



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge-Central

on 10/08/2014

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory

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

Standard 3: Shelter Care

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

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

Standard 2: Intervention and Case Management

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

Satisfactory Compliance

No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.

Limited Compliance

Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.

Failed Compliance

The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Lilliam Blundell, Counselor II, Lutheran Services Florida Southwest

Keith Carr, Statewide Contract Manager, Forefront LLC



Megan Wiston, Quality Management Specialist, Children's Home Society West Palm Beach

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 2 Case Managers | 1 Maintenance Personnel |
| <input checked="" type="checkbox"/> DJJ Monitor | 3 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|---|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 3 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 19 Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input type="checkbox"/> Precautionary Observation Logs | 10 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 0 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 9 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 7 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- | | | |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 3 Other |
|---------|---------------------|---------|

Observations During Review

- | | | |
|--|---|--|
| <input type="checkbox"/> Admissions | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input type="checkbox"/> Confinement | <input checked="" type="checkbox"/> Program Activities | <input type="checkbox"/> Tool Inventory and Storage |
| <input checked="" type="checkbox"/> Facility and Grounds | <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage |
| <input checked="" type="checkbox"/> First Aid Kit(s) | <input checked="" type="checkbox"/> Searches | <input type="checkbox"/> Transition/Exit Conferences |
| <input type="checkbox"/> Group | <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings |
| <input checked="" type="checkbox"/> Meals | <input type="checkbox"/> Sick Call | <input type="checkbox"/> Use of Mechanical Restraints |
| <input type="checkbox"/> Medical Clinic | <input type="checkbox"/> Social Skill Modeling by Staff | <input type="checkbox"/> Youth Movement and Counts |
| <input type="checkbox"/> Medication Administration | <input checked="" type="checkbox"/> Staff Interactions with Youth | |

Comments

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

Rating Narrative

Strengths and Innovative Approaches

Rating Narrative

Miami Bridge Central Shelter (MB Central) is a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by Miami Bridge Youth and Family Services, Inc. The program has a central office and shelter located in North Miami, Florida, and a south shelter located in Homestead, in southern Miami-Dade County. The program serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also a Staff Secure Shelter and is also a provider for youth referred through the Juvenile Court for domestic violence. MB is designated by the National Safe Place Program as a Safe Place site which collaborates with other safe place sites in the community to provide help and access to run away and homeless youth.

Miami Bridge is currently accredited by the Council of Accreditation (COA) and recently received re-accreditation through August 31, 2017. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. Miami Bridge employs professionally licensed staff for both mental health and medical services. Its licensed Mental Health professionals provide oversight over its counseling services in both the residential and non-residential CINS/FINS programs at both program location in Miami and Homestead. In addition, there is a Licensed Practical Nurse on site to oversee the referral for health care services and medication management of youth in care.

Since the last onsite monitoring visit, MB has received funding through the CRA and Community Development Block Grant to improve the physical structure of the facility in Homestead. The funds will be used primarily for the Homestead Shelter for new hurricane impact windows and doors, repainting of the facility, and renovation of the bathrooms, and improve overall structure of the facility.

Finally, the Book of Leaders, known as Miami's Hall of Fame, recognized Mary Andrews, CEO, and Board Member Boo Zamek for being a part of Miami's Leaders 2014 in its September 29th issue. Each year's book profiles 52 Newsmakers and Achievers and Miami Bridge is honored to be among these prominent leaders.

Standard 1: Management Accountability

Overview

Narrative

MB Central, located at 2810 NW South River Drive, Miami, Florida, is under the leadership of a Board of Directors, Executive Director, Chief Operations Officer, Chief Financial Officer, Chief Quality Improvement Officer, and Chief Clinical Officer. Mary Andrews, Executive Director oversees the Miami Bridge program and the services provided through its two (2) service locations in central Miami and Homestead, Florida. The residential component at each site is managed by Shelter Directors as well as Shift Leaders on each of the three shifts. The clinical component for both locations was recently under the supervision of a Director of Clinical Services but that position became vacant five days prior to the QI Review. In the interim, clinical supervision is the responsibility of the Chief Clinical Officer.

At the time of the quality improvement review, the program reported only one vacancy, as aforementioned, the Director of Clinical Services. The MB Central facility is licensed by the Department of Children and Families for 28 beds, with the current license in effect until May 31, 2015.

The agency handles all personnel functions of its 2 service locations through its Human Resources division located at its central office in Miami, Florida. This office processes all state and local background screenings and human resource functions. Annual training is tracked according to the employee's date of hire.

The program has added the 2014-2015 training requirements to their list of ongoing trainings so they will be prepared to train staff in every required training. Training files are organized and easy to read and maintain. There is a tracking sheet for each training year. It lists every training required and which trainings have been completed. This tracker adds each training hour so it is easy to see total number of trainings completed to date. The provider agency conducts orientation training to all shelter personnel through a combination of training sources that include the Florida Network, local area and in-house trainers.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers prior to any offer of employment or service. The policy requires all staff and volunteers to complete a DJJ Background Screening in accordance with FS 985.407 that includes good moral character documentation, criminal history background screening and electronic submission of Department of Homeland Security E-verify for new employees confirming work eligibility. In addition, the provider conducts a drug screening and conducts a local law enforcement check, a driving history check with the Division of Motor Vehicles, and pre-employment TB test prior to the hiring of all staff.

