Florida Network of Youth and Family Services Quality Improvement Program Report

Review of LSF SW- Oasis

on 11/29/2017

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 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/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory
3.08 Video Surveillance System	Satisfactory

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

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

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

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

Ashley Davies, Lead Reviewer and Consultant, Forefront LLC

Mary Williams, Program Director, Center for Family and Child Enrichment

Ben Kemmer, Co-CEO, Florida Keys Youth Shelter

Erik Kline, Residential Supervisor, Family Resources Bradenton

Sebastian Roth, Non-Residential Program Supervisor, Youth and Family Alternatives

Persons Interviewed

- [ ] Chief Executive Officer
- [ ] Chief Financial Officer
- [x] Program Coordinator
- [ ] Direct-Care On- Call
- [x] Clinical Director
- [x] Case Manager
- [x] Nurse
- [x] Executive Director
- [x] Program Director
- [x] Direct- Care Full time
- [ ] Volunteer
- [x] Counselor Licensed
- [ ] Advocate
- [ ] Chief Operating Officer
- [x] Program Manager
- [ ] Direct-Care Part Time
- [ ] Intern
- [x] Counselor Non- Licensed
- [x] Human Resources

2 Case Managers
1 Program Supervisors
1 Health Care Staff

0 Maintenance Personnel
0 Food Service Personnel

2 Clinical Staff
0 Other

Documents Reviewed

- [ ] Accreditation Reports
- [x] Affidavit of Good Moral Character
- [x] CCC Reports
- [x] Logbooks
- [x] Continuity of Operation Plan
- [ ] Contract Monitoring Reports
- [ ] Contract Scope of Services
- [x] Egress Plans
- [x] Fire Inspection Report
- [x] Exposure Control Plan
- [x] Fire Prevention Plan
- [x] Grievance Process/Records
- [ ] Key Control Log
- [x] Fire Drill Log
- [x] Medical and Mental Health Alerts
- [x] Table of Organization
- [x] Precautionary Observation Logs
- [x] Program Schedules
- [ ] Telephone Logs
- [ ] Supplemental Contracts
- [x] Vehicle Inspection Reports
- [ ] Visitation Logs
- [x] Youth Handbook

5 # Health Records
5 # MH/SA Records
11 # Personnel Records
8 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
0 # Other

Surveys

5 Youth 5 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Program Activities
- [ ] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [ ] Youth Movement and Counts
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [ ] Meals

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Lutheran Services Florida - Oasis Youth Shelter located in Fort Myers, Florida provides the Children in Need of Services/Families in Need of Services (CINS/FINS) program. Lutheran Services Florida (LSF) is the designated CINS/FINS provider for Lee, Charlotte, Collier, Hendry, and Glades Counties. The Oasis Youth Shelter provides non-residential and short-term residential services for youth ages ten to seventeen.

Since the last quality improvement visit there has been several changes, including the following:

-The shelter has implemented the electronic logbook since the last on-site Quality Improvement review.

-The previous Shelter Supervisor resigned from the position and a new staff person was hired to fill this position.

-The shelter has implemented a “Ties on Tuesdays” campaign. It caught the attention of United Way of Lee County and they partnered with the shelter and the entire community became involved. Donations of nice clothing and many ties came in from all over. This is a program that helps young men learn to dress professionally, and is mentored by staff to address others and how to present in many situations, including job interviews. Male staff also wear ties on Tuesdays.

-The shelter held its first Career Fair in June 2017. Many attended, including Oasis youth, non-residential youth, child welfare independent living recipients. The presenters were from varied backgrounds and careers.

-The non-residential Program Director implemented the Intensive Case Management Services program in Circuit 20, a five-county area.

-The residential counselors are both registered mental health counseling interns being supervised internally.

-Lutheran Services just completed their COA re-accreditation.

Standard 1: Management Accountability

Overview

Narrative

The program management team is comprised of a Vice President of Programs located in Tampa, Florida: Executive Program Director located in Fort Myers; a Clinical Director (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 Shelter Case Manager; a part-time Registered Nurse, and a Senior Administrative Assistant.

The program provides first year training, as well as annual training, to ensure that all staff are properly trained for the jobs they perform. The program staff, the Florida Network, the Fort Myers Fire Department, the Red Cross, and other outside agencies provide training.

The program has numerous inter-agency 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 youth at risk and their families.

1.01 Background Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedures addressing background screening of employees and volunteers, which was last revised and approved on August 24, 2016 by the program's Executive Director, Clinical Director, and Shelter Manager.

The policy and procedures comply with the requirements for background screening of all Department of Juvenile Justice employees, contracted providers, and volunteers as well as anyone else with direct and unsupervised access to youth. The Annual Affidavit of Compliance with Good Moral Character Standards (form IG/BSU-006) must be completed by the program and sent to the DJJ Background Screening Unit by January 31st of each year.

According to the program's written procedures, any potential new hire must have a background screening conducted prior to the hiring of an employee or volunteer. This is conducted using The Department of Juvenile Justice's (DJJ) Background Screening Unit (BSU) Live Scan. In addition to the DJJ Background Screening, the provider also conducts a driver's license screening for new hires and then annual driver's license screening thereafter. The agency will update the Affidavit of Compliance with Good Moral Character Standards annually and provide appropriate documentation that accompanies this form by January 31st of each year.

A total of eleven personnel files were reviewed for seven new hires and four five-year re-screened staff. All seven new hires were screened and received an eligible screening result prior to their hire dates.

The provider had four eligible five-year rescreening due during the review period. The five-year re-screenings were submitted to DJJ's BSU and the result was obtained prior to the employees' five-year anniversary date. Reviewed documentation reflected the Annual Affidavit of Compliance with Good Moral Character Standards was received by DJJ's BSU on January 19, 2017 (prior to the January 31st requirement).

There were no exceptions to this indicator.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has one policy titled "Provision for an Abuse Free Environment" that addresses all elements of the indicator. The policy was last reviewed and approved in August 2016 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The agency requires staff to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. LSF Southwest's Employee Orientation Packet includes information about the required Code of Conduct and Abuse Reporting. The packet includes an acknowledgement of receipt forms for the employee to sign and the signed copy goes in the employee's file. The policy also requires staff training on Child Abuse reporting to the Florida Abuse Hotline. There are comprehensive procedures regarding the reporting of abuse and

neglect as well as information about signs of abuse/neglect.

