CCC), which falls under the CCC requirements of the standard and the provider's policy. After bringing the incident to the program's attention, the medication error was called into the CCC, but was not taken by the CCC operator.

No supervision process is included in the internal incident reports as no signatures were included for the program supervisors or director which is required by the standard and the provider's policy.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive training policy approved on 9/29/17. The policy identifies all the training requirements and required time frames for all agency staff including management/supervisory, direct care, clinical and interns/volunteers.

A review of the policy and the training standards show that all the CINS/FINS training requirements have been incorporated into the Agency policy. All direct care CINS/FINS staff shall have a minimum of 80 hours of training for the first full year of employment and 24 hours of training each year after the first year.

Upon review of training files many of the staff members both direct care and clinical have surpassed the training hours required. There is a robust training curriculum being offered and delivered to staff on a regular basis. In the shelter, an annual shelter training plan has been developed and each month, instructor led and online training is offered to shelter staff.

In July 2017, the Network revised the training policy/requirements that include a list of training courses that must be completed during the first one hundred twenty (120) days of hire. This reviewer reviewed a total of ten (10) training files. Four (4) files were from longer term employees and six (6) files were from new hires (less than a year of employment).

Upon examination it was discovered a couple of employees had missed completing every required course by the 120 days deadline. It appears these employees were part of the large group of staff hiring that occurred this summer. There is a third shift employee and one other new hire that had not completed the required hours in a timely way. The third shift employee is also a college student so coordinating schedules has been a challenge, but the required training has been scheduled.

Additionally, it was noted that few of the files had completed all of the Skill Pro required training. While there is still time to complete all the training and be in compliance, inquiries to staff surfaced some slight misconceptions about which employees had to complete which specific trainings. The management will be communicating to staff that all the Skill Pro required training (including the two additional hours of suicide prevention training outside of Skill Pro) must be completed by all staff within the year to be compliant.

Exception:

The required documentation form for Non Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk was not available for relevant staff in their personnel files. After some discussion with management it was confirmed the form had been overlooked and the forms will be competed and placed in the appropriate files.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure; “Analyzing and Reporting Information” (1.05 YFS-PMM 2012 - 6.01), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Regional Director on September 29, 2017.

The program collects and reviews several sources of information to identify patterns and trends which 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.

Interview with several Currie House management team staff members and observations of documents found evidence of monthly NetMIS data reports, and annual reports that contain documentation on non-residential and residential (shelter) outcome data. This report documentation is shared with the management team through emails, on-line, and monthly meetings with program staff. There was documentation of CINS/FINS Client Satisfaction Surveys that are compiled into a single annual report. There are quarterly and monthly staff meetings among the administrative and direct care staff to present findings of program incidents, accidents, and grievances.

There were no exceptions to this indicator.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure; “Client Transportation” (1.06 YFS-PMM 2015 - 5.07), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Regional Director on September 29, 2017.

Written program procedures include approved agency drivers to drive clients in agency or approved private vehicles and the documentation of a valid Florida driver’s license being covered by the company insurance policy. The third party is approved volunteer, intern, agency staff or other youth. Documentation of the use of vehicles that notes name or initials of drivers, date and time, mileage, number of passengers, purpose of travel and location. Guidelines for third party requirements during travel were one staff for up to three youth, two staff for four to six youth and three staff for transports with seven or more youth.

Interview with staff report that all employees are hired as approved agency drivers. All staff have to meet the driving criteria at the time of hire. Staff have to produce a valid driver’s license and are checked by the Department’s background screening. Review of the daily vehicle logs were complete for both vehicles used. Both logs reviewed included the date and time, initials of driver, number of staff and clients in transport, mileage, and purpose of travel and/or location. Six months of travel logs were reviewed.

Exception:

The van log revealed eight examples of four youth transported with one staff, which violates the program’s policy guidelines of client transportation.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedure; “Outreach and Interagency Agreements” (1.07 YFS-PMM 2010 - 1.01, 6.05), which addresses the key elements for this indicator. This policy and procedure was last reviewed and signed by the Regional Director on September 29, 2017.

The program’s policy states the program will participate with the Department’s local board and council meetings to ensure CINS/FINS services are represented to increase public safety by reducing juvenile delinquency through effective prevention, intervention, and treatment services. The program maintains written agreements with other community partners. A lead staff member will be designated to attend local and circuit level meetings convened by the Department.

Interagency agreements were reviewed between Esca-Rosa Coalition On the Homeless (ECOH), Boys and Girls Club of the Emerald Coast, HIVEvolution, A Safe Port Counseling Center, Pensacola Police Department (PPD), Avalon Center of Lakeview, Twelve Oaks Alcohol & Drug Treatment Center, Children’s Home Society of Florida, Escambia County Sheriff’s Office, and a memorandum of understanding with the School Board of Escambia County. A folder of meeting agendas from the Escambia Juvenile Justice Council, Circuit 1 DJJ Advisory Board, Circuit 1 Human Trafficking Task Force, Santa Rosa Bridge Board of Directors, Coordinated Entry Working Group, Esca-Rosa Coalition of the Homeless were provided with meeting notes for review. In addition, participation with the various groups was determined based on plans and event fliers. The outreach coordinator also spoke at length during an interview regarding various grant opportunities within the community.

There were no exceptions noted for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The LSF-NW agency provides residential and non-residential services to youth ages 6 - 17. The Non-Residential program is under the direct supervision of a Licensed Mental Health Counselor (LMHC). The agency LMHC supervises an all Master's Level counseling team of Counselors that service clients in Pensacola, Florida service areas. The Non-Residential program services client needs across several counties. Several of these counties are in rural and outlying areas.

