Florida Network for Youth and Family Services
Compliance Monitoring Report for

LSF NW – Currie House
4610 West Fairfield Drive
Pensacola, Florida 32506

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the LSF NW – Currie House for the FY 2020-2021 at its program office located at 4610 West Fairfield Drive, Pensacola, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF NW – Currie House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2020 through June 30, 2021.

The review was conducted by Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from LSF NW – Currie House present for the entrance interview were Beth Deck, Regional Director; Sherri Swanson, Clinical Director; and Sherry Kuss, Youth Care Specialist III. The last onsite QI visit was conducted March 11 - 12, 2020.

In general, the Reviewer found that LSF NW – Currie House is in compliance with specific contract requirements. **LSF NW – Currie House received an overall compliance rating of 100% for achieving full compliance with eleven indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, no recommendation was made for an indicator rated as conditionally acceptable.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-18-2020

Agency Name: LSF NW – Currie House	Monitor Name: Ashley Davies, Lead Reviewer
Contract Type : CINS/FINS	Region/Office: 4610 W Fairfield Dr., Pensacola, FL
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): November 18 - 19, 2020

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has two staff members certified as DJJ QI Peer reviewers. One of the staff have participated as a peer reviewer this season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional contracts for FY 2020- 2021 was provided by the provider. The list includes name, funding source, contract amount, and beginning date. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, substance abuse, mental health partners, and other treatment providers. All of the agreements reviewed had recent contract/agreement dates.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						Provided by Market Global Reinsurance Company. The provider's General Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. The providers Automobile insurance provides limits of coverage of $1,000,000 combined for each accident. The providers Excess/Umbrella Liability insurance provides limits of coverage of $1,000,000 each/aggregate. The provider's Professional Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider's Abuse/Molestation insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate.	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Coverage for the above policies is in effect for the current FY 2020-2021, 6/1/2020 – 6/1/2021. The certificate does list the Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal policies are in place signed by the VP of Finance and the CFO with a revision date of 4/27/2017. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	**No recommendation or Corrective Action.**
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY2020-2021, as of 7/1/2020	**No recommendation or Corrective Action.**

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(standard account numbers / separate funds for each revenue source, etc.). **PTV**						to 09/30/2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS, ICMS, and SNAP programs separately. The Ledgers showed current balances and differences.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation and Documentation: No change in practice was reported for the agency since the last onsite program review in March 2020. Reviewed petty cash Policy and Procedure. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a secure locked location in the building. The agency produced past documentation of monthly petty cash reconciliations. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required. Petty Cash fund was reviewed during the on-site visit.	**No recommendation or Corrective Action.**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

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invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**						Reviewed Bank Statements and Bank Reconciliations for the past six months for one account with Bank of America. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are signed by two parties. Checks disbursed are signed by two parties. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinets in the Program Administration office.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of payroll taxes and deposits for quarters two and three of 2020. A Collection Details report showed funds deposited every two weeks and an EFTPS Paid Tax report showed all payments made.	**No recommendation or Corrective Action.**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget Report including the current fiscal year to 9/30/2020. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified. CINS/FINS, ICMS, and SNAP are tracked separately. The program budget is reviewed and approved by the agency's Pres/CEO, Board, and Regional Director B. Deck.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2019 – 2018 by BDO USA, LLP. A copy was submitted directly to the Florida Network of Youth and Family Services for before November 2019. At the time of the review, the FY 2020 audit was underway and should be completed by December 2020.	**No recommendation or Corrective Action.**

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	Explain Rating						
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided multiple Policies and Procedures. No changes in Confidentiality and Security protocols. The policies have been applied consistently across the required areas that include Data Back Up Systems; Information Security; and Confidentiality. Policies are signed by the Regional Director with a revision date of 4/27/2017.	**No recommendation or Corrective Action.**

CONCLUSION

LSF NW – Currie House has met the requirements for the CINS/FINS contract as a result of full compliance with eleven applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no recommendations as a result of this review.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida/Northwest–Currie House
CINS/FINS Program

November 18 – 19, 2020

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

Indicator	Rating
1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 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

Indicator	Rating
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/ Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	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 & Special Populations

Indicator	Rating
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Video Surveillance	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

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.55%
Percent of indicators rated Limited: 3.45%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

Ashley Davies - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

April Denney - Department of Juvenile Justice

Robert Ashley – Anchorage Children's Home

Gina Dozier - CCYS

Theresa Clove – Thaise Exposure and Educational Tours

Quality Improvement Review

Lutheran Services Florida/Northwest – Currie House – November 18 – 19, 2020
Lead Reviewer: Ashley Davies

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

☐ Chief Executive Officer
☐ Chief Financial Officer
☐ Program Coordinator
☐ Direct – Part time
☐ Volunteer
☒ Clinical Director
☒ Counselor Non-Licensed
☐ Advocate
☐ Nurse – Full time
☐ Executive Director
☐ Program Director
☒ Direct – Care Full time
☐ Direct – Care On-Call
☐ Intern
☒ Counselor Licensed
☒ Case Manager
☒ Human Resources
☐ Nurse – Part time
☐ Chief Operating Officer
☒ Program Manager
1 # Case Managers
1 # Program Supervisors
NA # Food Service Personnel
NA # Healthcare Staff
NA # Maintenance Personnel
1 # Other (listed by title): **Regional Director**

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Logbooks
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☐ Contract Scope of Services
☒ Egress Plans
☒ Fire Inspection Report
☒ Exposure Control Plan
☒ Table of Organization
☒ Fire Prevention Plan
☒ Grievance Process/Records
☐ Key Control Log
☒ Fire Drill Log
☒ Medical and Mental Health Alerts
☒ Precautionary Observation Logs
☒ Program Schedules
☐ List of Supplemental Contracts
☒ Vehicle Inspection Reports
☐ Visitation Logs
☒ Youth Handbook
5 # Health Records
5 # MH/SA Records
12 # Personnel /Volunteer Records
8 # Training Records
6 # Youth Records (Closed)
4 # Youth Records (Open)
NA # Other: _____

Surveys

10 # Youth
11 # Direct Care Staff
0 # Other: _____

Observations During Review

☐ Intake
☒ Program Activities
☐ Recreation
☐ Searches
☒ Security Video Tapes
☒ Social Skill Modeling by Staff
☐ Medication Administration
☒ Census Board
☒ Posting of Abuse Hotline
☐ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Discharge
☐ Treatment Team Meetings
☐ Youth Movement and Counts
☒ Staff Interactions with Youth
☒ Staff Supervision of Youth
☒ Facility and Grounds
☒ First Aid Kit(s)
☐ Group
☐ Meals
☒ Signage that all youth welcome

Comments

Due to COVID-19, this review was conducted **on-site and virtually**.