LSF Southwest has a code of conduct form that all staff sign during orientation. LSF Southwest has dress code expectations that staff are informed of during orientation. The program requires that calls made to the Abuse Hotline be documented in the client's progress notes and/or a copy of the report will be placed in the client's file. The policy and procedure also covers the grievance procedure for staff outlining how youth may acquire a written grievance form from staff, which is also a topic of staff orientation. Client Grievance procedure is outlined in the Youth Handbook given to each youth at intake.

Posting of the Abuse Hotline number was observed during the tour on a wall in the youth day room and youth bedrooms. The Abuse Hotline number is also included in the youth handbook. The program's policy specifically complies with DJJ policies related to incident reporting, and requires program employees and volunteers to report all known or suspected cases of abuse and/or neglect to the Florida Abuse Hotline. Both staff and volunteers are expected to abide by the agency's rules of conduct that foster an abuse-free environment and prohibit intimidation, physical abuse or force. All new staff members receive training regarding the requirement of reporting incidents of alleged child abuse as a part of their initial orientation training. The program does have a binder where all abuse hotline calls are logged.

The program also has a grievance policy in place that requires families and youth to be informed of their right to grieve; youth acknowledge their understanding of the process by their signature at intake. The program maintains blank grievance forms easily available for all clients. A grievance box is mounted next to the staff office for depositing of completed grievances. Per the agency's procedures, completed grievance forms should be given directly to a manager or placed directly in the grievance box. The grievance box is checked daily by the Residential Services Manager and he will address all grievances in the box at that time. If the Residential Services Manager cannot resolve them then the Executive Program Director will handle the grievances. There were no instances during the review period of management needing to address any incidents relating to staff misconduct.

There were no exceptions to this indicator.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has one policy titled "Incident Reporting" that addresses all elements of this indicator. The policy was last reviewed and approved in August 2016 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The policy reflects procedures for the notification of reportable incidents to the Department of Juvenile Justice's Central Communication Center (CCC) within two hours of the incident or within two hours of becoming aware of the incident. The program also completes follow-up communication tasks/special instructions required by the CCC in order to close the case and assure the incident has been fully attended to as needed. Incident reporting procedures are part of employee orientation training.

Incidents are documented on an agency incident reporting form that captures pertinent information including date, time, location; client status; participants/witnesses; individuals notified; corrective action and follow-up; and signatures of individuals who reviewed the incident. An Incident Reporting summary is attached to the Incident Report Form.

During the reporting period, fourteen incidents were reported and met CCC criteria and was accepted by the CCC. Thirteen CCC incidents were reported within the two-hour limit and included follow-up. One CCC incident on August 14, 2017 was documented as being reported late by the CCC. All notifications and corrective actions were handled as stated in the policy. Follow-up documentation was noted in all incidents.

During the on-site review there was one incident reviewed involving a youth being transported off-site for emergency medical services that was not reported to the CCC as required.

Exceptions:

There was one incident that was not reported to the CCC in the two hour required time frame.

During the on-site review there was one incident reviewed involving a youth being transported off-site for emergency medical services that was not reported to the CCC as required.

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has one policy titled "Training Requirements" that addresses all elements of this indicator. The policy was last reviewed and approved in October 2017 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The policy states all direct care CINS/FINS staff (full-time, part-time, and on-call) 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. Direct care staff in residential programs licensed by DCF are required to have 40 hours of training per year after the first year. Training for staff includes training as required by DJJ, Florida Network of Youth and Family Services, DCF, COA, and any other funders.

A total of eight files were reviewed-- three in the first year of training, three reviewed for evidence of in-service training, and two specifically for evidence of counseling and/or management training. Two of the files reviewed met the criteria for documentation of non-licensed mental health clinical staff training in assessment of suicidal risk. Both staff received the required Non-Licensed Mental Health Assessment of Suicide Training's.

The remaining six files reviewed, met the requirements for first year and in-service training. All six files had completed or were on target for completing the training hours and all files included training topics required annually or had time to complete the necessary training. Each staff's training file was maintained neatly in a separate file.

There were no exceptions to this indicator.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has one policy titled "Analyzing and Reporting Data" that addresses all elements of the indicator. The policy was last reviewed and approved in August 2016 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

LSF Southwest collects and reviews several sources of data to identify patterns and trends including:

1. Quarterly Case Record Reviews
2. Quarterly Review of Incidents, Accidents, and Grievances
3. Customer Satisfaction Data
4. Annual Outcome Data
5. Monthly NetMIS Data Review

LSF staff complete monthly peer reviews for the shelter and non-residential client files. Two binders reviewed contained documentation of the peer reviews. A review of the CQI monthly spreadsheet and staff meeting agenda indicate monthly review/discussion of incidents, accidents, and grievances; customer satisfaction data; outcome data; and NetMIS benchmark data. Team Meeting Minutes document both residential and non-residential discussion and planning efforts. The Companion Report documents the program's plan for addressing any issues or trends and who will be accountable for each task. The Residential Nurse monitors Pyxis reports to track users and discrepancies. She provided a current discrepancy report for the review.

There were no exceptions to this indicator.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has one policy titled "Client Transportation" that addresses all elements of this indicator. The policy was last reviewed and approved in August 2016 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

LSF Southwest procedure addresses the following: 1) Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle; 2) Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy; 3) Third party is an approved volunteer, intern, agency staff, or other youth; and 4) Documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.

The agency has procedures outlining several aspects of client transportation. It states staff must ensure they are never in a one-on-one situation with any youth while transporting. When another Youth Care Staff is unavailable to assist with transportation, the youth care staff may utilize interns, volunteers, or may utilize other youth during transport. Only in extreme cases are staff permitted to transport youth one-one; however, they must receive permission from the Shelter Manager to do so. This approval must be documented in the van log by the van driver.

A list of authorized drivers will be kept by the program's Senior Administrative Assistant. All staff must make themselves aware of behavior management alert code information and plans for the clients for who they are providing transport. Each vehicle owned or leased by the program will have a van logbook. Each book will record the name and signature of the driver, where they are traveling to, and the odometer readings traveled. The log book must be completed for each trip the van makes even if clients are not present. The agency will develop and implement procedures for the annual inspection of all vehicles used to transport youth. Vehicles will be inspected on a weekly basis by the designated YCS III and all issues/problems will be reported to management as soon as they are observed. All vehicles used to transport youth shall be equipped with first aid kits, a fire extinguisher, seat belts, a seat belt cutter, and a window punch. The program will maintain adequate supplies and place orders as needed and on a regular basis.