The agency provides several services. The referrals for services are received from parents, school, counselors, the court system, the youth themselves and other sources. The services provided by LSF-NW 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/community. Youth also receive referrals for substance abuse and mental health services.

2.01 Screening and Intake

Satisfactory Limited Failed

Rating Narrative

Lutheran Services Florida NW Currie House has a written policy and procedure that addresses all the key elements of Indicator 2.01. The policy was reviewed on 9/29/2017 and signed by the Regional Director.

The agency policy indicated that there is a central intake service being offered at this location 24 hours a day, seven days a week. Services include screening for eligibility, crisis counseling, information and referral. The initial screening for eligibility must occur within 7 calendar days of referral by trained staff.

The procedure states that the following are given during intake:

1. Available service option
2. Rights and responsibilities of youth and parent/guardian
3. Possible actions occurring through involvement with CINS/FINS services and
4. Grievance procedures.

Lutheran Services Florida NW Currie House centralized intake services are provided 24 hours, 7 days a week at the shelter for Residential and Non-Residential screenings and intakes. A total of 4 Residential and 4 Non-Residential files were reviewed. All files were screened for eligibility within 7 days of the referral by a trained staff person using the NetMIS screening form. During intake, all youth and parents/guardians were given in writing the rights and responsibilities, available service options, the grievance procedures, a CINS/FINS brochure which has the possible actions occurring through involvement with CINS/FINS services. In each file, the youth and parent/guardian signed a form stating that they received the above items during the intake session.

There were no exceptions noted for this indicator.

2.02 Needs Assessment

Satisfactory Limited Failed

Rating Narrative

Lutheran Services Florida NW Currie House has a written policy and procedure that addresses all the key elements of Indicator 2.02. The policy was reviewed on 9/29/2017 and signed by the Regional Director.

The agency policy indicates that a Needs Assessment is completed to gather and analyze information for all youth receiving services. The Needs Assessment procedure states that it is

1. Initiated within 24 hours of admission
2. Completed within 2 to 3 face to face contacts following the initial intake
3. Needs Assessment is completed by a Bachelor's or Master's level staff and signed by a supervisor
4. If a risk of suicide component is required as a result of the screening, then it must be reviewed, signed and dated by a license clinical supervisor or written by a license clinical staff.

A total of 4 Residential and 4 Non-Residential files were reviewed. The Needs Assessments were all initiated within one day of the admission and completed within 1 to 2 face to face contacts. The Needs Assessments were completed by a Master's level staff and signed by the supervisor. Seven (7) out of eight (8) files had an elevated suicide risk as a result of the Needs Assessment. The seven files had an Assessment of Suicide Risk completed and signed by a license mental health professional. All were found to have a low suicide risk.

There were no exceptions noted for this indicator.

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services Florida NW Currie House has a written policy and procedure that addresses all the key elements of Indicator 2.03. The policy was reviewed on 9/29/2017 and signed by the Regional Director.

The agency procedure indicates that a case plan is developed within 7 working days of completing the assessment and the plan is developed base on the information gathered during the initial screening, intake and assessment. The case/service plan is reviewed by the counselor and parent/guardian within 30, 60 and 90 days for progress and/or making necessary revisions to the case/service plans.

The plan includes the following:

1. Identified needs and goals
2. Type, frequency, and location of services
3. Persons responsible
4. Target dates for completion
5. Actual dates of completion
6. Signature of the youth, parent/guardian, counselor, and supervisor and
7. Date plan is initiated.

A total of 4 Residential and 4 Non-Residential files were reviewed. All Case Plans were developed with the youth and family within one day of the assessment and was developed based on the needs gathered during the screening, intake and assessment. Each Case Plan included the following: identified needs and goals, type, frequency and location, person responsible, target and actual completion dates, date the plan was initiated and signatures of the youth, parent, counselor, and supervisor.

Five (5) out of the eight (8) case files were due for a 30 or 60-day review. One (1) of the 30-day reviews were not due to be complete at this time and two (2) were discharged before the 30-day reviews became due.

Exception:

Five (5) of the case file 30 and/or 60 day reviews were completed but were completed 3 to 10 days late. The reviews must be completed within 30, 60 and 90 days of the admission date.

2.04 Case Management and Service Delivery

Satisfactory
 Limited
 Failed

Rating Narrative

Lutheran Services Florida NW Currie House has a written policy and procedure that addresses all the key elements of Indicator 2.04. The policy was reviewed on 9/29/2017 and signed by the Regional Director.

The agency policy indicates that each youth is assigned a counselor/case manager who will follow the youth’s case plan and ensure appropriate delivery of services. The procedure indicates that the process of case management will include:

- 1. Establishing referrals needs and coordinating referrals**
- 2. Coordinating service plan implementations**
- 3. Monitoring youth’s/family’s progress**
- 4. Providing support for families**
- 5. Monitoring out of home placement**
- 6. Referrals to the case staffing team**
- 7. Recommending and pursuing judicial interventions**
- 8. Accompanying youth and parent/guardian to the court hearings and related appointments**
- 9. Referral to additional services**
- 10. Continued case monitoring and review of court order**
- 11. Case termination with follow-up.**

A total of 4 Residential and 4 Non-Residential files were reviewed. Counselors were assigned to each youth that provided a case plan that met their individual needs. The counselors implemented services, monitored the youth and family progress, provided support to the family as it was needed and documented the details in the progress notes.

There were no Case Staffings or court hearing in any of the above 8 case files. Two (2) Residential and two (2) Non-Residential files were completed and terminated with a discharge summary and notes. There was one (1) case file that was due for a 30 and a 60 day follow-up. The follow-ups were completed and the forms were placed in the youth’s case file.

There were no exceptions noted for this indicator.