A total of nineteen (19) applicable personnel files were reviewed for fourteen (14) staff and two (2) volunteers, and three (3) staff eligible for 5-year re-screening. The fourteen (14) staff were hired after the last onsite QI visit and all fourteen received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. Two (2) of the three (3) staff who were eligible for 5-year re-screenings had the re-screening conducted within the required timeframe prior to the staff's five-year anniversary dates.

The program has two (2) volunteers providing service during the review period. Both volunteers received eligible screening results from DJJ prior to their service start dates.

In addition to the DJJ Background Screening, the agency also requires employees to pass a drug screening and conducts local law enforcement check, a driving record history check, and verifies previous employment history, and contacts up to three references. Electronic submissions of Department of Homeland Security E-verify for the 14 new employees were verified, confirming the employees' work eligibility.

Exception:

The Annual Affidavit of Compliance with Good Moral Character Standards was completed on January 3, 2014. Email notifications of the Annual

Affidavit of Compliance with Good Moral Character Standards were sent to the Florida Network and to the DJJ Contract Manager; however, a copy was not sent to DJJ's Background Screening Unit (BSU) as required. Upon notification during the onsite review, the provider submitted its Annual Affidavit of Compliance with Good Moral Character Standards to the DJJ BSU.

The 5-year re-screening for one (1) of the three (3) eligible staff was completed over 12 months prior to the staff's five-year anniversary date, in excess of the required 5-year re-screening timeframe.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy for an abuse free environment. Its policy, 1.02 - Provision of an Abuse Free Environment states that program staff adheres to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. The policy requires that staff is trained to follow this code of conduct and to report all allegations of child abuse to the Florida Abuse Hotline. The policy also states the staff should also adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation.

There are procedures in the policy regarding the documentation of the abuse reporting and chain of command throughout the facility. It also outlines the behavioral expectations for the staff which includes dress code expectations.

In practice, the Employee Handbook has a section for Code of Business Conduct which includes (but is not limited to) dress code, compliance responsibility, cell phone, and fraternization. The handbook includes an acknowledgement of receipt for the employee to sign and the signed copy goes in the employee's file. Proof of the signed receipt was found in an employee file along with a new signed receipt when the manual was updated on 7/1/14.

There is a process for all abuse or neglect reported by clients. The procedure is included in Policy 1.02.

Based on tour of the facility, there are signs posted in the main recreation room and both bedroom areas stating that a child can call the abuse registry and the posters include the abuse hotline number. The posters also include other emergency numbers as well as listing all the rules of the facility.

According to the youth surveys completed with three youths on-site, two youth stated they knew the abuse hotline was available to them to report abuse. Two youths knew where the number was located. None of the surveyed youth stated they had attempted to call the hotline while in the shelter.

Three staff were surveyed and asked to describe how youth are allowed to call the abuse hotline. The three staff described the procedures slightly differently as follows: One staff member stated that if youth ask to make the call, they will allow them to do so at any time. Another staff member stated youth are allowed to call at any time but the staff dials the phone and the youth will report. One staff member stated youth have access to the abuse hotline but the staff would call for the youth and make the report. None of the staff have ever observed a co-worker telling a youth they could not call the abuse hotline.

There are no exceptions documented for this indicator.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy, 1.03, for incident reporting (risk management). Also, under policy 5.05 (Continuous Quality Improvement), there are procedures for internal quality monitoring which include quarterly assessment of all major incidents and grievances reported. The policy clearly states the program needs to notify CCC within 2 hours of the incident or within 2 hours of becoming aware of the incident. An employee needs to complete the incident report before leaving his/her shift.

The policy gives details for the practice of this incident reporting system. The policy also lists details how to approach different runaway youth (community based care, crisis, and court-ordered). It also details riots and major disturbances, threat of actual harm, and assaultive behaviors.

Incident reports are kept in binders in chronological order from most recent incident date. There were 11 incidents in the 6 month reporting

period (4/8/14-10/8/14). All incident reports were located in the DJJ/CCC Incident Report binder. All 11 incidents were reported to CCC within the 2 hour required reporting period. Note that this is an improvement over the last review where there were 2 incidents reported outside the 2 hour window. Also, in the last review, some CCC reportable incidents were located in the non-CCC binder. This did not occur in this current review.

There are no exceptions documented for this indicator.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy, 1.04, for training requirements. Policy 1.04 is the policy for first year of hire training and policy 1.04.01 is the policy for ongoing employee training. The training schedule for first year employees mimics the FL Network training requirements. The program has individual training files for each employee. According to their own policy, the training files are kept separate from the personnel files for the purpose of contract monitoring and quality assurance reviews. The files are organized by training year and include a cover page with tracking sheet of all trainings.