According to the Indicator 1.06, if a driver is transporting a single youth in a vehicle, there must be evidence of a supervisor being aware prior to the transportation and consent is to be documented accordingly on the vehicle log. A review of the logbooks reflected there was a total of twenty-six instances of one-on-one transportation with a single staff member and a single youth. Twenty-three of the twenty-six one-on-one transports had evidence of the Shelter Manager's approval on the log; however, three did not: 10/20/2017, 10/13/2017, and 8/11/2017. Since the last review, cameras have been installed in both vans. The program manager has the ability to review footage if needed.

Exception:

Three single-client transports did not document the Shelter Manager's approval prior to the transport.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has one policy titled "Outreach Services" that addresses all elements of the indicator. The policy was last reviewed and approved in September 2015 and signed by the Executive Director, Clinical Director, and the Shelter Manager.

The program provides presentations in the community and distributes written information about their services. These written documents include annual reports, brochures, and posters. The Executive Director, Managers, and the Outreach Specialist recruit collaborative partners based on identified needs.

The agency has a binder for maintaining twenty-six interagency agreements that meet all contractual requirements. The agency also keeps a binder with outreach activities completed by the administrative or counseling staff. The binder also contains meeting minutes for attendance to DJJ Circuit Meetings.

There were no exceptions to this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

The Lutheran Services Oasis Shelter provides an array of prevention services through a residential and non-residential program for youth and their families who display risk factors such as truancy, ungovernability, runaway behavior, domestic violence, substance abuse, and family conflict. Referrals may come from the youth themselves, parents/guardians, schools, law enforcement, or other community entities.

The residential program provides centralized intake and screening twenty-four hours per day, seven days per week. Trained staff are available to determine the needs of the family and youth. The youth and family participate in a screening and intake process in order to ascertain eligibility and develop an individualized plan of services meeting their needs. Residential counseling services include individual, family, and group therapy. Case management and substance abuse prevention services are also offered, 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. The Non-Residential services provided include individual, family, and group counseling along with case management services.

Lutheran Services Oasis coordinates the case staffing committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing committee meets at a minimum of 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

Lutheran Services has a written policy that addresses all of the requirements for the Screening and Intake indicator. The policy was reviewed and last updated on September 4, 2017 and signed by the Executive Director, Clinical Director, and Residential Services Manager.

The procedures for screening and intake are as follows: The initial screening is to be received by phone or face-to-face by a trained staff. Information is to be gathered to determine if the youth is eligible for CINS/FINS services within seven days. Once the youth is deemed eligible for service, the Non-Residential and Residential staff is to be assigned to the youth and schedule an intake session with the client and his/her guardian. Both will initiate the Needs Assessment within 72 hours of completing the Intake Assessment. The Non-Residential Services will complete the Needs Assessment within two to three sessions or visits and the Residential Services will complete the Needs Assessment within seven days of completing the Intake Session.

There were a total of five Residential files and five Non-Residential files reviewed. All screenings were received and were screened for eligibility within the seven day requirement. All the screenings were deemed eligible within one to three days of the referral and were assigned to a counselor within that time-frame. The intake assessment and Needs Assessment were completed within the same day of the intake and/or within the time-frame allotted.

The parent and the client received in writing the available service options, the right and responsibilities, the grievance procedure, the agency handbook, and the possible actions that could occur during involvement with CINS/FINS services.

There were no exceptions to this indicator.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Needs Assessment indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director, and Residential Shelter Manager.

The agency's procedures are clearly identified. For the shelter, a Bachelor’s level staff is to complete a written Needs Assessment within 72 hours of admission. For Non-Residential Services, a Bachelor’s level staff is to initiate and complete the Needs Assessment within two to three

face-to-face contacts following the initial Intake. A supervisor must review and sign the Needs Assessment upon completion for both Non-Residential and Residential Services. If a youth is identified as having a suicide risk behavior during the Needs Assessment, it must be reviewed (signed and dated) by a licensed clinical supervisor or written by licensed clinical staff.

There were a total of five Residential files and five Non-Residential files reviewed. The Needs Assessments were implemented and completed on the same day as intake by a bachelor's level staff and were signed and reviewed by the supervisor.

One Non-Residential youth was identified as having suicide risk behaviors and was given an Evaluation of Suicide Risk Among Adolescents. The evaluation was reviewed by a licensed clinician.

There were no exceptions to this indicator.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Case/Service Plans indicator. The policy was reviewed and last updated on October 2, 2017 and signed by the Executive Director, Residential Service Manager, and Clinical Director.

Once a case is open a Case/Service plan is to be developed within seven working days following the assessment. The assessment form should be documented and contained in the youth file so that the service plan can be developed. The Case/Service Plan should identify the services that will be rendered to the client/family to assist them in reaching their goal.

There were a total of five Residential files and five Non-Residential files reviewed. The Case/Service Plans were developed on the same date as the Needs Assessments in all of the files reviewed. The Case/Service Plans all addressed the following areas: Identified Needs and Goals, Type, Frequency, and Location, Target Dates, Actual Completion Dates, Date plan was initiated, and Signature of the youth, parent, counselor, and supervisor. The Case/Service Plans were reviewed with parent or youth on a consistent basis.

There were no exceptions to this indicator.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Case Management and Service Delivery indicator. The Policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director, and Residential Service Manager.

The agency requires that each youth is assigned a counselor/case manager who will follow the client's case and is provided an array of services that utilizes appropriate resources for children and their families.

There were a total of five Residential files and five Non-Residential files reviewed. In the five Residential files, the youth were assigned a counselor and were offered services. In the five Non-Residential files the youth were referred for additional services while participating with Lutheran Services or at the time of discharge. In each of the ten case files, the youth and family were provided the required services as stated in this indicator.

There were no exceptions to this indicator.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Counseling Services indicator. The policy was reviewed and last updated on August 24, 2016 and signed by the Executive Director, Clinical Director, and Residential Service Manager.

The program's procedures address how the youth can access services, whether the youth needs respite services as a cooling off period, who are being identified for services, targeting at risk youth, how services are provided, who provides the services, monitoring the client's level of lethality risk throughout the service delivery process, and that the Non-Residential and Residential Services will be subjected to a quality assurance review.

All Residential and Non-Residential services provided counseling for the youth and for the families. Their presenting problems were addressed in their service plans and their progress was documented in their individual case files. The supervisor reviewed the files monthly and documented the review by signing a case note in the files. The discharge plans were completed and recommendations were made for the youth that were discharged. The residential services offered group counseling for the youth in shelter. All requirements (according to the indicator) were met for group counseling sessions.

There were no exceptions to this indicator.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Adjudication/Petition Process indicator. The policy was reviewed and last updated on October 2, 2017 and signed by the Executive Director, Clinical Director, and Residential Services Manager.