2.05 Counseling Services

Satisfactory
 Limited
 Failed

Rating Narrative

Lutheran Services Florida NW Currie House has a written policy and procedure that addresses all the key elements of Standard 2.05. The policy was reviewed on 9/29/2017 and signed by the Regional Director.

The agency procedure indicates that the youth and families will receive counseling services in accordance to the youth’s case plan to address needs identified during the assessment process. Shelter programs

provide individual and groups counseling sessions. Group sessions are held a minimum of 5 days a week and can be conducted by a staff, youth or guest.

A group structure includes:

1. Clear leader or Facilitator
2. Relevant topic
3. Opportunity for youth to participate
4. 30 minutes or longer

A total of 4 Residential and 4 Non-Residential files were reviewed. Each youth received counseling individually, or either with the youth and their family or in groups at the shelter. The Residential youth attended groups 5 days a week at the shelter. The shelter had a group log that indicated the leader of the group, the topic, list of participating youth and the time frame which was from 45 minutes to an hour in length.

The Non-Residential progress notes addressed the counseling services that were provided for the youth and the family. The counseling services were related to the case plan and the needs of the youth and family.

The case file progress notes were in chronological order, neat in appearance and were signed by the counselor. The supervisor completes the ongoing internal process that ensures clinical reviews of the case records. The supervisor reviews the files monthly and makes a supervisory case note in the file.

There were no exceptions noted for this indicator.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services Florida NW Currie House has a written policy and procedure that addresses all the key elements of Indicator 2.06. The policy was reviewed on 9/29/2017 and signed by the Regional Director.

The agency procedure indicates that a case staffing committee is scheduled to review the case of any youth or family that is determines to be in need of services or treatment if:

1. The youth/family is not in agreement with services
2. The youth and family will not participate in the services
3. The program receives a written request from the parent/guardian or any other member of the committee.

The case staffing committee is convened within 7 days (working days) from the receipt if the written request.

A total of 4 Residential and 4 Non-Residential files were reviewed. There were no youth staffed for Case Staffings this year. The Clinical Supervisor indicated that they do not presently have a case staffing committee in place due to the fact that they have not had a case to staff in over 8 years. She stated that if a need arises that they could gather a group of professionals to form a case staffing team. The clinical supervisor further indicated that they are very active in truancy court and attends the truancy case staffings quite often.

There were no exceptions noted for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Lutheran Services Florida NW Currie House has a written policy and procedure that addresses all the key elements of Indicator 2.07. The policy was reviewed on 9/29/2017 and signed by the Regional Director.

The agency procedure indicates that the program must maintain confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program.

Records must be marked "confidential" and kept in a secure room or locked file cabinet that is marked confidential.

Youth records are to be maintained in a neat and orderly manner.

A total of 4 Residential and 4 Non-Residential files were reviewed. All files were marked confidential, were neat and in an orderly manner. The files were locked in a secure room with "Confidential" label on the door. The file cabinets were not marked confidential, but after a best practice suggestion of placing the word confidential on the file the Clinical supervisor implemented it right away.

Lutheran Services NW Currie House has two black, opaque portable containers that are marked confidential. These containers are used to transport files from one location to another.

There were no exceptions noted for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Currie House is licensed by the Department of Children and Families (DCF) as a Child Caring Agency. The Currie House youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services and other special populations. Specifically, 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 shelter building includes a day room, individual girl's and boys sleeping rooms, individual bathrooms, kitchen, laundry room, residential and counseling staff offices. The building also has a separate medication and camera room. The exterior includes a back yard with a small basketball court and recreation area. The shelter received new flooring last year and this year they have a new van, carport, and light pole. This is in addition to two new exterior cameras.

The building was found to be in good running condition and clean. At the time of the review, the furnishings are in adequate condition and decorated for the season of the year.

The bathroom floors were tile and the plumbing was in good working order. The sleeping rooms house (2) youth in each room with each youth having their own a bed, dresser, lines, pillows.

The program has policies and procedures in place for its Shelter Care programming. The Direct Care workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all the key elements of the indicator. The policy dated 9/29/17 was signed by the Regional Director.

Policy indicates the Maintenance Tech takes the lead in maintaining the grounds and general care of maintenance. The Shelter Supervisor and YCS assure the facilities are well maintained on a daily basis. The policy indicates the Dietary Specialist takes the lead in overseeing operations in the kitchen and the YCS takeover in the absence of the Dietary Specialist. Bathrooms are stated to be inspected by the YCS and cleaned daily.

1. Health and Fire inspection are current (Health inspection completed 1/5/18, Fire Inspection completed 8/9/17, and Fire Alarm inspection completed 9/5/17).
2. Furnishings seemed in good repair. Facility appeared clean.
3. The facility was free of infestation.
4. Grounds and landscape were maintained. There is a new carport, van, and new light pole in the parking lot.
5. The bathrooms and showers were clean and in working order.
6. There was no graffiti on the walls, doors, or windows.
7. The bedrooms were clean and each youth had his/her own bed, linens, pillow, and dresser.
8. Lighting in the facility appeared adequate.

9. There is a safe in the YCS office available for youth's personal belongings to lock up if requested.
10. There is a posted daily schedule in the living area with times designated for education, activities, etc. Staff report there are various outings, such as the museum, that is provided for recreation. Idle time is avoided.
11. The posted schedule provides for physical activity.
12. Based on interview with Shelter Supervisor, it seems there had been many opportunities in the past for youth to participate in faith-based activities; however, it seems recently that has not been consistent. She did report intentions on getting those opportunities back in routine for the residents. She reported that if a youth is not willing to participate then the youth would "stay back" and watch a movie.
13. The daily schedule provides for study time/quiet time.
14. Daily schedule is posted on a bulletin board in the living area.