Overview

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

Due to COVID-19, the program has had to change the way some services are offered. Non-residential services were initially limited to phone and virtual sessions but quickly returned to in-person, socially distanced sessions.

The shelter didn't allow family visits or outings for several months. All visitations that were allowed, were outdoors. In their attempt to comply with COVID protocols, they limited their bed number to eight. For much of that time, they were fortunate to have three or four clients, which directly impacted their ability to meet their deliverables.

With the Care Act funds, from their Basic Center grant, they were able to purchase laptops, so counselors could work from home; installed a security device on their exterior doors, which allows them to screen visitors prior to them entering the building; purchased new wipeable chairs in the lobby; installed air purifiers and hand sanitizers throughout the building; put a plexiglass shield surrounding the receptionist's desk; and transformed an extra storage room into a large counseling room, to accommodate large families.

While most of their Outreach efforts are now provided via virtual platforms, the Outreach Coordinator (OC) has established a new partnership with Moreno Court, which is a low-income rental housing complex, available through the Area Housing Commission. Every Tuesday, the OC shares the donated food they receive from Publix and Walmart, with over 40 families who live in that community. The OC also provides agency information to each family.

The Life Skills Coach developed a week-long Common-Sense Camp, which ended with a special outing to Wonderworks, educational hands-on science exhibits that "challenges the mind and sparks the imagination."

The program has a couple of new activity highlights with one being a health and fitness group conducted every Wednesday. This group is geared towards teaching the youth the importance of nutrition and physical activity. Another activity highlight involves the program participating in the Children's Home Society Street Outreach team's weekly group to help the youth in the shelter develop a personal plan to achieve their goals, build upon their interest to pursue potential careers, developing interviewing and employment skills, and much more.

Narrative Summary

Lutheran Services Northwest (LSF-NW) is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services in the Northwest region of the Florida Panhandle. The program provides residential and non-residential counseling and case management services over two counties, Escambia and Santa Rosa, across Circuit 1. The youth shelter operates 24 hours a day, 365 days a year, and is licensed for up to twelve CINS/FINS shelter beds. LSF-NW is managed by a Regional Director who oversees a Quality Services Manager and a Clinical Director. The agency as a whole provides a broad range of service offerings to those youth and families in need through Outreach efforts in their immediate service region. The agency's primary focus is providing residential and non-residential CINS/FINS services to youth and families in short-term crisis situations.

Standard 1: This standard has a total of seven indicators regarding management accountability. All seven indicators were rated satisfactory. There were exceptions noted in indicators 1.01 Background Screening, 1.03 Incident Reporting, 1.04 Training Requirements, and 1.05 Analyzing and Reporting Information. The exception noted in 1.01 was due to all suitability assessments reviewed being completed after the employee was hired and containing no results to determine if the employee was suitable for the position they were hired for. The exception noted in 1.03 was due to one incident reported to the CCC outside of the two-hour time frame. The exception noted in 1.04 was due to one first-year staff training file reviewed missing some of the required trainings and hours. The exception noted in 1.05 was due to minimal documentation to address weaknesses that were identified.

Standard 2: This standard has a total of ten indicators that relate to intervention and case management. All ten indicators were rated satisfactory with exceptions noted in 2.01 Screening and Intake and 2.09 Special Populations. The exception noted in 2.01 was due to one parent not present at intake and there was no documentation the parent ever received the required forms and information. The exception noted in 2.09 was due to one Domestic Violence youth who was in the program longer than 21 days and was not transitioned to a CINS or Probation Respite bed.

Standard 3: This standard has a total of seven indicators regarding shelter care. All seven indicators were rated satisfactory. There were exceptions noted in 3.01 Shelter Environment and 3.07 Video Surveillance. The exception noted in 3.01 was due to chemical inventories being completed monthly rather than weekly. The exception noted in 3.07 was due to some missing supervisor reviews of the video surveillance.

Standard 4: This standard has a total of five indicators regarding mental health and health services. Four of the five indicators were rated satisfactory. Indicator 4.03 Medication was rated a limited due to the program not having a Registered Nurse (RN), for twelve months now, to oversee the medication process. An exception was noted in 4.01 Healthcare Admission Screening due to the preliminary healthcare screenings not being reviewed by an RN due to the program not having an RN.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

Standard 4: Indicator 4.03 Medication was rated a limited due to the program not having a Registered Nurse (RN), for twelve months now, to oversee the medication process.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.01 Background Screening of Employees and Volunteers that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
a. Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth.	☐	☒	☐	☐	☐	A total of twelve new staff were hired since the last onsite QI review. Eight of the staff met the criteria for a pre-screening assessment. The agency uses the Predictive Index. All staff had a Predictive Index completed.	**Exception:** All eight Predictive Index's completed for the newly hired staff were completed after the staff's hire date. There were also no results from the assessments to determine if the individual was an appropriate level of suitability for the position they were hired for.
b. Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	☒	☐	☐	☐	☐	A total of twelve new staff and two interns were hired since the last on-site QI review. All fourteen staff were background screened prior to hire.	
c. Five-year re-screening completed every 5 years from initial date of hire	☐	☐	☒	☐	☐	There were no staff due for a 5-year rescreening during this review cycle.	
d. Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	☒	☐	☐	☐	☐	The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 1/07/2020.	