The reviewer looked at 3 first year employees. Two employees had recently completed their first full year of employment. One completed 116 hours of training and the other completed 93 hours of training. The first employee completed all training requirements except four trainings which were added by FL Network on 7/1/14. The second employee did not complete all core training requirements. He was missing Title IV-E Procedures and Fire Safety Equipment. He was also missing six trainings which were added by FL Network on 7/1/14. The third employee was hired less than one year ago. This employee is on target for meeting the training requirement and has completed 59 hours of training to date.

The reviewer looked at 3 in-service employees. Two employees completed all required annual trainings and both completed over 40 hours of training in the year (47.5 hours and 41.5 hours). The third employee only completed 33.5 hours of training during the last year training year. This person also did not complete two of the required annual trainings: Crisis Intervention Skills and Suicide Prevention. The employee has 14 days until his hire date anniversary to complete these trainings and obtain the full 40 hours of training for the year.

Effective 7/1/14, there is a new training requirement for Non-Licensed Mental Health Clinical Staff for Assessment for Suicide Risk. The Chief Clinical Officer has created a binder to track the 20 hours of training completed by each clinical staff employee. One employee is waived from the training. There is written confirmation by the Chief Clinical Officer stating that this individual has received training and is competent to conduct this assessment. For the other staff, the Officer is keeping a log with training and assessment experience for each individual. The reviewer looked at the binder and the tracking system and it appears thorough and sufficient. Each clinical staff member appears to be on track to complete the 20 hours of training within the time frame.

Trainings are scheduled throughout the year. There is availability to complete training online and in person. Some training is completed by on-site staff; some training is completed by local agencies. Also, in the central copy room, there is a large bulletin board with QI and Training notes. It includes a monthly schedule of in-house training opportunities. It also includes a list of all staff members with a note next each one that tells them what trainings are due within the month. It is very organized and easy to read. Online trainings are highlighted in red.

Exceptions:

One first year employee did not complete Title IV-E Procedures and Fire Safety Equipment training within the first year of hire.

One in-service employee did not complete Crisis Intervention Skills and Suicide Prevention trainings during the last training year. This employee also did not complete 40 hours of training required by the program within the year (33.5 hours were completed). This employee has 14 days until his hire date anniversary to complete these trainings and obtain the full 40 hours of training for the year.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy for analyzing and reporting information (Policy 1.05). It clearly states the program collects and reviews several sources of information to identify patterns and trends. It includes all reporting sources listed on the FL Network policy 1.05. All data and reports are presented at Quarterly CQI Committee Meetings and the minutes are typed and filed in a binder by year.

The program completes quarterly record reviews and record review reports. The shelter staff and the First Stop staff switch records and review their peers' records. The reports are thorough and complete and include a purpose, methodology, results, and findings (which include recommendations).

The program reviews incidents, accidents, and grievances on a quarterly basis with a written report which includes data in graph form. Trends and issues are discussed at the quarterly meetings. The report includes factors contributing to the reported incidents.

The client and employee satisfaction surveys were completed and discussed at the 9/18/14 quarterly CQI meeting. The results were compiled and shown in relation to last year's results. The total number of surveys completed was down from the previous year. The summary noted that all questions were answered favorably but there was still room for improvement. There was a recommendation section at the end of the results which stated the program needs to increase the number of total surveys completed, and closing notes on a case should document that a survey was completed by the client before exiting. If a survey was not completed, the reason should be noted. It also encouraged staff to view the full report on the FL Network site.

Outcome data is reviewed quarterly in this program. The reports are separated by Emergency Shelter and First Stop for Families. The outcome measures translate directly to contract measures from the programs' funders. Demographic data on clients served is also included. Both reports contains a CQI summary and plan for improvements.

Netmis data reports are presented at monthly staff meetings. Copies of the reports are included with the meeting minutes in meeting binders. Meeting minutes from the CQI quarterly meetings specifically reflect discussion on Netmis data. The data reports are also emailed to staff monthly.

There are no exceptions documented for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Miami Bridge Youth and Family Services is contracted to provide both shelter and nonresidential services for youth and their families in Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week status offenders that include runaways, truants, ungovernable and lockout youth. The program has an Admission's Director who is responsible for Intake and Admissions. Additionally, trained staff members are available to determine the needs of the family and youth. Residential services include individual youth, family and group services. Case management and substance abuse prevention education are also offered. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance.

At the time of this review, according to agency's Organization Chart and vacant Director of Clinical Services position, the Chief Clinical Officer is responsible for supervision of the Counseling program and staff while the Shelter Director manage the day-to-day operations of the residential program and Direct Care staff. The counselors are responsible for providing case management services and linking youth and families to various community services. The First Stop non-residential program is responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. However, the provider has not initiated case staffing for any youth during the review period and/or since the last onsite QI review.

2.01 Screening and Intake

Satisfactory
 Limited
 Failed

Rating Narrative

Agency policy 2.01 Screening and Intake provides for and reflects indicator 2.01 while including all necessary elements.

Six files were reviewed for 3 residential and 3 non- residential youth. In 6 out of 6 files reviewed, the eligibility screening was completed within 7 calendar days of referral.

Similarly, all 6 files reviewed documented the provision in writing of available service options, rights and responsibilities of youth and parents/guardians, parent/guardian brochure, and the program's grievance procedures.