A walk-through was completed along with staff observations and interviews (YCS and Shelter Supervisor). The shelter appeared clean and well kept.

According to Shelter Supervisor, Fire Drills are supposed to be completed 3 times per month. When reviewing the Fire Drill logs, the dates were inconsistent and out of order. There were also no Fire Drills completed in the month of September.

Supervisor reports the YCS oversee the daily cleaning of the shelter and there are certain chores the youth do as well as part of the BMS.

Supervisor reports the Maintenance Tech oversees the landscaping of the property.

Exceptions:

When reviewing the Fire Drill logs, the dates were inconsistent and out of order.

There were also no Fire Drills completed in the month of September.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy that addresses the key elements of the indicator reviewed on 9/29/17 and signed by the Regional Director.

The policy indicates that the Orientation process follows the intake and provides youth the information required in the indicator such as program expectations, program rules, and the Behavior Management system, consequences of rule violations and disciplinary action.

A total of 6 open files were reviewed. Elements of the following were found in the client file: Provided Client Handbook, Behavior Management Explained, Grievance Procedure, Emergency/Disaster Explained, Contraband Rules, Room Assigned.

All files contained documentation that youth received Orientation within 24 hours of admission. The youth signs a client intake checklist indicating that they have received the Client Handbook which includes items such as client rights and responsibilities, grievance, behavior management.

The documentation was difficult to locate. The documents needed were located in various places including not in the client's file.

Exceptions:

One out of the 6 files did not have a room number assigned for that youth according to the Client Room

Assignment section in the CINS/FINS Intake Form.

Two out of the 6 files did not have Parent signature in the Placement Agreement.

One of 6 files did not have parent signature for acknowledgement of Behavior Management Policy, Shelter Schedule, Notice of Non-Denomination Bible Study, Guide to CINS/FINS for Parents.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all of the key elements of the Youth Room Assignment Indicator:

- Review of available information about the youth's history, status, and exposure to trauma**
- Initial collateral contacts**
- Initial interactions with and observations of the youth**
- Separation of younger and older youth**
- Separation of violent youth from non-violent youth**
- Identification of youth susceptible to victimization**
- Presence of medical, mental or physical disabilities**
- Suicide Risk**
- Sexual aggression and predatory behavior.**

The policy also states an alert is entered into the program's alert system when a youth is admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors

This policy was reviewed and signed by the Regional Director on 9/29/17.

The program does implement an alert system that assesses all youth who enter the shelter for potential harm at intake, as well as medical issues, allergies, and behavior risks. A colored dot system is used as a quick reference for alerts.

The policy states that after the intake, the YCS reviews the last page of the intake form that list the specific areas of concern for the staff to take into consideration before assigning the youth to a room and that staff will discuss any concerns with the counselor or on-duty supervisor.

The facility uses the Room Assignment section on the CINS/FINS Intake Form. Five (5) open files were reviewed. All 5 files had a section to be filled out that included: Age, Gender, History of Violence, Physical Size/Strength, Gang Affiliation, Sexually aggressive behavior, Gender Identification.

The Health Screening form addresses any disabilities.

The Screening and Intake form address the suicide risk as well as history of the youth and the status and exposure to trauma.

Five out of the five files contained all required information on the forms.

In one of the five files, there was no written summary of observations/comments made in the Room Assignment section.

One out of the 5 files did not have a bed assigned to the youth.

There were no exceptions for this indicator.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses the key elements of the requirements in the indicator, including:

1. Highlighting entries that could impact the security and safety of the youth.
2. All entries are to include date and time of the incident, entry, or activity; names of youth and staff involved; a statement providing pertinent information; the name and signature of the person making the entry.
3. All recording errors are struck through with a single line. The staff person must initial or sign for the deleted entry.
4. The program director or designee reviews the facility log book every week and makes a note in the log book indicating the dates reviewed and if any corrections, recommendations and follow-up are required and sign/date entry.
5. The oncoming supervisor and shelter counselor reviews the log book of the previous two shifts to become aware of any unusual occurrences, problems, etc. They make an entry in the log book that they have reviewed it and the dates reviewed.
6. Direct care staff review the log book for previous two shifts in order to become aware of any unusual occurrences, problems, etc. and makes an entry indicating they have reviewed it.

The policy does not have a date of approval or signature of an approved person.

The policy indicates the top of each page is dated electronically to maintain accurate chronological record of events. Incidents are color-coded: intakes/discharges are blue, important items pink, very important items in yellow. Staff are to sign at the end of each entry and each entry must include the date and time along with a clear, concise statement of what, where, who, and how. Log must be utilized for sign-in, sign-out, and passing of the keys. If there is an error, one line needs to be drawn through the entry "void" is written by the error and the correction is made and the staff signs the correction.

The facility utilizes an Electronic log book. All entries related to safety and security were highlighted according to the policy's color-coding system. The date, time, and activity of the entry were documented, along with the signature of the writer.

Reviewer was unable to view any voided entries.

The Shelter Supervisor reports reviewing the log book everyday she is at work. She does not document that she reviewed it, though reviewer was able to view entries supervisor made in regard to acknowledging or correcting entries she read.

Reviewer was able to see entries where staff had documented coming on shift, noting he/she reads the log book, as well as entries of passing over keys from shift to shift.

Reviewer was able to view headcounts, a youth being put on sight and sound, as well as sight and sound checks.

The log book documents when a youth leaves the shelter, when a youth goes on a visit, and when someone comes to visit a youth.

There were no exceptions noted for this indicator.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy that addresses all the key elements of the indicator. This policy was reviewed and signed by the Regional Director on 9/29/17.