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Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
e. Proof of E-Verify for all new employees obtained from the Department of Homeland Security	☒	☐	☐	☐	☐	Documentation of approval of E-Verify work eligibility was provided for all twelve new staff hired.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.02 Provision of an Abuse Free Environment that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Abuse Free Environment							
a. Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	☒	☐	☐	☐	☐	Reviewed policy 1.02 Provision of an Abuse Free Environment. The program maintains a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation that all staff must adhere to. This is reviewed with staff at hire.	
b. Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	☒	☐	☐	☐	☐	Child Abuse telephone number was observed posted in the lobby and the dayroom of the shelter during the on-site tour of the facility.	
c. Youth were informed of the Abuse and Contact Number (see youth survey results)	☒	☐	☐	☐	☐	All five residential files reviewed documented the youth were informed of the Abuse Hotline number during orientation.	
d. Management takes immediate action to address any incidents of threats or abuse	☒	☐	☐	☐	☐	The program reported there were no incidents of abuse or threats identified and/or reported during the review period needing management action.	
Grievance Process							
a. Agency has a formal grievance process	☒	☐	☐	☐	☐	Reviewed policy 1.02 Provision of an Abuse Free Environment.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
b. Locked box accessible to only management and available to youth in a common area	☒	☐	☐	☐	☐	During the on-site tour it was observed that the program has an accessible grievance box, that is locked and located in the dayroom of the shelter. The shelter supervisor is the only person who has a key to this box.	
c. Direct care does not handle the complaint/grievance unless assistance is asked for by the youth	☐	☐	☒	☐	☐	The program has had no grievances filed since the last on-site QI review.	
d. 72-hour resolution requirement by management	☐	☐	☒	☐	☐	The program has had no grievances filed since the last on-site QI review.	
e. Grievance maintained on file for a minimum of 1 year	☐	☐	☒	☐	☐	The program has had no grievances filed since the last on-site QI review.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.03 Incident Reporting that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
a. During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	☐	☒	☐	☐	☐	The program had two incidents reported the CCC since the last on-site review. One incident was report within the two-hour time frame although it was not accepted by the CCC.	**Exception:** There was one incident reported to the CCC outside of the two-hour time frame.
b. The program completes follow-up communication tasks/special instructions as required by the CCC	☒	☐	☐	☐	☐	All follow-up tasks were completed as required in the one CCC that was accepted.	
c. Incidents are documented in the program logs and on incident reporting forms	☒	☐	☐	☐	☐	The program had eleven other non-reportable incidents documented on internal reporting forms. All reportable and non-reportable incidents were documented in the program's log book.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
d. All incident reports are reviewed and signed by program supervisors/directors	☒	☐	☐	☐	☐	All incident reports were reviewed and signed by program leadership.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.04 Training Requirements that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
First Year Direct Care Staff							
a. Direct care staff receives all mandatory training during the first 120 days of employment	☒	☐	☐	☐	☐	There were four direct care staff training files reviewed. All four staff documented all mandatory trainings during the first 120 days of employment.	
b. Direct care staff completes all mandatory Florida Network and SkillPro training during the first year employment.	☐	☒	☐	☐	☐	There were four direct care staff training files reviewed. Three of the staff have already documented over the required 80 hours of training for the first year and most of the required trainings have been completed. All three staff still have between four and six months to receive additional trainings and hours.	**Exception:** One staff training file reviewed documented the staff had completed their first-year training cycle. This staff only documented 70.25 of the required 80 hours and was missing all Skill Pro trainings as well as Title IV-E, Serving LGBTQ, and Cultural Humility.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
a. Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	☒	☐	☐	☐	☐	There were two applicable staff. Both staff documented the required Assessment of Suicide Risk training with twenty hours of training and five supervised Assessments of Suicide Risk.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
b. Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	☒	☐	☐	☐	☐	All trainings and supervised Assessments of Suicide Risk were completed by and signed by the Licensed Mental Health Counselor.	
In-service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	☒	☐	☐	☐	☐	Four in-service direct care staff training files were reviewed and all four had already documented over 40 hours of training for 2020. Each staff still needed to complete between one and two required trainings; however, still have time left in the training cycle to receive these trainings.	
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	☒	☐	☐	☐	☐	In all training files there was a spreadsheet with all trainings, date completed, and hours. Also, training files included training certificates and training worksheets.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.05 Analyzing and Reporting Information that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Quarterly Reviews							
a. Case record review reports demonstrate reviews are conducted quarterly, at a minimum	☒	☐	☐	☐	☐	Case record reviews are completed quarterly for both residential and non-residential files. The last quarter for each was reviewed.	

FLORIDA NETWORK of youth and family services

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
b. The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	☒	☐	☐	☐	☐	The program documented a review of incidents, accidents, and grievances in April, May, July, August, and October in the YCS meeting minutes.	
Annual Reviews							
a. The program conducts an annual review of customer satisfaction data	☒	☐	☐	☐	☐	The program documented a review of customer satisfaction data in April, May, July, August, and October in the YCS meeting minutes.	
b. The program conducts an annual review of outcome data	☒	☐	☐	☐	☐	The program documented a review of outcome data in April, May, July, August, and October in the YCS meeting minutes.	
Monthly Reviews							
The program conducts a monthly review of NetMIS data reports	☒	☐	☐	☐	☐	The program reviews two reports received from the FNYFS each month.	
Quality Improvement Process							
a. The program has a process in place to review and improve accuracy of data entry & collection	☒	☐	☐	☐	☐	Program leadership review the two reports received from the FNYFS each month to ensure youths information in each system is correct. If any changes are needed in NetMIS they are made at that time and if changes are needed in JJIS a DIO request is submitted.	
b. There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	☒	☐	☐	☐	☐	There was documentation through meeting minutes that findings are communicated to staff and stakeholders.	
c. There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	☐	☒	☐	☐	☐	There is evidence in monthly YCS meeting minutes that strengths and weaknesses are identified, and staff are informed and involved throughout the process.	**Exception:** There was minimal documentation in meeting minutes of what improvements were implemented to address the weaknesses that were identified.

1.06: Client Transportation

Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.