Exception:

In 3 out of 3 residential files reviewed, there was no documentation reflecting possible actions occurring through involvement with CINS/FINS services. Also, in 3 out of 3 non-residential files reviewed there was no documentation reflecting possible actions occurring through involvement with CINS/FINS services.

2.02 Psychosocial Assessment

Satisfactory
 Limited
 Failed

Rating Narrative

Agency policy 2.02, Psychosocial Assessment, provides for and reflects all the requirements of indicator 2.02. However, the title of the policy was not updated to reflect the revised name "Needs Assessment". The agency's policy further describes in detail the agency's procedure.

In 1 of 3 residential files reviewed the needs assessment was conducted within 72 hours of admission. In 3 of 3 residential files reviewed the needs assessment was completed within 2 to 3 face to face contacts.

In 3 of 3 non-residential files reviewed the needs assessment was completed within 2 to 3 face to face contacts.

In all six files reviewed the needs assessment was completed by Bachelor's or Master's level staff. Similarly, the needs assessment included a review signature by a supervisor in all six files.

None of the six files reviewed were assessed to have an elevated risk of suicide. However, the program has procedures in for the completion of

Assessment of Suicide Risk , appropriate staff supervision of youth in care, and/or for referral to a Baker Act Facility.

In 2 of 3 residential files reviewed the needs assessment was not conducted within 72 hours of admission. Indicator 2.02 Psychosocial Assessment, in the procedure manual, should be changed to Needs Assessment

2.03 Case/Service Plan

Satisfactory

Limited

Failed

Rating Narrative

Agency policy 2.03 Case/Service Plan (Development) provides for and reflects indicator 2.03 while including all necessary elements. The agency policy further describes in detail the agency practice and the expectation that the service plan includes measurable objectives and that the agency responsibility in assisting with the goals is outlined. Agency policy 2.03.01, Case Service Plan (Implementation, Review and Revision), provides for and supports 2.03. This policy describes in detail the agency's protocol for assigning a counselor who is responsible for implementing the service plan at completion of the assessment process. It also states that the service plan is reviewed every 30 days during the first three months and every six months thereafter.

A total of six files were reviewed for three residential and three non-residential youth. In 6 of 6 files reviewed the case plans were developed within 7 days of the needs assessment. In 6 of 6 files reviewed, the goals were individualized and prioritized as identified by the needs assessment. Similarly, the service type, frequency, person(s) responsible, and location were clearly documented in the Case/Service Plans of all 6 files. All 6 files reviewed had target dates for completion. Completion dates were not applicable in 4 of the 6 files as the target dates had not yet been reached and goals were not yet achieved. The youth, parent/guardian, counselor, and supervisor signed the case plans in all 6 files reviewed.

Exception:

Service plan reviews were not evident in all of the files reviewed. In 1 of 3 non-residential files, the 30 day review was completed and documented. In 1 of 3 non-residential files reviewed the 60-day review was not completed/ documented. In 2 of 3 non-residential files reviewed, progress reviews appear to have been done but not documented in the progress notes and did not have the youth and parent signature

One of the non-residential files documented completion dates. In 1 of 3 non-residential files reviewed - there were two target dates past due - no documentation was noted that the goals were actually achieved and/or target date was extended.

2.04 Case Management and Service Delivery

Satisfactory

Limited

Failed

Rating Narrative

Agency policy 2.04, Case Management and Service Delivery, provides for and reflects the requirement of Indicator 2.04. The agency's policy further describes in detail the agency's protocol for meeting this requirement.

Each youth is assigned a counselor/case manager who follows the youth's case and ensures delivery of services through direct supervision or referral. Referral needs are established and coordinated, the service plan implementation is coordinated, youth/family progress is monitored, support is provided for families, out of home placement is monitored if needed, and whenever necessary, referrals to case staffing committee to address the problems/needs of the family, recommending and pursuing judicial intervention is conducted.

A total of six files were reviewed for three residential and three non-residential youth. All six files reviewed had a counselor/case manager assigned to the youth. Five of the six files demonstrated youth were referred for appropriate referrals. In one of the three residential files reviewed there was no need for referrals based on the needs assessment. Service plan implementation was evident in all six files and demonstrated case monitoring to determine progress made in achieving goals. It was also evident in all six files reviewed that family support was provided and noted in progress notes. Additionally, the three residential files documented appropriate monitoring of the youths' out of home placement. Referral to Case Staffing was applicable to only one of the six files reviewed. The referral was made to the case staffing committee meeting scheduled for 10/17/14.

There are no exceptions documented for this indicator.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

Agency policy 2.05, Counseling Services and Family Involvement, provides for and reflects the requirement of Indicator 2.05. The provider's policy requires that non-residential programs provide therapeutic community based services designed to prevent involvement of youth and families in the delinquency and dependency systems. Services are provided in the youth's home, a community location or the local provider's counseling office.

In 3 of 3 residential files reviewed, youth and family receive counseling services in accordance with case service plan. The program provides individual/family counseling as well as multiple group counseling sessions. There are attendance sheets by day and group sessions. The 3 residents reviewed had attended groups more than 5 times in a week. The youths' presenting problems were addressed in the needs assessment and the initial case service plan. There are case notes for counseling services documented in the progress notes and a supervisor signed all clinical notes, needs assessment, and case service plan.