The policy indicates the goal of the behavior management program is to assist the youth in this transition by allowing each one to be solely responsible for his/her own behavior. Policy states that staff are trained in the BMS and the supervisor provides feedback to the staff.

The policy states there are Observation Reports, data base notes, and entries in the NoteActive regarding observations of youth's behaviors.

The facility uses a Behavior Management Motivation System based on the Boys Town Model. The policy explains the point system and the Achievement System and how the points operate if a youth absconds.

The policy states interventions used are the least restrictive and do not violate the rights of youth. The policy states manual restraints are seldom used and used as a last resort and only staff that have had CPI training are allowed to use manual restraint. The policy explains steps that follow if a manual restraint is used, such as debriefing with the parents and with staff involved.

The policy states Group Discipline is prohibited and no youth is allowed to discipline another youth.

Room restriction is used only as part of a system that ensures the least restrictive means possible and is utilized to maintain the safety and security of the youth and other in the program. It is not used for youth who are physically and/or emotionally out of control.

Disciplinary measures do not deny the youth any of the following: regular meals and snacks, clothing, sleep, physical health services or mental health services, educational services, exercise, correspondence privileges or contact with the parents or guardians, attorney of record, juvenile probation officer or clergy.

Based on interview with a YCS, the Behavior Management System seems well implemented and appears to promote positive behavior.

The BMS is explained in the Client Handbook.

The YCS was able to explain how the system works, how a youth is introduced to the system, and how youth can earn points back if he/she loses points. Youth are responsible for keeping up with their cards and there are card conferences each night with the youth to discuss positive and negative behaviors each day. Once a youth reaches a specific number they move to the achievement level. The YCS was able to explain what that was and provided the "Achievement Menu" which shows what youth can purchase with his/her points on that level. Reviewer interviewed a youth who was able to explain the point system as well. Reviewer witnessed an interaction in which youth was helping the Dietary Manager for extra points.

Reviewer interviewed Program Supervisor regarding feedback to the staff. Supervisor reports she reviews the point cards and if she sees anything out of the ordinary she will address it with the staff and will follow-up with continually looking at point cards and speaking with the staff.

Based on interviews with staff and youth, it is apparent there is training regarding the BMS; however, the documentation in the training files was inconsistent.

There were no exceptions noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy reviewed on 9/29/17 and signed by the Regional Director. The policy requires a maintained ratio of 1:6 awake and 1:12 during sleep. The policy states there is at least 1 staff on duty of the same gender as the youth including sleep periods and overnight shifts must always provide a minimum of 2 staff present. The policy states the staff schedule is provided to staff or posted in a visible place and that there is a roster which includes the home numbers of staff who may be accessed when additional coverage is needed. The policy states that staff will observe youth every 10 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction.

The policy state the Shelter Supervisor develops the schedule to consider best practices, staff training requirements, regular days off, holidays, vacation, etc.

A list of all employees names and phone numbers is maintained to ensure adequate staff coverage and that scheduled activities and routines are maintained.

Policy states schedule is posted in an area accessible to all staff. If the Shelter Supervisor or YCS II is not on schedule, the most experienced person in shift will be considered the lead person, or the shift leader.

Policy states management attempts to staff one female staff member and one male staff member when possible. Two males are never to be on shift at one time without female staff.

Bed checks will be conducted every 10 minutes while youth are in their sleeping rooms either during sleep period or at other times, such as illness.

Staff schedule is located in a binder in the YCS office. YCS are aware of its location and have free access to it. There is no current formalized process for holdover or overtime rotation roster. Shelter Supervisor indicates that they have part-time staff that they will call if the need arises. Shift times are staggered with one staff member staying over for an hour when the new shift comes on. There is a list of names and phone numbers of staff located in the binder in the YCS office.

Staff schedules show coverage for required ratios. However, in reviewing, first shift very seldom had a male on shift. Second and third shift had more male coverage; however, not on all shifts. There were never two males on a shift together alone. Supervisor reports they have had difficulty finding male staff. She reports they recently attempted to hire a male, but he did not pass the drug screen. She reports they interviewed male yesterday as well. It appears many attempts are being made to hire male staff.

The agency is equipped with surveillance cameras that are well positioned in the shelter.

Reviewer viewed 3 random night shifts at different time intervals and was able to see consistent bed checks every 8-10 minutes.

Exception:

The schedule has many shifts where there is not a male and female on each shift. There are shifts where there are two females alone on shifts; however, there were no scheduled shifts where there are two males alone on shift. Interview with Shelter Supervisor indicates there has been difficulty in hiring and retaining male staff to cover the the staffing requirements.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

There is currently a policy and procedure in place that addresses Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite (DV), and Probation Respite. It was last approved on September 29, 2017.

Services are provided to youth charged with DV, except for youth: having current or past fire setting

behaviors; with violent or sexual offenses (except for DV); in need of acute inpatient care or crisis stabilization; and/or who is a security or safety risk to other youth or staff. If this is determined after a youth arrives at the shelter, the Department of Juvenile Justice is notified and arrangements for removal of youth will be made within forty eight (48) hours of notification.

Within the past six months, the agency has not served any Probation Respite, Domestic Minor Sex Trafficking, or Staff Secure Youth.

At the time of the review, the agency had four (4) youth that had been admitted to the program for DV charges. All four youth have pending DV charges and supporting documents are located in the file. There was documentation in the case plans that focused on interventions to cope with aggression, develop healthy coping skills and develop effective communication skills. None of the youth exceeded the 21 days of respite placement and services are consistent with all other CINS/FINS program requirements.

There were no exceptions noted for this indicator.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy in place reviewed on 9/29/17 and signed by the Regional Director. The program has a video surveillance system that is instituted and in operation 24 hours a day, 7 days a week. The purpose is to guarantee personnel accountability while capturing the agency happenings to ensure safety of all youth, staff, and visitors.