Provider has a written policy and procedure that meets the requirement for Indicator 1.06	☒ YES ☐ NO (explain)	

Quality Improvement Review

Lutheran Services Florida/Northwest – Currie House – November 18 – 19, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						The agency has a policy in place titled 1.06 Client Transportation that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Approved agency drivers							
a. Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	☒	☐	☐	☐	☐	The agency maintains a list of nineteen staff approved to transport clients.	
b. Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	☒	☐	☐	☐	☐	All staff have a valid Florida driver's license and covered under company policy.	
Third party present in the vehicle							
a. Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	☒	☐	☐	☐	☐	Reviewed policy 1.06 Client Transportation.	
b. In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	☒	☐	☐	☐	☐	Transportation logs from May 2020 through October 2020 were reviewed. There were twenty-seven single client transports documented. The program documents supervisor approval in the log book. A sample of single transports were randomly chosen to verify supervisor approval and all documented approval in the log book prior to the transport taking place.	
c. The 3rd party an approved volunteer, intern, agency staff, or other youth	☒	☐	☐	☐	☐	Reviewed policy 1.06 Client Transportation.	
Transportation documentation							
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location	☒	☐	☐	☐	☐	Reviewed transportation logs from May 2020 through October 2020. All logs documented the date, the start time, the mileage, the number of	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						passengers, the purpose of travel, and the location.	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.07 Outreach and Interagency Agreements that addresses the requirements of this indicator. This policy was last reviewed on October 2, 2019 by the Regional Director.	
a. The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	☒	☐	☐	☐	☐	The agency has a representative from the program attend numerous different community meetings monthly including: Drug Endangered Children and Communities, Northwest Florida Prevention Coalition, United Way, Circuit 1 Human Trafficking Task Force, and Opening Doors. There were agendas and meeting minutes from each one of these meetings attended by a staff member. The agency also has a representative from the program attend the Circuit 1 Department of Juvenile Justice Circuit Advisory Board Meetings for Escambia and Santa Rose counties. There were meeting minutes and agendas from each one of these meetings for the months for August, September, and October 2020.	
b. Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	☒	☐	☐	☐	☐	The agency provided an outreach report which included title of event, date of event, number of youth and adults in event, purpose of event, and what area event took place in the community. Report was provided from 5/5/2020 – 10/27/2020 and included numerous	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						outreach events each month at local schools, meetings, and community events each month.	
c. The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	☒	☐	☐	☐	☐	The program maintains written agreements with community partners which include services provided and a referral process. Written agreements the program has on file include: Big Brothers Big Sisters of Northwest Florida, Opening Doors, HIV evolution, Lakeview Center –Victim Services/Rape Crisis Center, Lakeview Center –Baptist Health Care, Pensacola Police Department, Boy and Girls Club of the Emerald Coast, Avalon Center of Lakeview, A Safe Port Counseling Center, Escambia County Sheriff's Office, Santa Rosa Kids House, Gulf Coast Kids House, CDAC Behavioral Healthcare, Inc., School Board of Escambia County, Santa Rosa County School Board, Children's Home Society, and Catholic Charities of Northwest Florida. All agreements reviewed were current and up-to-date.	
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.01 Screening and Intake that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Eligibility screening is completed within 7- calendar days of referral	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (two open and three closed) and five non-residential (two open and three closed.) All ten	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						had eligibility screening completed within seven calendar days of referral.	
Youth and parents/guardians receive the following in writing: • Available service options • Rights and responsibilities of youth and parents/guardians	☐	☒	☐	☐	☐	There were ten files reviewed, five residential (two open and three closed) and five non-residential (two open and three closed.) Nine out of the ten files documented the youth and parents received all required information at intake.	**Exception:** One residential file documented the parent was not present at intake. There was no documentation the parent ever received any of the required forms.
The following is also available to the youth and parents/guardians: • Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) • Grievance procedures	☐	☒	☐	☐	☐	There were ten files reviewed, five residential (two open and three closed) and five non-residential (two open and three closed.) Nine out of the ten files documented the youth and parents received all required information at intake.	**Exception:** One residential file documented the parent was not present at intake. There was no documentation the parent ever received any of the required forms.
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.02 Needs Assessment that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Completion of Needs Assessment							
a. Shelter Youth: Needs Assessment initiated within 72 hours of admission	☒	☐	☐	☐	☐	Five residential youth files were reviewed (two open and three closed). The Needs Assessment was initiated within 72 hours in all five files.	
b. Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	☒	☐	☐	☐	☐	Five non-residential youth files were reviewed (two open and three closed.) The Needs Assessment was completed within 2 to 3 face-to-face contacts in all five files.	
c. Needs Assessment is conducted by a bachelor's or master's level staff member	☒	☐	☐	☐	☐	All Needs Assessments were conducted by a bachelor's or master's level staff member.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
d. Needs Assessment includes a supervisor's review signature upon completion	☒	☐	☐	☐	☐	A supervisor's signature was present on all Needs Assessments reviewed.	
Suicide Risk as a Result of the Needs Assessment							
a. Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	☐	☐	☒	☐	☐	None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
b. If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional	☐	☐	☒	☐	☐	None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.03 Case/Service Plan that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Case/Service plan is developed within 7 working days of Needs Assessment	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (two open and three closed) and five non-residential (two open and three closed.) All ten files had a Service Plan developed within seven days of the Needs Assessment.	
Case/Service Plan includes:							
• Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment • Service type, frequency, location • Person(s) responsible • Target date(s) for completion and Actual completion date(s) • Signature of youth, parent/guardian, counselor, and supervisor • Date the plan was initiated	☒	☐	☐	☐	☐	All ten files included all elements required by the indicator.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	☒	☐	☐	☐	☐	There were five Service Plans applicable for 30-day reviews. All five documented all reviews were completed as required.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.04 Case Management and Service Delivery that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Counselor/Case Manager is assigned	☒	☐	☐	☐	☐	Each of the ten files reviewed showed a counselor was assigned to the youth.	
The Counselor/Case Manager completes the following as applicable: • Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs • Coordinates service plan implementation • Monitors youth's/family's progress in services • Provides support for families • Monitors out-of-home placement (if necessary) • Makes referrals to the case staffing to address problems and needs of the youth/family • Accompanies youth and parent/guardian to court hearings and related appointments • Refers the youth/family for additional services when appropriate	☒	☐	☐	☐	☐	All ten files established referral needs and coordinated referrals for services. All ten files coordinated service plan implementation. All ten files monitored the youth's and family's progress in services. All ten files provided support for families. None of the files were applicable for monitoring out-of-home placement. None of the files were applicable for referrals to the case staffing committee. None of files were applicable for accompanying the youth or parent to court hearings or appointments.	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Explain any items that have any deficiencies, exceptions or are not applicable. For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
• Provides case monitoring and reviews court orders • Provides case termination notes • Provides follow-up after 30 days of exit • Provides follow-up after 60 days of exit						All ten files referred the youth/family for additional services when needed. All ten files provided case monitoring. All six applicable files provided case termination notes. All five applicable files provided follow-up after 30 days of exit. All four applicable files provided follow-up after 60 days of exit.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.05 Counseling Services that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	☒	☐	☐	☐	☐	Service plans and/or case notes maintained demonstrated all ten youth received individual counseling services as identified during the assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	☒	☐	☐	☐	☐	Applicable to five residential files reviewed. All five demonstrated individual and/or family counseling was offered.	
Group counseling sessions held a minimum of five days per week	☒	☐	☐	☐	☐	Applicable to five residential files. All five files documented group sessions at least five days per week.	
Group counseling sessions consist of: • Length of at least 30 minutes	☒	☐	☐	☐	☐	Group logs were reviewed from May 1, 2020 – October 31, 2020. Group counseling sessions	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
• Opportunity for youth engagement • Clear and relevant topic (informational/developmental/educational) • Clear leader or facilitator						consisted of a clear leader or facilitator, relevant topic, date and time of group, list of participants, an opportunity for youth to participate, and the length of groups was at minimum thirty minutes.	
Non-residential Program							
Non-residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	☒	☐	☐	☐	☐	Applicable to the five non-residential youth files. Therapeutic services provided by agency staff were documented in the case notes. Referral needs were established and provided to all five youth.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	☒	☐	☐	☐	☐	Coordination of services was observed in all ten files reviewed.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	☒	☐	☐	☐	☐	Individual youth file was maintained for all ten youth files reviewed, marked confidential, and securely maintained.	
Case notes maintained for all counseling services provided and documents youth's progress	☒	☐	☐	☐	☐	All ten files included case notes that documented services provided including counseling.	
On-going internal process that ensures clinical reviews of case records and staff performance	☒	☐	☐	☐	☐	Case records are reviewed quarterly. Record reviews were reviewed for the past two quarters for both residential and non-residential. All assessments and treatment forms in all ten files reviewed were signed and reviewed by a supervisor.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.06 Adjudication/Petition Process that addresses	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	
The youth, family and case staffing committee are contacted within a minimum of five working days • Notification to youth/family no less than 5 working days prior to staffing • Notification to committee no less than 5 working days prior to staffing	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	
Other members may include: • State Attorney's Office • Others requested by youth/family • Substance abuse representative • Law enforcement representative • DCF representative • Mental health representative	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	
The program has an established case staffing committee, and has regular communication with committee members	☒	☐	☐	☐	☐	The program has an established committee with regular communication. The program is also very active with Truancy Court and participates weekly in those meetings.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	☒	☐	☐	☐	☐	Policy titled 2.06 Adjudication/Petition Process	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	