In 3 of 3 non-residential files reviewed the families received counseling services in accordance with the case service plan. As with the Residential youth, the program provides individual/family counseling. The youth's presenting problems were addressed in the needs assessment, initial case/service plan, and case plan reviews. Case notes are maintained and document services provided to the youth.

The agency has monthly clinical staff meetings, morning debriefings 2-3 times a week, and weekly multidisciplinary meetings. Meeting minutes, agendas, handouts, and sign-in sheets are kept in a supervisors log book/binder.

Exception:

In 3 of 3 non-residential files reviewed, there is no evidence of an on-going internal process that ensures clinical reviews of case records and staff performance.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a system in place outlined in their Policy and Procedures Manual explaining the Case Staffing process. Practice could not be evaluated since no case staffing committee meetings have been held during the past year. However, staff is aware of the procedures and requirements and have documented their efforts to communicate with the members of the Case Staffing Committee.

The agency also has a CINS/FINS petition binder with monthly tabs in which communication - via email- with the various committee members is kept. There is documentation dated 10/2/14 stating that all the committees are in place for this year and that a staffing will take place in October. In 1 of 3 non-residential files reviewed, there was a letter sent to parents notifying them of the case staffing meeting to be held on 10/17/14.

There are no exceptions documented for this indicator.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Agency policy 2.07, Youth Records, provides for and reflects indicator 2.07 while including all necessary elements.

Six files were reviewed - 3 residential and 3 non-residential. All of the youth records reviewed were consistently organized and were marked "confidential", and kept in a secure manner. Residential youth records are maintained in a locked file cabinet in the staff office in the shelter and non-residential files are maintained in a locked cabinet in the administrative First Stop building. In addition, all 6 files reviewed were maintained in a neat and orderly manner so that staff can quickly and easily access information.

There are no exceptions documented for this indicator.

Standard 3: Shelter Care

Overview

Rating Narrative

Miami Bridge is licensed by the Department of Children and Families (DCF) for twenty-eight (28) beds and it primarily serves youth from Miami Dade County. The shelter building includes a large day room, girls' and boys' sleeping rooms, dining room, kitchen, laundry, staff offices and a conference room. During the Quality Improvement review, the shelter was found to be in good condition, the furnishings in good repair, and the rooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 bathrooms, one each dorm wing. The bathrooms floors are tiled and the plumbing appeared functional. The sleeping rooms house fourteen (14) youth each. The sleeping room is equipped with bunk beds and each youth has an individual bed, bed coverings and pillows. The windows are frosted to provide privacy for youth. In addition, the youth have access to a recreational games, volley ball court and basketball. This youth shelter is designated by the Florida Network of Youth and Family Services to provide staff secure services.

Staff members in the Residential Program include: a Shelter Director, two Counselors, 11 Youth Activity Workers, a Health Care specialist, and a Food Specialist/Cook. The provider also employs a Maintenance staff who is responsible for facility repairs and maintenance for both the Central and South Miami program facilities. The Direct Care workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the Licensed Practical Nurse or Health Care Specialist who maintains inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administers first aid when needed, and coordinates all offsite appointments to medical providers. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication office, and kitchen. All medications are stored in a locked cabinet in the Health Care Specialist office. Oversight of clinical services is provided by Chief Clinical Officer.

The program has policies and procedures in place for its Shelter Care programming. This writer found that the staff, supervisors, and management team work well together and have a program that emphasizes the practice of its policies and procedures with fidelity. The Shelter Environment, Program Orientation, Youth Room Assignment, Log Books, and Behavior Management Strategies policy and procedure were all well written, as they mirrored the Florida Network's standards and in some instances went beyond. However, the actual practice of the policy and procedure makes the program stand out and provides the youth served with an environment that's conducive to growth.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that outlines procedures to maintain a safe and clean shelter environment. An inspection of the shelter interior areas and exterior perimeter was conducted during this on site program review. The shelter is located in a densely populated urban area of Miami.

The facility is located in a low traffic area near the Miami River and Miami International Airport. The program is situated on a large lot that includes the Emergency Shelter and general administration building in the same building. The property also includes the Non-Residential building and school equipped with two (2) Miami-Dade County instructors and a Teacher's Aid. The agency has record of a Child Caring Agency certificate of license issued by the Florida Department of Children and Families issued on June 1, 2014. In addition, the agency is accredited by the Council on Accreditation (COA) through August 31, 2017.

At the time of this on site review there were a total of eighteen (18) residents. The residents are a combination of CINS/FINS, DCF and Unaccompanied Alien/Minors.

The agency has two (2) dorms specified by gender. Each dorm has fourteen (14) beds that are numbered for classification and bed assignment. The agency has a Disaster Plan (3) on site. Two (2) Disaster Plans were found with different dates that they were last reviewed. All had latest contact numbers for 2014-2015.