The policy states the video system can capture and retain photographic images which must be stored for a minimum of 30 days and it can record date, time, location and facial recognition. The policy states there is back-up capability in case of power outage. Cameras are placed in common areas and never in bedrooms or bathrooms. Video surveillance is only accessible to designated personnel with a list maintained which also includes off-site capability per personnel. Supervisory review is conducted a minimum of once every 14 days and noted in the log book. The reviews assess the activities of the facility and include a review of a random sample of overnight shifts. All cameras are visible and a written notice is conspicuously posted on the premises for purpose of security.

There are written notices of surveillance cameras that were visible on the front door of the Administration building as well as the door of the entrance to the shelter. There are approximately 16 cameras between the interior and exterior of the building that are placed in common areas where staff and youth frequent, along with the entrances and exits. There were no cameras in the bedrooms or bathrooms and the cameras are able to capture and retain video images including facial recognition. The supervisor reports that she, Administration supervisors, and the nurse are the only ones with access to view the camera footage.

The supervisor reports there is a process if a third party such as police or DCF needs a copy of a video. She stated in the past they had put it on a thumbdrive.

Reviews of the cameras were completed on 3 different days within the allotted 9 days of video available:

1.2.18 with checks at 1:56 AM, 2:04 AM, 2:13 AM, 2:21 AM

1.6.18 with checks at 4:22 AM, 4:29 AM, 4:37 AM, 4:45 AM

1.5.18 with checks at 5:05 AM, 5:13 AM, 5:22 AM, 5:29 AM

All checks were within the requirement for Program's 10 minute policy.

Exceptions:

At this time the surveillance camera system does not have the ability to backup coverage of the last 30 days. The maximum amount is 9 days. The supervisor reports awareness of this and that they are

attempting to alleviate the problem. She reports they added 2 new cameras outside and that she believe it is taking up a lot of the power to be able to keep backup.

The supervisor was unaware if there was a back-up system for the cameras if there was a power outage.

There was no documentation of camera reviews being completed at a minimum of 14 days. Supervisor reports she reviews cameras often, though there is no documentation available to show the dates, times, and activities of reviews.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The LSF-NW agency has detailed policies and procedures related to the screening, health admission screening, classification, assessment and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. All youth receive an initial assessment to determine the youth's risks, needs and issues. All staff members are trained on risk screening methods that immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health (acute and chronic), or security risk factors. Once risks are identified through the screening and assessment process, residents are placed on the appropriate supervision level or referred out to other local mental health facilities as needed. Depending on the risk identified, the residents are placed on the applicable alert status.

The agency ensures that measures are taken to maintain a safe and secure placement and supervision are provided by direct care staff during the resident's shelter stay. The agency maintains a program log, general alert system, pass down/shift exchange forms, and other notification systems. Youth admitted to the shelter with prescribed medications are also provided their medications during their shelter stay. Staff members participate and conduct emergency drills on a routine basis. The agency's staff receives orientation and annual training courses that include Universal Precautions, Safety and General Program Risk Management training, CPR and First Aid. In addition, the agency does have a certified Managing Aggressive Behavior (MAB) Trainer in the organization.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy on screening clients for health issues. The policy is called 4.01 Healthcare Admission Screening. The policy requires that the program complete a preliminary health screening for each youth upon admission to the shelter program. The most recent review of this policy was conducted and signed as approved by the Regional Director on September 29, 2017.

The agency procedures require staff members to complete a preliminary health screening upon admission to the program. If the program's Registered Nurse is present, the nurse is required to complete the health screening. The procedures also state that in the event that the nurse does not conduct the preliminary screening, the nurse must review it within five (5) days. The program must screen for the presence of past or current general medical conditions that include illnesses, allergies, physical pain or distress. The screening process must also screen for scars, tattoos, or other skin markings. The screening forms that must be used to complete this process include the CINS/FINS Intake Form and the Shelter Intake Packet. The agency must follow up with medical care if conditions indicate that such actions are necessary.

A review of six (6) open residential client files reviewed contained documentation of the CINS/FINS Intake form that was completed by direct care residential and screening staff. A review of each of the 6 health screening documents revealed that the agency is capturing health screening findings according to the requirements of this indicator. The agency has a separate form that documents the observation of scars, marks or tattoos. All 6 files reviewed contained the required forms. The agency has an active medical or injury referral process and follow-up medical care on an as needed basis when applicable. The agency has a nurse that does conduct health screening when she is on duty. The reviewer also found two (2) cases that had evidence that the Registered Nurse followed to conduct a review of 2 screenings. The health screenings are primarily being conducted by YCS staff. These staff are conducting the screenings using the CINS/FINS Intake form. The staff are also screening for scars, tattoos and marks. Depending on the results of the screening, the agency will make referrals, physicals or contact parent on medical issues that require follow up.

No exceptions are documented for this indicator.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The agency has a suicide assessment and prevention policy. The current policy includes the requirements that the agency have a written detailed policy that addresses the suicide prevention process. In general, the policy requires that all residential and non-residential clients meeting CINS/FINS eligibility services and admitted to the program be screened for suicide risks as part of the initial intake and screening process. The policy states that the youth awaiting assessment by a licensed professional are placed on constant sight-and-sound supervision. This policy review results in the opinion of the monitor that this Suicide Prevention policy meets the general requirements of the indicator. The policy was last reviewed and approved by the Northwest Regional Director on September 29, 2017.