Lutheran Family Services has developed a case staffing committee (also labeled as TURN) that is committed to ungovernable, runaway and truant youth. The case staffing committee plays an essential role in service delivery process. The committee is critical to the CINS process and ensuring appropriate service and proper recommendations are made for legal process of filing CINS petition. The case staffing team meets as needed in Lee County and consist of a host of representatives from DJJ, schools, the state attorney, CINS/FINS representative, and more.

Three Non-Residential files were reviewed. All three Non-Residential youth were chosen to go through case staffing. The cases followed the protocol for scheduling a case staffing. The counselor initiated the staffing and sent a letter notifying the parent of the case staffing. The letter was sent out in the appropriate time-frame. As a result of the case staffing, a new Case/Service Plan was implemented and signed by the client and the parent when present. In one case, the family was present and was issued a new Case/Service Plan. In another case, the family was present via phone and the counselor mailed the new Case/Service Plan to the family. In the third case, the family was present to the first staffing but a second staffing was required due to non-compliance. At the second staffing the Case Staffing Committee made a recommendation to file a CINS petition. A review summary was completed prior to the court hearing.

There were no exceptions to this indicator.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Lutheran Services has a written policy that addresses all the requirements for the Youth Records indicator. The policy was reviewed and last

updated on August 24, 2017 and signed by the Executive Director, Clinical Director, and Residential Services Manager.

The agency has developed a procedure that assures a case record is maintained for each youth enrolled in the program and that the case files are marked confidential and kept in a secure, locked location.

All ten files reviewed were marked confidential and were kept in a secure, locked file cabinet and in a locked room. The file cabinets were also marked confidential. The files are transported in a large, black, digital lock rolling case and a small, black, hand held, digital lock carrying case. Both were marked confidential. Files are maintained in a neat and orderly manner.

There were no exceptions to this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

The Oasis Youth Shelter, operated by Lutheran Services Florida, is a twenty-two bed residential shelter that is licensed by the Department of Children and Families (DCF).

The program has policies and procedures in place for its Shelter Care programming. The Shelter Environment, Program Orientation, Youth Room Assignment, Logbook/Electronic Logbook, Behavior Management Strategies, Special Populations, and Video Surveillance are all covered in the policy and procedure manual. Policy and procedure are all adequately written and have been updated to reflect the Florida Network's standards when needed.

This shelter is designated by the Florida Network to provide services for Special Populations as well. These populations include Staff Secure services, Domestic Violence Respite (DV), Probation Respite (PR), and Domestic Minor Sex Trafficking (DMST). No staff secure were reported in this review period.

The LSF-SW Oasis shelter building includes a large day room, six bedrooms housing girls and boys separately, kitchen, laundry room, medication room, staff offices, and a secured internal courtyard area. The furnishings are in adequate condition and the rooms and common areas are clean. The sleeping quarters are divided into two separate areas, one for boys and one for girls. Two of the bedrooms are closed for renovation due to flooding that happened before and during Hurricane Irma. The bedrooms can hold up to four youth each. The bedrooms are equipped with two metal bunk beds and each youth has an individual bed, bed linens, and pillows. The bedrooms are also very well maintained and clean. The windows are fitted with blinds for privacy for the youth. There are two bathrooms-- one for each gender with two bathroom stalls, two showers, and a sink. The bathrooms appear to be very sanitary and clean. The bathrooms also have a checklist on the bathroom door for staff to check the cleanliness and a sign off section for staff accountability.

The shelter staff consists of a Residential Program Manager, a Clinical Manager, a Youth Care Specialist Supervisor, a Youth Care Specialist Shift Supervisor, Youth Care Specialists, Counselors and a Case Manager. The Shelter runs three shifts per day and maintain a schedule consistent with staff to client required ratios. They provide individual, group and family counseling services for CINS/FINS youth as well as youth involved with DCF and the Foster Care System. The average length of stay for youth is eighteen days as stated by the Residential Program Manager.

The Direct Care Workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. 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 in several locations throughout the facility to include the medication office and kitchen. All medications are stored in the Pyxis Med Station.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Shelter Environment indicator. The policy states, the shelter's environment is to be safe, clean, neat, and well maintained. The program provides structured daily programming to engage youth in activities that foster healthy, social, emotional, intellectual, and physical development.

Health and fire Inspections are to be conducted annually. Shelter furnishings are to be kept in good condition for aesthetic reasons and to ensure safety in the use of those furnishings. Pest Control comes to the shelter quarterly and the landscaping is maintained on a weekly to monthly basis depending on seasonal needs. Bathrooms and shower areas are to be inspected by shelter staff at least once each shift. All rooms are to be inspected for contraband and for graffiti a minimum of once each day. At admission, each youth is to be assigned to an individual bed and issued one pillow, one blanket, one fitted sheet, one flat sheet, and one pillowcase. Linens are to be laundered at least once each week or as necessary at the request of the youth. Each room is to have sufficient lighting to allow youth to read or to perform other tasks in any given area of the shelter. Youth may request that any personal belongings be kept in a locked place. Those belongings are to be placed in a plastic bag with the youth's name attached to it and locked in a file cabinet located in the Youth Care Office.

During a walk-through of the shelter with the shelter manager, the reviewer observed the shelter's environment to be safe, clean, neat and well maintained. All health and fire safety inspections are current and up-to-date. All furnishings appear to be in good condition. The beds were made and the rooms were free from clutter. The program is free of insect infestation and is treated by pest control on a quarterly basis and on an as needed basis. Grounds and landscaping are well maintained and serviced by a professional landscaping company as required seasonally. Bathrooms and shower areas are clean and functional. Bathroom checks are conducted by staff in 15 minute intervals. This supersedes the current policy of only having to be done at least once on each shift.

No graffiti was seen around the shelter. Lighting is adequate for tasks to be performed. There is a closed off section for the dumpster. Doors and agency vehicle is secure. Agency vehicle is equipped with all major safety equipment. Key control is in compliance. Every room has a detailed map and egress plan of the facility. Grievance forms are readily available to the youth and the grievance box is located outside of the kitchen in the living quarters. Abuse hotline number is posted in every bedroom as well.

A schedule is posted in the shelter that lays out the daily activities to include homework time, groups and leisure activities. Physical activities are provided at least one hour a day. Department of Children and Families license is current (February 2017) as well as Fire Extinguishers (October 2017), Sprinkler System (September 2017), Fire Alarm System (July 2017), and kitchen range hood (October 2017). Material Safety Data Sheets are current and inventory is done daily. Kitchen appears to be clean and sanitary and all food is properly stored, marked, and labeled.