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Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	
Case Manager/Counselor completes a review summary prior to the court hearing	☐	☐	☒	☐	☐	The program has not had any case staffing's since the last on-site Quality Improvement review.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.07 Youth Records that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
All records are marked "confidential	☒	☐	☐	☐	☐	All ten youth files reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	☒	☐	☐	☐	☐	During the on-site tour, files were observed to be stored in locked file cabinets marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	☒	☐	☐	☐	☐	When the youth files are transported offsite, they are locked in an opaque container marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	☒	☐	☐	☐	☐	All ten files reviewed were observed to be organized and maintained in a neat and orderly manner.	
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain)	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						The agency has a policy in place titled 2.08 Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of this indicator. This policy was last reviewed on October 2, 2019 by the Regional Director.	
Use of youth's preferred name/pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards	☐	☐	☒	☐	☐	There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	
Youth in need of specialized support is referred to qualified resources (as applicable)	☐	☐	☒	☐	☐	There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	☐	☐	☒	☐	☐	There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	☐	☐	☒	☐	☐	There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	☒	☐	☐	☐	☐	During the on-site tour of the facility signage was observed in the dayroom of the shelter and the lobby area.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09 for EACH special population served i.e. Staff Secure, DMST,DV, PR, ICM and FYRAC.						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.09 Special Populations that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019.	
Staff Secure							

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☒ No			☐N/A			The provider has not served any youth meeting the criteria for staff secure since the last QI review.
Staff Secure policy and procedure outlines the following: • 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 • Collaborative aftercare	☒	☐	☐	☐	☐	Reviewed policy 2.09 Special Populations.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	☐	☐	☒	☐	☐	No applicable youth files to review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	☐	☐	☒	☐	☐	No applicable youth files to review.	
Agency provides a written report for any court proceedings regarding the youth's progress	☐	☐	☒	☐	☐	No applicable youth files to review.	
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☒ No			☐N/A			The provider has not served any youth meeting the criteria for DMST since the last QI review.
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements	☐	☐	☒	☐	☐	No applicable youth files to review.	

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FLORIDA NETWORK of youth and family services

Quality Improvement Review
Lutheran Services Florida/Northwest – Currie House – November 18 – 19, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Services provided to these youth specifically designated services designed to serve DMST youth	☐	☐	☒	☐	☐	No applicable youth files to review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	☐	☐	☒	☐	☐	No applicable youth files to review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	☐	☐	☒	☐	☐	No applicable youth files to review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	☐	☐	☒	☐	☐	No applicable youth files to review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	☐	☐	☒	☐	☐	No applicable youth files to review.	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☒Yes	☐ No		☐N/A			
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	☒	☐	☐	☐	☐	There were three closed DV files reviewed. All three files had a face sheet indicating a pending DV charge and were screened by the JAC and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☒	☐	☐	☐	☐	There was evidence of data entry at intake and release in all three files.	