The agency has record of recent Fire Safety Inspections that were completed on the fire extinguishers in September 2014 and in effect for 1 year. The annual agency fire inspection was conducted on March 21, 2014 and the agency's Fire Safety Plan was approved on April 10, 2014. A facility Biomedical Waste was conducted and a critical violation is documented as being corrected by the agency for not having a plan to manage biomedical waste. The agency's last Food Service Inspection indicates that there was a violation for not providing a dumpster plug bin to prevent entry/attraction of vermin. Although, the agency's last inspection indicates exceptions, it was given an overall Satisfactory Rating by Department of Health of August 22, 2014.

All living, sleeping and eating areas are clean and orderly. There is an exceptional butterfly garden. The area grounds and exterior are well landscaped and manicured. At the time of this review there were not major building issues or areas in disrepair or out of order.

There are exceptions noted for this indicator.

Agency has one air conditioning vent above the doorway into the girls dorm that has moisture accumulating. The accumulation of moisture develops in to small water drops on the tile file. This could pose a potential slip and fall incident.

An AC vent above the bathroom in the boys' bathroom stalls has a loose screw that causes the vent to hang on one side.

Area rug on boys' side is raised and could contribute to a resident or staff member tripping over the raised edge.

At the time of this on site program review, it was observed that the metal wand detector was not functioning as required. The Shelter Manager identified that the batteries were dead and the wand is now working as required.

The emergency drills are being conducted a minimum of 3 times per shift. However, only 1 drill in the last 6 months is documented as being completed on the overnight work shift.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. At the time of this on site program review, the agency has a total of ten (10) CINS/FINS residents in care at the facility.

A review of six (6) program orientation files indicates that all residents receive a detailed orientation. Of these files, the documentation indicates that all residents receive information on program rules, client rights, the behavior management system, as well as the grievance process. The youth all have signed documents to verify and confirm a review of the aforementioned program areas via a comprehensive Client handbook.

The agency also posts a grievance box, an egress plan, and a daily activities schedule. Orientation information is very clear and comprehensive.

There are no exceptions noted for this indicator.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy that includes all the components that meet the general requirements of the indicator. The reviewer conducted a compliance assessment on a total of five (5) residential client files. All files reviewed contained evidence of the youth receiving general classification and room assignment within 24 hours of being admitted in the youth shelter. All files include evidence of youth's general history, age, gender, history of violence, disabilities, conditions, illnesses, physical size, suicide risk, sexually aggressive, and alerts if applicable. All files are organized and review-friendly for easy identification of specific sections and documents.

The agency's documents the placement of all residents in the Client Room Assignment Section located on page 2 of the CINS/FINS Intake Assessment form. All trained agency direct care staff that conduct intakes evaluate the youth on the aforementioned traits and circumstances (age, gender, height, weight, build, history of assault or aggressive behavior, history of mental health/substance use issues and attitude scale of 1-10) prior to documentation of the placement. The document captures the designated module (A or B) and the actual bed number assignment (1-14).

There is one exception that is noted for this indicator. Of the five (5) client files reviewed, 4 out of five had the correct module and bed assigned as required. The monitor verified that an agency staff person corrected this finding while on site.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive Logbook Policy. The policy is 3.04 and focuses on the agency's procedures for maintaining a professional,

accurate and concise written documentation of major activities, events and incidents. The agency requires all staff to read the professional log at the beginning of shift and document reading the 2 preceding shifts. The agency has a total of six (6) logbooks of recorded entries from April 2014 to present. A review of several logbooks from May 2014 - October 2014 was conducted onsite by the reviewer. In general the reviewer found logbooks to document staff member entries that include evidence of reviewing the logbook in most cases.

The agency's logbook captures all major events including admissions, intakes, incidents, visitors and discharges. There is a high frequency of logbook entries being recorded by the agency. On average the agency completed a 304 page logbook in 28-30 days or less. This results in the agency documenting at a rate of 10-12 pages per day.

Specifically, the agency's policy requires all persons visiting a resident to provide a copy of their personal identification or employee identification. If the visitor is a CBC Case Worker or works with an area local services provider, they must provide a copy of the employee identification. The Logbook also presents evidence of all on site visits and calls for law enforcement officers. The logbook also captures documentation of when medication is distributed to clients, absconds, outings, youth counts, shift change, key control, searches and weather index notification. The Agency staff do not use highlighters. Instead, staff utilizes colored pens to distinguish specific types of entries. All items in red indicate entries that are critical safety and security issues pertinent to residents and staff members. Red entries typically include medication distribution, medical appointments, incidents, facility checks, contraband searches, ALERTS to staff and Administration, DJJ CCC calls and runaway incidents. Green entries include information pertaining to Shift Change, house being turned over to another Shift Leader, House Census, House Status, Court, signing-in and out for duty and lunch, weather conditions, Referrals information, Read logbook and Administration review of logbook. Blue and Black entries include documentation of all visitors, head counts, and general log of shelter activities.

The use of green and red entries in cases of emergency is confusing at times and seems to be used contrary to the agency policy.

A total of nine (9) incidents documented since May 2014-October 2014 found that all incidents were documented as required. In addition, the agency's Shelter Director is generally reviewing the program logbook on a weekly basis as required.