There were no exceptions to this indicator.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Program Orientation indicator. The policy states that youth are to be given an opportunity to learn about the program and its expectations through a positive orientation process. Within at least twenty-four hours and preferably immediately upon completion of each youth's intake, staff should begin the orientation process by discussing the program's philosophy, goals, services, and expectations. A review of program rules and behavior management strategies is also to be discussed with the youth.

The program's procedure for orientation involves providing a comprehensive Residential Handbook to the child at intake. This provides the youth a brief description of the program, an explanation of HIPPA and confidentiality, a description of Safe Place including addresses of the three closest Safe Place locations, the client grievance procedure, a diagram showing the facility layout and indicating exit routes, first aid box locations, and other important locations throughout the facility, a list of shelter staff and their job titles, client rights and responsibilities, house rules and disaster preparedness instructions, and an overview of the behavior management system.

There was a total of five files reviewed for program orientation, all of which were active. In all five files, orientation was done with the youth and parent within the required twenty-four hours. During the orientation review, the following are gone over with the youth: Disciplinary Action Process, Grievance Procedure, Emergency/Disaster Plans, Contraband Rules, Physical/Facility layout map, Room Assignment, Suicide Prevention, Daily Activities, and Abuse Hotline Numbers. After all topics are gone over with the youth, both staff and youth place their signatures on the Orientation Forms. The policy meets the Florida Network standard of only requiring the youth and staff to sign the orientation form but LSF Practice states the parent/guardian must sign as well.

There were no exceptions to this indicator.

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Youth Room Assignment indicator. The policy states that the program will demonstrate the goal to protect youth through a classification system that ensures the most appropriate sleeping assignment.

During a youth's intake, shelter staff will complete a CINS/FINS Intake Assessment and the entire intake packet. The completed forms will gather information regarding the youth that will assist in determining the most appropriate room assignment. When possible, staff will utilize other collateral contacts to assess the youth's needs regarding room assignment. Room assignments will be determined by age, maturity level, presence of any disabilities, gang affiliations or behaviors, apparent emotional, mental health or substance abuse issues, and presence of any aggressive behaviors. Generally, Youth Care Staff will place youth between the age groups of 10-12, 13-15, and 16-17 unless there is a presence of aggressive behaviors, or disabilities. This form is to be kept in the youth's file.

There was a total of five files reviewed for program orientation, all of which were active. In all five files reviewed, the program used the CINS/FINS Intake Form provided by the Florida Network. This form captures each area needed per the Florida Network Standard and LSF Policy and Procedures Manuel. All required areas of the form were filled out to address the required areas. The reason for room assignment was noted in all five files. Alert stickers are placed on the spine of the file when needed. All files had a parent/guardian signature where needed.

There were no exceptions to this indicator.

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Logbook/Electronic Logbook indicator. The policy states that the log book is to document routine daily activities, events and incidents in the program, and are reviewed by direct care and supervisory staff at the beginning of each shift. Any entries that could impact the security and safety of the youth and/or program are highlighted.

All log book entries are to include: Date and time of incident, names of youth and staff involved, a brief statement providing pertinent information, and the name and signatures of the person making the entry. All recordings will be struck through with a single line, the staff person must initial or sign for the deleted entry. Shelter manager or designee will review the log book weekly and make a note indicating the dates reviewed. Each oncoming staff member will review the logbook for the previous two shifts (at a minimum) and record an entry in the logbook and sign/date that they have reviewed it, and the dates reviewed.

Log Book entry should be made at a minimum of every fifteen minutes. All logbooks are to be kept in storage for a period of seven years. No pages are ever to be torn out of a log book. General entries into the logbook should include the following: Head Count and what activity they are engaged in. Any visitors to the shelter. Any outings the youth or youth and staff are on. Any altercations or problematic behaviors that are ongoing. Any needed shelter repairs. Any visitors to the shelter, who they are and whom they came to see. Any deviance from the regularly scheduled activities. Administration of the Behavior Management System. Any noted minor illnesses or injuries of clients or staff. Any severe weather or other actions taken. Any emergency or fire drills conducted.

The shelter is utilizing an electronic logbook where all entries are being entered into a notepad. The logbook documents daily activities, events, and other major occurrences. Safety and security issues are documented and highlighted in green. Blue for signing in and out of the logbook. All incidents entered into the logbook include the youth and staff involved, date, time, and signatures. All recording errors are struck through with a line and initialed or signed. Supervisory reviews are conducted weekly, dated, signed, and highlighted in red. Supervisors and all staff review the logbook when they come on to shift daily and review at least two shifts back. All safety and security issues are documented. Supervision and resident counts are documented. Visitation and home visits are documented, Fire and Emergency drills are documented. Also noted in the electronic logbook are resident bed checks every fifteen minutes. All of the fifteen bed checks reviewed by this reviewer matched with the logbook entries.

There were no exceptions to this indicator.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Behavior Management Strategies indicator. The policy states that the program has a behavior management strategy that is designed to not only gain compliance with program rules, but to influence the youth to make positive pro-social choices and increase personal accountability and social responsibility. The program will have a detailed written description of the behavioral management strategies.

The program has a behavior management strategy that is designed to not only gain compliance with program rules, but to change the behavior of the youth and increase accountability. The BMS is clearly explained in the handbook. The BMS is designed to gain compliance with program rules and change behavior through accountability. The program utilizes a wide variety of rewards and appropriate consequences and sanctions based on client behavior. The BMS is utilized to encourage youth to increase positive and decrease negative behaviors. All staff and supervisors are trained in BMS theory and practice.

The program has a detailed written description of the Behavior Management Strategies and it is explained to the client during program orientation. The Behavior Management Strategies is being used to gain compliance with program rules, influence positive behavior and increase accountability. A wide variety of awards/incentives (prize cabinet, movies, dinner, bowling, etc.) are being used to encourage participation and program completion. Appropriate Behavior Management Strategies consequences and sanctions are used by the program. Consequences for behavior are logical and designed to promote skill-building for the youth.

The program utilizes 3 phases (phase 1, 2, and 3), all of which offer different perks. Each phase requires an assignment by the client to move up to the next phase. Phase 1 requires the client to complete a goal setting paper and an I statement paper. Phase 2 requires the client to right a one page letter to someone they hurt or victimized. Phase 3 requires a skit or group to be taught to the rest of the clients and staff. Loss of Privilege is used when consequences and accountability need to be utilized. Loss of Privilege includes early bed time, loss of privileges, or sit time where the youth writes a letter on various topics. The census board in the day room indicates what phase a youth is on, along with any loss of privilege or other sanctions.