The agency's suicide assessment procedures require that a multi-step screening process be followed by the shelter staff. The initial screening process requires that if a youth indicates an initial positive for suicide risks, the direct care staff are required to place the resident on elevated supervision status. Following this step, the procedures then require that staff conduct observation checks at a minimum of every 30 minutes or less until an assessment is completed. A licensed professional or a non-licensed professional under the supervision of a licensed clinician must then complete an assessment on the youth on supervision within 24 hours or less. The agency has an on-call schedule for all master level counselors. The agency uses an Evaluation of Imminent Danger of Suicide (EIDS) tool to assess the level of suicide risk. A low rating of risks results in the youth being placed on low risk status and placed on general supervision status. If a youth is deemed to be in question of potentially committing a self-harm act or suicidal behavior, the youth is to remain being on elevated supervisor one-to-one supervision. If the youth require a Baker Act determination, the agency contacts law enforcement. The agency uses the EIDS and consults the licensed clinician. Following the assessment of suicide risk, the youth supervision status can stay the same or only be removed from the status by the licensed clinician. All staff in the residential shelter must maintain one-to-one supervision or constant supervision and document observation checks on the status of the resident every 30 minute or less interval on observation log sheets.

A review of five (5) client files found that all 5 files contained evidence of the CINS/FINS intake form and the Evaluation of Imminent Danger of Suicide (EIDS) form. The suicide risk screening forms and the EIDS assessment documents are present in all 5 client files. A total of 3 out of 5 client files are fully completed as required. Assessment forms are completed in all applicable cases. One case has an assessment that has a calculation error that determines whether to place the youth on high or low elevation status. This case was corrected by the master's level clinician during the secondary review of the EIDS. All client files possessed evidence of observation logs documenting the times, behavior status and person conducting the check.

Three (3) out of the five (5) client files possess evidence of all observation checks. Further review of the said files reflect documentation of accurate and complete counts in intervals of 30 mins or less. All applicable client cases were placed on the appropriate level of supervision consistent with the suicide risk assessment result. All cases had evidence that the client is placed on sight and sound supervision until they were assessed by a licensed clinician or a non-licensed staff member under the direct supervision of a licensed professional. All cases had documented evidence that the supervision level of the client placed on supervision was not changed/reduced until the licensed clinician or non-licensed mental health professional under the supervision completed a further assessment to determine the status.

The agency has two (2) licensed clinicians that oversee non-licensed staff delivering client services for both residential and non-residential programs. Both clinicians have licenses that are in effect. All direct

care staff are trained to complete a CINS/FINS intake and an EIDS assess form.

Exceptions:

Two (2) out of the five (5) client files possess evidence of observation checks that reflect inconsistent documentation of completed counts in intervals of thirty (30) mins or less. One case does not have evidence of observation logs that account for consistent, accurate and complete checks for 4 days that the resident was on elevated supervision.

The 30-minute observation logs were not found for suicide risk observation checks for a second case that includes no evidence of observation checks. In general, there is evidence of inconsistent documentation of observation counts. Some forms are documenting counts for one work shift and not documentation of counts on across other shifts.

4.03 Medications

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy titled Medications 4.03. The policy addresses the safe and secure storage, access, inventory, disposal and distribution of medication in accordance with The Florida Network of Youth and Family Services/DJJ Health Services Manual. The policy was reviewed and approved by the LSF – NW regional director on September 29, 2017.

The agency procedures include all shelter staff or YCS staff received training for medication storage, access, inventory, disposal and the safe and effective distribution of medication. Medication training must be initiated within the first 48 hours of employment. Training includes the use of the Pyxis MedStation 4000 cabinet. Training included a review of policies and procedures, observation and a demonstration of the new employee being able to complete these procedures in practice. Staff are required to document information related to the clients' medication on the CINS/FINS intake form, the health screening form, the medication board, the shift passed down log, electronic logbook, progress notes, and other forms as required. All medications of residents admitted to the shelter must be confiscated and locked securely. All medications must be verified upon the resident being admitted to the program. All medications including both prescription drugs and non-prescription drugs must be stored and locked in the Pyxis MedStation 4000 and/or the medication refrigerator.

All medication counts must be witnessed with two (2) people. All medication that is controlled and narcotic drugs must be counted on each shift three (3) times per day. All medications are required to be maintained in a perpetual inventory. Each medication must be inventoried, and an individual file created for residents taking prescription and/or over the counter medication. All narcotics and controlled substances are to also undergo a shift to shift count with a witness. Topical medications are stored separately from oral medications. Designated staff are required to have over the counter medications on a weekly basis.

A review of the agency's medication practice was conducted to determine their adherence to the medication standard 4.03.

A review of the medication storage practice found that all medications are stored in a Pyxis MedStation 4000 medication cabinet. All medications include topical, oral, and liquid medications. All medications are stored in separate cubicles in the Pyxis MedStation cabinet. The cabinet is housed in a medication specific room that is not accessible to the resident of the shelter. This room is secured by a lock and includes cameras.

The agency has a total of more than two (2) Super Users. The agency has a total of six (6) regular users. Agency has secured a registered nurse that performs twenty (20) hours of work per week. The nurse performs duties on Tuesday, Wednesday, Thursday, and Friday.

The agency has a medication specific refrigerator. At the time of this review there are no medications that

require refrigeration. The medication refrigerator is secured by a locking padlock and includes a working thermometer inside the refrigerator. Temperatures inside the refrigerator registered at 38° at the time of this review.

The agency maintains sharps on site in the same room where the MedStation is housed. Sharps are stored in the bottom drawer of a four (4) drawer metal cabinet. The cabinet has a locking mechanism. Each cabinet door is locked with the keypad lock. Inside the drawer includes sharps including 23 razors, 16 scissors, 4 clippers, for nail trimmers, and one tweezer. The agency uses a binder to track the counts of all sharps. Sharps are counted one time per week. The results of the count for the last month include generally consistent counts over the last 6 months.