The agency policy 3.04 Logbooks states that "shelter staff has the following responsibilities regarding the Professional Log Book that includes Place day/date at top of each page, indicate the time, and sign each entry". The review found logbooks not documenting day and date at the top of each page as required by agency policy.

Many logbook entries by staff members do not indicate that they have read the last two (2) shifts as required by policy 3.04.

The use of green and red entries in cases of emergency is confusing at times and seems to be used contrary to the agency policy. One case indicates a youth experiencing a medication side effect and subsequently is taken to hospital by EMS is listed in Red per agency policy. Then youth is listed in green on all following House Census counts. This youth absence is then documented in the following House Census counts list you as being out of house at the ER in Red.

Rating Narrative

The agency has a detailed policy 3.06, Behavior Management System (BMS), that describes the agency's current BMS process and practice.

The current policy generally meets the requirements of this indicator. The current policy is designed to set a standardized method and practice with the goal of setting clear rules, defined rewards, as well as consequences for resident behavior during their shelter stay. To this end, the agency operates to change behavior in a positive manner and increase individual accountability.

The current BMS provides clear definition of the rules and expectations for residents. The current BMS includes rewards and consequences and sanctions. These rewards and sanctions are delivered according to behavior that ensures rewards outnumber consequences. The agency's BMS is designed to implement both consequences for violation of program rules and rewards are applied logically and immediately.

The agency also delivers a 3-hour training on BMS, delivered by Dorcas, Chief Clinical Officer. Agency uses the Positive Action Client Point evidence-based system that tracks point accumulation per each shift. The points that can be obtained is 0-3 points for items such as wake up, hygiene, behavior, chores, school, free time, groups, house meeting, dinner clean up, and bedtime. The agency maintains a binder that houses all Client Daily Point Sheet Logs. The Client Daily Point Sheet Log provides a summary point total for each child's behavior. This form is posted on the window to the Youth Activity Worker Officer. The system helps recognize and award positive behavior. It's also a way for the staff to determine who's been in shelter for longer periods of stay. The points also act as a deterrent for the child not to randomly exhibit problem behaviors.

The program focuses on efforts to incorporate positive behavior management strategies into its program related to in-house rules and on outings and field trips (Community Service, Zoo, Dolphins, Marlins, Hurricanes, FIU, Panthers, Rusty Pelican, local art and cultural destinations).

The program also provides opportunity for youth to be exposed to successful adults who come into the program on Tuesdays to interact with youth and provide positive discussions and lessons to the shelter residents.

All staff are trained during their initial training during the orientation process. The agency also provides an in-depth follow up power point training that is delivered by its Clinical Director. The agency also monitors the use of the BMS on its clients by receiving feedback from residents. The agency also monitors the point accumulation by each resident through posting each resident's BMS points on a Client Daily Point Sheet Log.

An interview with three (3) direct care staff members and Clinical Director and Shelter Manager indicates that 3 out of 3 were familiar with the process. A group interview with six (6) residents regarding their knowledge and opinion of the agency's BMS was conducted. All residents interviewed expressed a high degree of familiarity of the BMS and found it to be fair. Residents explained their point accumulation and experiences with gaining and not gaining points. None expressed dissatisfaction with their current experience with the BMS.

No exceptions are noted for this indicator.

3.06 Staffing and Youth Supervision

Satisfactory Limited Failed

Rating Narrative

The agency has a detailed policy 3.06 that includes the major components required to meet the requirements of this indicator. The agency has a detailed schedule that is posted in a conspicuous area. Agency schedule information consistently documents that its staffing meets the minimum number of staff required to meet 1:6 during awake and 1:12 supervision requirements during sleeping hours.

The overnight shift staffing is verified by viewing camera surveillance tapes that revealed staffing compliance for 1:6 and 1:12 staffing numbers, as well as gender compliance. The program also has a staggered or holdover overtime function built into its schedule.

The agency has a sixteen (16) digital camera surveillance system that can produce back up footage for the last 30 days. A random selection of camera views was selected to determine adherence to the compliance requirements of this indicator. The agency documents all youth supervision counts every 15 minutes on each shift. Some bed check counts while youth are sleeping are not consistent on the overnight work shift.

Exception:

A review of surveillance camera recordings of random overnight counts was conducted during the review with the agency's Chief Compliance Officer and the Residential Shelter Director. During the review of the recording, the monitor found that bed check counts were not consistent. Some bed check counts for male staff on the overnight shift are delayed. The monitor did find that in one (1) instance, there was one (1) night in which a resident was experiencing a sleeping issue that interrupted consistent counts for a 30 minute period. However, other counts viewed by the monitor had no such interruption that would prohibit consistent bed check counts of 15 minutes or less. At the time of this program review there is no evidence that agency management conducts random camera surveillance reviews of overnight staff to ensure accountability for 15 minute bed checks. The facility design can impact effective supervision and monitoring of youth during sleeping hours if staff has to tend to an emergency.

3.07 Special Populations

Satisfactory Limited Failed

Rating Narrative

The agency has a detailed policy 3.09 Staff Secure and Special Populations that address the general requirements for this indicator. The agency has a defined process for receiving and addressing primary causal issues related to Domestic Violence Referrals. The agency maintains a binder with copies of all DV cases. The agency has a total of 14 DV client referrals documented between May and October 2014 in the aforementioned binder.