There were no exceptions to this indicator.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Staffing and Youth Supervision indicator. The policy states that adequate staffing is provided to ensure the safety and security of youth and staff. The program will maintain a 1 staff to 6 youth ratios during awake hours and 1 staff to 12 youth ratio during the sleep period. There will always be at least one staff on duty of the same gender as the youth. If a program accepts both males and females, there should always be both a male and a female staff present, including overnight or sleep period. Overnight shifts must always provide a minimum of two staff present. Staff schedule is provided to staff and posted in a place visible to staff. Staff observe youth at least every 15 minutes while they are in their bedrooms, either during the sleep period or at other times, such as during illness or room restriction.

The agency will develop and implement a staff coverage schedule that will provide adequate supervision of youth and ensure the safety and security of all youth and staff. Program holiday and vacation coverage schedules are planned on a quarterly basis. Policies related to staff leave are contained in the agency's Personnel Policy and Procedures Manual. A list with the names and phone numbers of all employees will be maintained and an on-call lists will be maintained to ensure adequate staff coverage and that scheduled activities and routines are maintained. The staff schedule will be maintained in the youth care office posted on the bulletin board.

The Residential Services Manager will oversee staff scheduling responsibilities and monitor and review this process. Schedules should follow a consistent format that contains the names of individual employees and is easy to comprehend. Schedules will be posted in the facility in an area accessible to all staff. Scheduling should take into account the needs of the youth, program schedules and routines, and individual employees' strengths, skills and abilities.

The program has a process in place to ensure adequate safety and security of youth and staff. Program has a policy in place that meets general staffing ratio requirements. Program maintains a ratio of 1 to 6 youth during awake hours and community events, and 1 to 12 youth during sleep hours. Overnight work shifts consistently maintain a minimum of two staff present. Program maintains at least one staff on duty of the same gender as the youth on each work shift including all overnight work shifts. Program staff schedule is provided to staff or posted in a place visible to staff. There is a staff phone list that includes contact numbers when additional coverage is needed. Staff are utilizing the electronic log book, making it easy to see who is coming and going for their shifts.

Video Surveillance was reviewed on four separate dates at a total of fifteen different time slots throughout the overnight shift to make sure bed checks are being recorded at a minimum of fifteen minutes and entered into the electronic log. There were no discrepancies to report and some bed checks were being conducted five minutes apart.

There were no exceptions to this indicator.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Special Populations indicator.

The program can be funded to provide staff secure supervision and assigned one staff to one youth as assigned by the court at any given time. The staff secure program will have a staff secure policy and procedure that outlines an in-depth orientation on admission, assessment and service planning, enhanced supervision and security with emphasis on control and appropriate level of physical intervention, parental involvement and collaborative aftercare. Only youth that have met the legal requirements outlined in Chapter 984 F.S for being formally court ordered into staff secure services will be accepted. A specific staff during each shift will be assigned to monitor the location and movement of the staff secure always. The program will document the assignment of specific staff to the staff secure youth for each shift through daily log book, a posted staff calendar or any other means that clearly denotes by name the staff person assigned to the staff secure youth.

Domestic Minor Sex Trafficking (DMST) services are designed to serve domestic minor sex trafficking youth approved by the Florida Network who may exhibit behaviors which require additional supervision for the safety of the youth or the program. All requests may be approved for a maximum of seven days. Approval may be obtained on a case-by-case basis. Staff assigned to youth under this provision are to enhance the regular services available through direct engagement with the youth in positive activities designed to encourage the youth to remain in shelter.

The program must meet the following criteria to serve domestic violence respite youth: Agencies that do not have assigned bed days must receive prior approval for any DV Respite placement. Youth must have a pending DV charge. Must be screened by JAC/Detention but does not meet the criteria for secure detention. Youth length of stay will not exceed 21 days. Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release. Documentation in file of transition to CINS/FINS or Probation Respite placement, if applicable, Case Plan reflects goals for aggression management, family coping skills, or other interventions designed to reduce propensity for violence in the home. Services provided to these youths should be consistent with all other CINS/FINS program requirements. Youth with DCF involvement are eligible.

Probation Respite services may be provided to youth on Probation whose adjudication has been withheld. Referrals must come from the Juvenile Probation officer. Many factors are considered to include seriousness of past charges, behavior history, current population, bed availability, etc. Referrals are submitted through the Probation Referrolator via the Florida Network and approval must be received prior to accepting the youth. The length of stay is determined at the time of admission. Length of stay is 14 to 30 days.

There were no staff secure cases to review.

There was one file reviewed for Domestic Violence (DV) Respite. The file reviewed indicated that the youth had been screened by the Juvenile Assessment Center and did not meet the criteria for secure detention. The youth's stay did not exceed the twenty-one day maximum. The switch from DV Respite to CINS/FINS was noted in the file. Case plan reflects goals focusing on aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home. All other CINS/FINS services were provided to the youth as well.

There was one file reviewed for Probation Respite (PR). In the file reviewed there was evidence that the agency received prior approval from the FNYFS for admission as a PR placement. The probation respite referral came from the Juvenile Assessment Center and was approved by the Chief Juvenile Probation Officer. Length of stay did not exceed the maximum and was less than fourteen days. Through evaluation of the case plan/treatment plan, the youth's case management and counseling needs were met. The youth also received all other services afforded to CINS/FINS youth.

There were two files reviewed for Domestic Minor Sex Trafficking (DMST), all of which was the same youth. There was evidence through email of communication with FNYFS for approval for the DMST youth. The services provided to the youth were specifically designated services designed to serve DMST youth. The placement of DMST youth required the youth to be placed on sight and sound throughout their stay. Proper documentation was provided for Sight and Sound checks. The youth did not exceed the maximum length of stay, seven days. The youth also received all other services afforded to CINS/FINS youth.

There were no exceptions to this indicator.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program does have a written policy in place as well as procedures that address all the requirements for the Video Surveillance System indicator. The policy states, all Lutheran Services Florida (LSF) Youth Shelters shall utilize a video surveillance system to promote the safety of all youth, staff, and visitors.