The agency maintains five over the counter medications in the Pyxis MedStation. The types of medication include Acetaminophen, Pepto-Bismol, Jr. Tylenol, Ibuprofen, and an antibiotic ointment.

The agency uses a medication distribution log, as well as other forms to document all medication activities on all applicable youth on medication during their shelter stay. The forms used during the medication process at the shelter include the prescription and OTC consent approval form, the medication distribution log, the client photo sheet, the photo ID of the parent form, and the offsite medication tracking form.

The nurse conducts monthly reviews of medication practice utilizing the Pyxis MedStation knowledge portal system. Reports that are generated by the nurse include a total of five (5) reports. These reports include the discrepancy audit details; canceled transactions; controlled substance discrepancy; profile override; and a user summary report.

The nurse also completes and conducts health mission screenings on all residents entering the shelter when on duty. Upon returning from being off duty the nurse reviews health screenings completed by YCS Staff. The nurse also verifies when medication discrepancies are present and cleared. Medication discrepancies are required to be cleared after each shift. At the time of this review, there were no medication discrepancies indicated on the Pyxis MedStation machine.

At the time of this review, the RN reported that she is not conducting groups with residents on issues related to health education issues.

A review of the medication files of all current open files in the shelter was conducted. All files reviewed had proper documentation of the medication forms and documentation of medication distribution during shelter stay.

Exception:

The agency has a total of seven (7) incidents that are documented as reported and received as official incidents to the Department of Juvenile Justice's Communication Center. These incidents are related to Complaints Against staff members for failing to provide assistance to youth obtaining medication that they were required to receive during their shelter stay. Of these incidents, 1 out of the 7 did not have evidence of the required follow up. This case required a remediation quiz to be administered to the staff that failed to assist in the delivery of the medication to the youth.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy called Medical/Mental Health Alert Process. This policy was last reviewed and signed by the LSF-NW Regional Director on September 29, 2017. The agency policy includes measures to ensure the provision of emergency medical and dental care. The policy addresses the current status of the youth's condition, physical activity restrictions, allergies, common side effects of prescribed medications, foods, and medication contraindication. Other pertinent treatment information is

communicated to all staff through a designated alert system. The content in this policy meets the general requirements of this indicator.

The agency's procedures stated all YCS, counselors and supervisors are required to complete a medical and mental health and behavior screening. Youth Care Specialist staff are required to document and inform nurses of clients with medical issues that need further assessment. Staff must ensure effective communication of medical issues through the health screening, professional log, case progress notes and other relative forms of program communication. The agency requires that critical care information be communicated to all staff by utilizing a couple of communication methods. The agency uses communication methods called a pass-down information log and a dry erase board on which general client information is listed. The agency requires that residential staff utilize a system of codes to protect client confidentiality. The agency utilizes files to designate the specific type of client that includes different colored folders for Families First Network-FFN and for CINS/FINS Staff Secure or Court-Ordered Clients; and a blue folder for all other CINS/FINS clients including DV Respite, Probation Respite, Staff Secure and Minor Sex Trafficking Victim. The agency also requires that staff use a color-coded dot system that uses an orange dot for Sight and Sound clients; a red dot to indicate High Risk clients; a green dot for youth on medication; and a blue dot for client admitted to the shelter for a Domestic Violence Respite (DVR). The pass-down log is a 1-page document that includes type of client; medications and allergies; side effects; mental health (HR High Risk, LR Low Risk, CO Court Order) Appointments; Corrective Actions; Chronic Complaints; Discharge Plans; and Visits and Outings. Additional codes used by the agency include Sight and Sound-SS; Run Risk-RR; and No Know Allergies-NKA.

A total of eight (8) files were randomly selected to verify the agency's adherence to the requirements of this indicator. Of these files reviewed, five (5) were open cases and three (3) were closed. All cases were appropriately marked for the corresponding documented alerts across the client files.

The agency also uses a general alert system in the YCS office area. The agency also uses a pass down log. This one sheet form tracks the condition and status of each child on a daily basis. All cases were appropriately marked for the corresponding documented alerts by verifying the content documented in the agency's Pass-Down log. All cases were appropriately marked for the corresponding documented alerts by verifying general non-confidential information documented on the agency general alert board located in the Youth Care Specialist office. In addition, a review of the logbook verifies the conditions and status of all 5 open cases.

No exceptions are noted for this indicator.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has an Episodic Event and Emergency Drill policy. The policy was last reviewed and approved by the Northwest Regional Director on September 29, 2017. The policy includes reference to procedures to ensure that agency staff execute the provision of emergency medical and dental care as required. A review of the agency's two-page policy verifies that the policy adheres to and meets the general requirements of the indicator.

The agency's procedures involve a process to address how the agency will respond to emergencies that require off-site emergency services; notifying parents/guardians; reporting all reportable incidents; documentation of events in a daily log; verification of medical clearance status upon return and any required medical follow up care. The agency must also have the required emergency equipment that includes first aid kits, knife for life, breathing barriers, fire extinguishers and blood borne pathogen kits in the facility.

The reviewer of the indicator found that the agency maintains the same binder of emergency event activity called the Episodic Care log. The log is a 3-ring binder that utilizes an Episodic Care and Drill Log. The binder's log system captures Date; Time; Shift; Duration; Number of staff; Number of clients; and Number of Admin Staff and Guests; Comments; and Event. The binder contains both mock exercises and real emergency events. All emergency events are documented as required. The agency does require staff members to participate in emergency, first aid, CPR and fire safety training when hired and on an on-going basis. The agency does have wire cutters, a knife for life emergency knife and first kits in the shelter and in the transportation vehicles.

No exceptions are noted for this indicator.