FLORIDA NETWORK of youth and family services

Quality Improvement Review
Lutheran Services Florida/Northwest – Currie House – November 18 – 19, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	☐	☒	☐	☐	☐	One youth did not exceed 21 days in the program. The other two youth did exceed 21 days and one of the two youth was transitioned to CINS/FINS on the 20th day.	**Exception:** One youth exceeded 21 days in the program was not transitioned to CINS/FINS or Probation Respite placement.
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	☒	☐	☐	☐	☐	All three Service Plans reviewed focused on anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	☒	☐	☐	☐	☐	All three youth received all other general CINS/FINS required services.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes	☒ No		☐N/A			The provider has not served any youth meeting the criteria for Probation Respite since the last QI review.
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	☐	☐	☒	☐	☐	No applicable youth files to review.	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☐	☐	☒	☐	☐	No applicable youth files to review.	
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)	☐	☐	☒	☐	☐	No applicable youth files to review.	
All case management and counseling needs have been considered and addressed	☐	☐	☒	☐	☐	No applicable youth files to review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	☐	☐	☒	☐	☐	No applicable youth files to review.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☐Yes	☐ No		☒N/A			This provider is not contracted to provide ICM services.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Youth receiving services was court ordered or referred by case staffing committee	☐	☐	☐	☐	☒		
Services for youth and family include: a. Six (6) direct contacts per month b. Six (6) collateral contacts per month	☐	☐	☐	☐	☒		
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)	☐	☐	☐	☐	☒		
Case plan demonstrates a strength-based, trauma-informed focus	☐	☐	☐	☐	☒		
Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones	☐	☐	☐	☐	☒		
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☐Yes ☒ No			☐N/A			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating	☐	☐	☒	☐	☐	No applicable youth files to review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	☐	☐	☒	☐	☐	No applicable youth files to review.	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program	☐	☐	☒	☐	☐	No applicable youth files to review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning	☐	☐	☒	☐	☐	No applicable youth files to review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	☐	☐	☒	☐	☐	No applicable youth files to review.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	☐	☐	☒	☐	☐	No applicable youth files to review.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.10 Stop Now and Plan (SNAP) that addresses the requirements of the indicator. The policy was	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
						last reviewed on October 2, 2019 by the Regional Director.	
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	☒	☐	☐	☐	☐	There were four files reviewed, two open and two closed. All four files had the NetMIS Screening form and SNAP Brief Intake Screening form.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	☒	☐	☐	☐	☐	Needs Assessment was initiated at intake in all four files.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)	☒	☐	☐	☐	☐	A pre CBCL was completed in all four files. A post CBCL was completed in both of the closed files.	
b. Teacher Report Form (TRF) completed by the teacher (pre & post)	☒	☐	☐	☐	☐	A pre TRF was sent to the teacher to complete in all four files. A completed TRF was not returned in any of the files; however, all four files documented a follow-up email with the teacher in attempts to get the form completed. A post TRF was not completed in the two closed files due to it being summer break and school was not in session.	
c. TOPSE (pre & post)	☒	☐	☐	☐	☐	A pre TOPSE was completed in all four files. A post TOPSE was completed in the two closed files.	
d. Prevention Assessment Tool (PAT) (pre & post)	☒	☐	☐	☐	☐	A pre PAT was completed in all four files. A post PAT was completed in both closed files.	
SNAP® discharge report summary	☒	☐	☐	☐	☐	Both closed files had a SNAP discharge report summary.	
SNAP® Boys/SNAP® Girls Child Group Evaluation Form	☒	☐	☐	☐	☐	Both closed files had Child Group Evaluation Form.	
SNAP® Boys/SNAP® Girls Parent Group Evaluation Form	☒	☐	☐	☐	☐	Both closed files had Parent Group Evaluation Form.	
SNAP in Schools							

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — Explain any items that have any deficiencies, exceptions or are not applicable. For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)	☒	☐	☐	☐	☐	All 13 weekly attendance sheets were present with youth names and teacher and facilitator signatures.	
"Class Shoot for Your Goal" sheet	☒	☐	☐	☐	☐	"Class Shoot for Your Goal" sheet was completed.	
Pre and Post Evaluations	☒	☐	☐	☐	☐	Pre and post evaluations were present for all youth and the teacher.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	☒	☐	☐	☐	☐	There was one Fidelity Adherence Checklist completed.	
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.01 Shelter Environment that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Facility Inspection	☐	☒	☐	☐	☐	An on-site tour of the facility revealed furnishings were in good repair. The program was free of insect infestation. Grounds were landscaped and maintained. Bathrooms were clean and functional. Lighting was adequate. Exterior areas were free of debris and grounds were free of hazards. Dumpster and garbage cans were covered. Doors are secure with key access required. Egress plans were posted in several locations along with grievance forms, abuse hotline number, and DJJ Incident	**Exception:** Chemical inventories were completed monthly rather than weekly as required.

	Rating						
		Explain					
Quality Improvement Indicators	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**	**Review Based Upon** **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Notes** **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						Reporting numbers. Agency vehicles were locked and equipped with major safety equipment including first aid kit, fire extinguisher, flashlight, glass breaker, seatbelt cutter, and airbag deflater. Interior areas of the facility did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and MSDS were maintained. However, inventories of the chemicals were completed monthly instead of weekly as required. The washers and dryers were operational and clean of lint. Current DCF license is displayed with an effective date of September 28, 2020. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens.	
Fire and Safety Health Hazards	☒	☐	☐	☐	☐	The annual fire inspection was completed on March 12, 2020 and shows the facility in compliance with fire safety codes. The annual fire safety equipment inspection was completed on July 16, 2020 and November 4, 2020 and shows fire safety equipment is valid and up to date. At least one fire drill was completed monthly on each shift since May 2020. Mock emergency drills were completed for the last quarter on each shift. Residential Group Care and Food Service inspection was completed on March 10, 2020. Menus were posted and signed by a licensed dietician on April 13, 2020. Cold food is properly stored, marked, and labeled, and dry storage/pantry areas are clean. Refrigerators/freezers are clean, and temperatures are maintained.	
Youth Engagement							