The program has procedures in place to complement its policy. The video surveillance system (VSS) shall capture and retain video photographic images which shall be stored for a minimum of 30 days. The VSS shall record date, time, and location. It shall maintain resolution that enables facial recognition and vehicle license plate at a distance. Back-up capabilities shall consist of the VSS ability to operate during a power outage. All youth shelters shall have cameras placed in interior and exterior locations to provide coverage for general locations of the shelter to include hallways, locations where youth and staff congregate, visitor entrances and exits. Cameras shall never be placed in bathrooms or sleeping quarters. All cameras shall be visible to persons in the area and a written notice shall be conspicuously posted on the premises for the purpose of security.

Consistent checks of the VSS shall be made to ensure security and video systems are in working order. Live feed from the security videos shall be monitored. Enforcement mechanisms with clear consequences shall be established and utilized. The video surveillance system shall only be accessible to designated personnel and a list of personnel shall be maintained. A supervisory review of surveillance shall be conducted on a biweekly basis and noted in the logbook.

Client information contained within the VSS or stored externally shall be treated as confidential under LSF Confidentiality of Client Information Policy and Procedure. Video records utilized to make a decision which affects a client, family member, visitor, or employee shall be retained for a minimum of seven years or indefinitely upon management determination. LSF staff shall not make any attempts to alter video recordings.

LSF can't guarantee unauthorized access to the video VSS outside illegal methods. All saved video recording shall be disposed of in a secure manner unless retained as stated.

The system is in operation twenty-four hours a day, seven days a week. A written notice is posted outside the front door telling anyone entering the shelter of the video surveillance. Cameras are placed in the interior and exterior locations of the shelter where staff and youth congregate, and where visitors enter and exit. All cameras are visible and none are placed in bathrooms or bedrooms. The video surveillance system captures and retains clear, concise video photographic images. The system can record date, time, location, and store video up to a minimum of thirty days. Cameras are connected to a generator and do operate when there is a power outage.

As of right now the only staff able to review cameras is the supervisor. The new YDS 3 will be able to review cameras shortly. Supervisor tries to review the cameras weekly but never goes over the fourteen-day window. There is a process in place for third party review of video recordings and third parties requesting video footage.

There were no exceptions to this indicator.

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, an initial assessment occurs to determine the most appropriate room assignment given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a room which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The shelter manager and/or Youth Care Supervisor is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented in the daily log, on the alert board, shift exchange forms, and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over-the-counter medication surrender those medication to staff during admission. Medications are stored in the Pyxis MedStation 4000 Medication Cabinet, and topical and/or injectable medications are stored separately from oral medication. The provider installed the Pyxis Medication System and has trained their staff to use it. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication and ensures that an approved staff is scheduled on each shift. Medication records are also maintained for each youth and stored in a MDL (Medication Distribution Log) Binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Healthcare Admission Screening. The policy was last reviewed on August 24, 2016 by the Executive Director, Clinical Director, and Shelter Manager.

Immediately upon arrival of a youth to the facility, the staff, or nurse, if on premises, are to assess any obvious or immediate medical needs by completing the CINS/FINS Intake Assessment Form which includes specific physical health screening and a visual inspection of the youth. In the event the nurse does not conduct the screening they will review all intakes with five business days. If there is a medical, dental, or mental health condition that exists, the Youth Care Specialists will immediately alert the on-call Counselor about the issue. The on-call Counselor or the Residential Services Manager will contact the parent/guardian to discuss the medical needs and arrange for treatment of these needs and any special medical attention the client may require while in shelter.

There were six open youth files reviewed. All six files documented the CINS/FINS Intake Form was completed on the day of admission. None of the youth had any type of medical condition requiring a follow-up; however, procedures are in place if needed.

The shelter also completes a Healthcare Admission Screening Form and a body chart on each youth. This form is a more in-depth health screening. The Healthcare Admission Screening and the body chart were completed in all six files reviewed on the day of admission. Three files documented the nurse signed and reviewed the Healthcare Admission Screening Form within five working days. The other three files were new admissions and had not yet been signed by the nurse but still had time remaining to be reviewed.

There were no exceptions to this indicator.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for Suicide Assessment. The policy was last reviewed and revised on October 2, 2017 and approved by the Executive Director, Clinical Director, and Residential Services Manager.

During the intake process, program staff will complete the CINS/FINS Intake Form that includes past and current suicidal behaviors. When indicated on this form that the youth has screened positive for suicide risk, the staff conducting the intake will refer the youth to appropriate agency staff or law enforcement for a clinical assessment of suicide within twenty-four hours or immediately if in imminent danger. The youth is

to be placed on Constant Sight and Sound until this assessment is completed.

The agency has four different levels of supervision. Regular supervision is for youth who have no known or reported risk factors. One on One supervision is for youth with a specific plan, who have verbally expressed a desire or intent to act on the plan, or who have had a recent traumatic event or significant loss. These youth are awaiting a Baker Act and are with a staff member at all times within arms length away. This is the highest level of supervision and is for youth who are an imminent risk. Sight and Sound Supervision is for youth who are a moderate risk for suicide. These youth may have a history of suicide attempts or behavior, or have a family history. These youth have generalized suicidal thoughts but no specific plan and no desire or intent to act on the plan. These are within sight and reach of staff at all times.

Each residential counselor is a Masters level counselor. One of the two counselors is currently a registered intern to become a licensed mental health counselor. The second Masters level counselor is in the process of becoming a registered intern to become a licensed mental health counselor. Each counselor has completed the twenty hours of assessments training. Those hours completed have been overseen by the agency's licensed clinical social worker. The agency's licensed clinician has a clinical license that is in effect through March 31, 2019 (verified through copy of the license presented at review).

There were six total files randomly selected to review for suicide precautions. Out of the six files, one was an open file and the other five were closed files. In all six files the CINS/FINS Intake form was completed at admission. All six files had a minimum of one positive suicide risk indicator documented on their respective CINS/FINS Intake forms. Each form was signed by the YCS completing the form and signed by a supervisor indicating a review of the form for accuracy.

All six files contained evidence, through observation logs, of the youth being placed on Sight and Sound Supervision immediately after the CINS/FINS Intake form was completed. All six files documented observation logs were maintained the entire time the youth were on suicide precautions. The logs documented observations at least every thirty minutes, with most observations being documented in increments of ten minutes or less. The shift supervisor signed the logs for each shift, for all logs reviewed. The Clinical Director also signed all observation logs, indicating a review of logs for any warning signs. There was documentation in each file on the last observation log that suicide precautions had been discontinued, with the time and signature of the staff member making this notation.

Each of the six youth was seen and assessed by a counselor, using an Assessment of Suicide Risk, within twenty-four hours of placement. All suicide risk assessments reviewed were completed by a master’s level counselor. Each assessment documented a consultation with the clinical director prior to the youth being removed from suicide precautions. A corresponding note was also found in the clinical section of the file documenting a more in-depth overview of the suicide assessment completed. This note also documented the consultation with the clinical director and method of contact, which was either by phone, email, or in person, in the six files reviewed.