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
• Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. • At least one hour of physical activity is provided daily. • Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. • Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. • Daily programming schedule is publicly posted and accessible to both staff and youth.	☒	☐	☐	☐	☐	Observed daily schedule posted and observed shelter activities during on-site tour. The daily schedule reveals that youth are engaged in meaningful, structured activities seven days a week. The schedule also provides for at least one hour of physical activity. Youth are given the opportunity to participate in faith-based activities with non-punitive activities offered for those who choose not to participate in those activities. Youth are given the time and opportunity to do homework and read. The program has a library with a variety of books for the youth to read.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.02 Program Orientation that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Youth received a comprehensive orientation and handbook provided within 24 hours	☒	☐	☐	☐	☐	Five closed residential files reviewed, two open and three closed. Orientation checklist was observed in all five files completed on the day of admission.	
Orientation includes the following							

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	☒	☐	☐	☐	☐	Orientation checklist was completed in all five files and covered all required elements.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	☒	☐	☐	☐	☐	Orientation checklist was completed in all five files and signed by the youth and staff.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.03 Room Assignment that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth	☒	☐	☐	☐	☐	Five residential files reviewed, two open and three closed. The Shelter Intake Assessment Form was completed in all five files and documented all required information.	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior							
An alert is immediately 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	☒	☐	☐	☐	☐	Reviewed the Shelter Intake Assessment Forms for the five residential files. Alerts for the youth were documented on the intake forms and the applicable color-coded dots were placed on the file, in all five files.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.04 Log Books that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	☒	☐	☐	☐	☐	Logbook entries were reviewed for the first week of May 2020, the second week of June 2020, the third week of July 2020, the fourth week of August 2020, the first week of September 2020, and the second week of October 2020. The program utilizes the NoteActive electronic log book. Entries that impacted the safety and security of the youth or program were observed highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	☒	☐	☐	☐	☐	All entries were brief and legible, included the date and time of the event, included names of youth and staff involved, provided a brief statement, and included the name and signature of the person making the entry.	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	☒	☐	☐	☐	☐	Errors were observed struck through with a single line and initialed.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	☒	☐	☐	☐	☐	Program director or designee reviewed the logbook every week and made a note stating dates reviewed with any recommendations.	
Supervisors and all staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	☒	☐	☐	☐	☐	Supervisors and all staff reviewed the logbook for at least the previous two shifts and included the dates they reviewed.	
Logbook entries include: • Supervision and resident counts • Visitation and home visits	☒	☐	☐	☐	☐	Entries were observed for counts, visitation, and home visits.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.05 Behavior Management Strategies that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
The program has a detailed written description of the BMS, and it is explained during program orientation	☒	☐	☐	☐	☐	The program has a written description of the behavior management system that is given to the youth at intake. This was confirmed in all five residential files reviewed.	
Behavior Management Strategies must include:							
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior	☒	☐	☐	☐	☐	The youth receive a detailed outline of how to be successful using the behavioral management system. The youth earn incentives by earning positive points throughout the day. Interventions are in place. The youth are promoted to different levels depending on their behaviors. The system also	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges						has a grievance procedure that three different phases put in place to ensure the youth has some autonomy. The system does not allow group discipline and only staff are able discipline youth. Room restriction is not used as part of the system. Youth are never denied any basic rights.	
Program's use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	☒	☐	☐	☐	☐	Training files for four new hires were reviewed and documented the staff are trained on the program's BMS at hire.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	☒	☐	☐	☐	☐	Reviewed policy 3.05 Behavior Management Strategies.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	☒	☐	☐	☐	☐	Training files for four staff were reviewed and on-going training was documented for staff on the use of the BMS system.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain)	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						The agency has a policy in place titled 3.06 Staffing and Youth Supervision that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	☒	☐	☐	☐	☐	There were five random samples of video surveillance reviewed, October 24, 2020 from 12am – 1am, October 30, 2020 2am – 3am, November 3, 2020 4am – 5am, November 8, 2020 11:30pm – 12:30am, and November 12, 2020 2:30am – 3:30am. A review of the above video surveillance sample, staff schedules, and log book entries documented required staffing ratios were met for awake hours and sleeping hours.	
Overnight shifts must always provide a minimum of two staff present	☒	☐	☐	☐	☐	There were five random samples of video surveillance reviewed, October 24, 2020 from 12am – 1am, October 30, 2020 2am – 3am, November 3, 2020 4am – 5am, November 8, 2020 11:30pm – 12:30am, and November 12, 2020 2:30am – 3:30am. The random sample above and log book entries documented two staff were present on these over night shifts.	
The staff schedule is provided to staff or posted in a place visible to staff	☒	☐	☐	☐	☐	During the on-site tour the schedule was observed posted and visible to staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	☒	☐	☐	☐	☐	The program has a blue binder in the Youth Case Specialist's (YCS) office which contains the staff schedule and the overtime rotation roster with home telephone numbers of staff who are available for additional coverage if needed.	

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	☒	☐	☐	☐	☐	There were five random samples of video surveillance reviewed, October 24, 2020 from 12am – 1am, October 30, 2020 2am – 3am, November 3, 2020 4am – 5am, November 8, 2020 11:30pm – 12:30am, and November 12, 2020 2:30am – 3:30am. The random sample reviewed above documented staff observe the youth at least every 15 minutes during the overnight sleeping hours.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.07 Video Surveillance System that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors	☒	☐	☐	☐	☐	Observed cameras and written notices during the on-site tour. Video surveillance system was reviewed on site with program staff. System can capture and retain video images for up to thirty days. A review of random samples of overnight video surveillance revealed system records date, time, and location, and enables facial recognition. Cameras have back-up capabilities in case of power outage. All cameras were visible, and no cameras were located in the bathrooms or sleeping rooms.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible							
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	☒	☐	☐	☐	☐	Reviewed list of designated staff who have access to video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	☐	☒	☐	☐	☐	The supervisory review of video included a random sample of overnight shifts and assessed the activities of the facility.	**Exception:** The reviews of the video were not completed every 14 days as required. The months of May and June had reviews done 3 days apart rather than 14 days apart. Reviews in July were conducted more than 14 days apart, July 3rd and July 29th. August only had one review conducted. September had two reviews that were conducted 3 days apart and then a 3rd review that was conducted 16 days apart. October only had one review conducted.
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	☒	☐	☐	☐	☐	Reviewed policy titled 3.07 Video Surveillance System.	

Standard Four – Mental Health /Health Services

4.01: Healthcare Admission Screening

Provider has a written policy and procedure that meets the requirement for Indicator 4.01	☒ YES ☐ NO (explain) The agency has a policy in place titled 4.01 Healthcare Screening Admission that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	

Preliminary Healthcare Screening

Quality Improvement Indicators	Rating: Satisfactory	Non-compliant	Explain: No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.; and g. Observation for presence of scars, tattoos, or other skin markings	☐	☒	☐	☐	☐	Reviewed five residential youth files, two open and three closed. The health screening section of the CINS/FINS Intake Form was completed in all five files and included all required elements.	**Exception:** Due to the program not having a nurse none of the preliminary healthcare screenings were reviewed by a Registered Nurse (RN).
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	☐	☐	☒	☐	☐	None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	☐	☐	☒	☐	☐	None of the youth required follow-up medical appointments.	
All medical referrals are documented on a daily log.	☒	☐	☐	☐	☐	Any medical referrals are documented in the log book and on the Pass-Down Log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	☒	☐	☐	☐	☐	Reviewed policy 4.01 Healthcare Screening Admission.	
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ YES ☐ NO (explain) The agency has a policy in place titled 4.02 Suicide Prevention that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Suicide Risk Screening and Approval							

Quality Improvement Review
Lutheran Services Florida/Northwest – Currie House – November 18 – 19, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Rating	Explain					
a. Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	☒	☐	☐	☐	☐	Reviewed five residential youth files, two open and three closed. All five files contained a suicide risk screening completed during the initial intake screening process that was signed by a supervisor.	
b. The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	☒	☐	☐	☐	☐	Reviewed the programs Suicide Risk Assessment tool.	
Supervision of Youth with Suicide Risk							
a. Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	☒	☐	☐	☐	☐	Two out of the five youth were placed on sight-and-sound supervision until assessed by a mental health professional. An Assessment of Suicide Risk (ASR) was completed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional.	
b. Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	☒	☐	☐	☐	☐	In both files observation logs documented the youth were monitored at least every thirty minutes while on sight-and-sound supervision.	
c. Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement?	☒	☐	☐	☐	☐	Youth were removed from sight-and-sound supervision after ASR was completed by or reviewed with the licensed professional.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 4.03 Medication that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Medication Storage							

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Oral medications are stored separately from injectable epi-pen and topical medications c. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) d. Narcotics and controlled medications are stored in the Med-Station	☒	☐	☐	☐	☐	An on-site tour of the Pyxis Med-Station was completed with program staff. The Pyxis Med-Station is located in a secure room and is inaccessible to youth. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately from topical medications located in the locked medical cabinet. There is a secure refrigerator in the medical room used only for medical purposes and maintained at 36 degrees F. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens	☐	☒	☐	☐	☐	An on-site tour of the Pyxis Med-Station was completed with program staff. A list of two Super Users was provided, as well as a list of six staff delineated to have access to secured medication. Training documents support all applicable staff were trained in medication distribution. A review of three youth files supported they took medication while in the program. All three files contained a Medication Distribution Log completed as required. Staff verify medication by calling the pharmacy.	**Exception:** The program has not had a Registered Nurse (RN) to oversee the medication process at the program in twelve months. Staff have not received training in the use of epi-pens by an RN due to the program not having an RN.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items for Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse							
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	☒	☐	☐	☐	☐	Medication Distribution Logs reviewed documented controlled substances were inventoried perpetually and shift-to-shift. Over-the-counter (OTC) medication inventories were reviewed and documented. OTC's are inventoried perpetually and weekly. Weekly inventories of sharps were reviewed and found to be accurate. There were no syringes on-site.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	☒	☐	☐	☐	☐	The Shelter Manager completes monthly reviews of medication management via the Knowledge Portal.	
Medication discrepancies are cleared after each shift.	☒	☐	☐	☐	☐	At the time of the review there were no open discrepancies. Staff interviewed knew the procedures for closing out a discrepancy accurately.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ YES ☐ NO (explain) The agency has a policy in place titled 4.04 Medical/Mental Health Alert Process that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	☒	☐	☐	☐	☐	Five residential youth files were reviewed, two open and three closed. The program uses a dot system, with color-coded dots corresponding with the different alerts. All files had the appropriate color-coded dots placed on the file.	

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Non-compliant	Rating: Explain: No Eligible Items for Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	☒	☐	☐	☐	☐	Five residential youth files reviewed, two open and three closed. The staff have access to a variety of documentation including the screening, Plan of Care, and Pass Down Log which include special alerts or conditions that may pertain to the youth.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	☒	☐	☐	☐	☐	Staff are provided instruction on how to appropriately recognize and respond to the need for emergency care upon hire. YCS shadow senior staff, attend meetings and trainings, practice skills, and receive Crisis Prevention and Intervention (CPI) training.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	☒	☐	☐	☐	☐	Program uses a color-coded dot system to identify alerts. Intake and Assessment Forms are maintained in the youth's file and document all alerts and the reasons for the alerts. Then the applicable color-coded dots are placed on the youth's file. Alerts are also documented in the log book and Pass Down Log.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ YES ☐ NO (explain) The agency has a policy in place titled 4.05 Episodic/Emergency Care that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file	☐	☐	☒	☐	☐	There were no youth requiring off-site emergency medical care in the last six months.	

FLORIDA NETWORK of youth and family services

	Rating					Review Based Upon	Notes
		Explain					
Quality Improvement Indicators	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided							
All staff are trained on emergency medical procedures	☒	☐	☐	☐	☐	Eight staff training files reviewed, and all were trained on Emergency Medical Procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	☒	☐	☐	☐	☐	During the on-site tour knife-for-life and wire cutters were observed.	
First aid kit/supplies are fully equipped and inventoried	☒	☐	☐	☐	☐	During the on-site tour first aid kits in the shelter were observed to be fully stocked and inventoried.	