In all six files reviewed the youth were removed from suicide precautions and placed on normal supervision levels after the first suicide assessment was completed. This information was communicated to staff, as observation logs were discontinued at the time of consultation with the clinical director.

There were no exceptions to this indicator.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy on Medications. The policy was last reviewed on August 24, 2016 by the Executive Director, Clinical Director, and Shelter Manager.

The policy has procedures in place for the use of the Pyxis Med-Station 4000 Medication Cabinet. There are procedures for the verification of medication. There are procedures for Medication Supervision and Monitoring, Verification, Documentation, and Disposal. All procedures comply with the Florida Networks Policy and Procedure Manual for CINS/FINS.

The agency provided a list of ten staff who are trained to supervise the self-administration of medications. The Registered Nurse (RN) is listed as one of the Super Users of the Pyxis Med-Station as well as the Residential Services Manager and a Youth Care Specialist (YCS) II staff.

The shelter has an RN on-site various hours through the week but is always on-site at least twenty hours each week. The RN will distribute any needed medications when on-site. Trained YCS with access to the Pyxis Med-Station distribute medications when the RN is not on-site.

The RN trains all staff on the use of the Pyxis Med-Station and the medication administration process at hire. The RN also conducts an additional refresher training, for current staff members, during the year. The RN conducts groups with the youth on various topics such as hygiene care, nutrition, and fitness.

All medication is stored in the Pyxis Med-Station, including over-the-counter (OTC) medications which are stored in the top bin of the Med-Station. Prescription medications are stored in the second thru fourth drawers of the Med-Station. The fifth drawer is used for over-sized

medications or liquid medications in bottles. Medications are verified at admission using one of the four approved methods by the Florida Network.

The RN reported there have been no major discrepancies with the Pyxis Med-Station. Reports reviewed for the last month revealed no discrepancies and there no open discrepancies in the Pyxis Med-Station. Staff were aware that should any discrepancy occur, it needs to be cleared out of the end of their shift.

The RN completes a weekly inventory of all medications on-site. Trained YCS complete an inventory every shift of all medications stored in the Pyxis Med-Station with the exception of the OTC's. This inventory is documented on the youth's Medication Distribution Log (MDL) and a staff member from the outgoing shift long with a staff from the incoming shift initial the inventory. An inventory of the medication is completed every time it is given and a perpetual inventory is also maintained.

The shelter has a system in place for refrigeration of medication if needed; however, there was no medication that required refrigeration during the time of review. There is also a separate locked file cabinet in the kitchen where sharps are stored. All sharps are also inventoried weekly and signed out when used.

The RN reviews four different reports from the Knowledge Portal each month: a Discrepancy Report, a Summary by Transaction Report, a User Summary Report, and a Profile Overrides Report. The RN also goes into the Knowledge Portal at least once a week to view different reports.

There were no current youth in shelter at the time of the review, requiring medication. As a result, there were three closed files reviewed to verify the medication administration process. The youth's Medication Distribution Log (MDL) is maintained in the youth's individual file after release. For the current youth, the MDL is maintained in a binder in the staff work area. All MDL's reviewed documented the youth's name, date of birth, physician, allergies, medication the youth was taking with dosage, route, times to be given, and reason. A picture of the youth is located in front of the MDL in the Medication Log Book. Side effects of the medications are attached to the back of the MDL's. The youth also signs the MDL. All MDL's reviewed on site document that perpetual inventory counts with running balances are being maintained on each youth. All MDL's reviewed for the youth also documented that all medications were given at prescribed times. All MDL's documented shift-to-shift inventories of all medication, signed by two staff members. Each MDL also documented a weekly review by the RN.

The shelter has had one CCC report in the last six months relating to a medication error. The error occurred on August 14, 2017 and was due to a youth not receiving a scheduled dose of a medication. The pharmacy was contacted and reported there would be no side effects and to continue with the next scheduled dose. The staff involved in the incident did receive re-training by the RN on medication administration procedures.

There were no exceptions to this indicator.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy in place for the Medical and Mental Health Alert Process. The policy was last reviewed on August 24, 2016 by the Executive Director, Clinical Director, and Shelter Manager.

The agency uses a color-coded system for Medical/Mental Health alerts. The applicable color-coded dots are placed on the spine of the youth's file and also on the alert board in the YCS office. The agency uses: dark blue to indicate a medical condition, light blue for sight and sound, orange for allergies, red for medication, light green for substance abuse, black for mental health, dark green for physically aggressive, pink for chronic runaway, and yellow for elevated suicide risk.

There were six youth files reviewed. All files documented color-coded alerts on the spine of the file that corresponded with alerts identified during the screening process. All alerts were also appropriately documented on the alert board in the YCS office. An interview with a YCS indicated staff are very well versed in the alert system.

There were no exceptions to this indicator.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for Episodic/Emergency Care. The policy was last reviewed on August 24, 2016 by the Executive Director, Clinical Director, and the Shelter Manager.

All staff shall be trained in first aid and CPR procedures. All staff shall be trained on the use of the knife-for-life, and locations of first aid kits. First aid kits are checked by the YCS III Supervisor on a regular basis to ensure they are complete and up-to-date. Any emergency medical care administered to youth in the shelter shall be documented in the youth file with outcomes and resolution. Each facility shall perform an emergency first-aid drill at least once per quarter.

The program has had four instances of emergency/episodic care in the last six months. All four instances were documented in the shelters electronic logbook. Three of the four instances were documented on the shelters Emergency Care Log. Three of the four instances were reported to the CCC. All four incidents had an internal incident report documenting the details of the incident and the notification of the youth's parents.

Each staff member is trained in CPR and First Aid. A random sample of five training files was reviewed and each file contained a current CPR and First Aid certification card.

First aid kits are located in the nurse's office and also in the dayroom. These first aid kits are maintained by Zee Medical and stocked once a month. Shelter staff review the kits on a weekly basis to ensure they are stocked with necessary items.

There are knife-for-life and wire cutters located on the wall in the laundry room and also in the staff office.

The shelter conducts emergency medical drills on each shift, each month. There drills were reviewed and were found to be completed for the last six months.

Exceptions:

One emergency medical incident was not documented on the shelter's Emergency Care Log.

Another emergency medical incident, involving an off-site transport by EMS to the local hospital due to suspected withdrawals, was not reported to the CCC.