Two out of four (4) Domestic Violence client files did have evidence of a treatment plan that focuses on aggression management and family coping skills or other associated violence reduction strategies. The remaining 2 DV cases were recent referrals that had previously scheduled parent/client treatment plan reviews for signatures.

There are no exceptions documented for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

MB Central has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate Room Module assignment, Module A or Module B, given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2. Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Chief Clinical Officer and Program Manager are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The provider has a Health Care Specialist, who is also a LPN, whose main responsibility is the provision of medical care and medication management in the facility. Medications are stored in a double locked medication cabinet and topical and/or injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

Satisfactory

Limited

Failed

Rating Narrative

The program has a written policy and procedures to ensure medical care for youth who are admitted to the program. The provider's preliminary health screening includes: current medications; allergies; existing medical conditions; evidence of recent injuries or illnesses; presence of pain or signs of physical distress; observation for evidence of illness, injury, physical distress, difficulty moving; and presence of scars, tattoos, or other skin markings. The latter is documented in the provider's CIS system and a copy is printed and placed in the youth's file.

The program has procedures to ensure medical care for youth admitted with chronic medical conditions which includes a referral process and mechanism for follow-up. The program has a Health Care Specialist (HCS), who is a Licensed Practical Nurse (LPN), to oversee all aspects of medical care for youth in the program. The Shelter Director and HCS are responsible for documenting any follow-up care identified for clients. The HCS maintains a medical file for each youth that includes: over-the-counter consent form, prescription consent form, offsite acknowledgement form for treatment, financial responsibility form, Camillus Health Concern form, All Family health forms, and Medicaid/Insurance forms. In addition, all documentation related to medical services received is maintained in the medical file. The agency maintains interagency agreements with Camillus Health for the medical care of youth needing non-emergency care.

Practice was exhibited in the three (3) files reviewed. Of the three files reviewed, the files document that the program performs preliminary physical health screening for each youth at the time of admission to the shelter. A preliminary health screening is documented in each of the files reviewed. None of the three youth were in need of medical care but the provider has a process in place for referring youth admitted with chronic medical conditions.

While none of the three (3) files reviewed required a medical referral, this reviewer did review a case where a non-chronic medical referral was required. The medical referral was documented on the "Emergency Medical Care Log", and a "Client Transported Offsite Due to Emergency Medical Attention" form was completed and appropriately documented in the log book.

No exceptions noted at the time of the visit.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

Agency has written policy and procedure to address suicide prevention and response procedures to promote health, well-being, and safety of youth.

Suicide risk screening is included as part of the initial intake and screening process using the CINS/FINS Intake Assessment Form in accordance with the Florida Network's Policy and Procedure Manual. If a suicide risk is indicated as a result of the screening, the provider has licensed staff, the Chief Clinical Director- LCSW, who is available to conduct an Assessment of Suicide Risk (ASR) or approve assessments completed by non-licensed clinical staff under her direct supervision. The Chief Clinical Director's license expires 3/31/15. The provider's Suicide Risk Response procedures also include provision for the various levels of youth supervision, referral to law enforcement/Baker Act, ongoing evaluation of suicide risk assessments to determine continued risk and/or removal from sight and sound or one to one supervision, documentation, notification of agency officials, outside authority, and parent/guardian, and staff training. Youth awaiting an ASR are placed on constant sight and sound where the YCS monitors the youth one-on-one and documents supervision on the Suicide Precautions-Observation Log at 15 minute intervals. The provider's Observation Log includes: the time of day, behavioral observations, any warning signs observed, and the observer's initials.

A review of three (3) youth files and the corresponding observation logs were reviewed. All 3 youth had a suicide risk screening completed using the CINS/FINS Intake Assessment Form and a suicide risk was indicated. The suicide risk screening was reviewed and signed by the supervisor and documented in the youth's file. An ASR was immediately completed for one youth and the youth was not assessed to be a risk. The other two youth were placed on sight and sound supervision and the supervision level was not changed until the licensed supervisor completed the ASR. It is evident in two of the three files that appropriated referrals are made to local community behavioral and mental health agencies for services needed by these youth.

Exception:

The program maintains a binder of observation logs in chronological order. The observation logs were completed at 15 minute intervals for the two applicable youth. However, for one youth, the shift supervisor of the 3-11 p.m. shift on 8/19/14 did not sign the observation log on page one as required; however, there was a signature on page 2. Also, on the 7am-3pm shift on 8/20/14 as well as 8/21/14, there were no shift supervisor signatures on page 2 of the observation logs.

On 6/13/14, the sight and sound observation for the second youth appears to have started over an hour later (6:30 p.m.) than the time the suicide risk was identified at 4:45 p.m. It was also observed that the last observation recorded was at 10:30 a.m. on 6/16/14, prior to the completion of the ASR which indicated removal from sight and sound at 11:00 a.m.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

The program has a policy and procedure for Medications that address the safe and secure storage, access, inventory, disposal, and administration/distribution of medication in accordance with the DJJ QI indicator and are conducted as follows:

1. All medications are stored in the Intake Office in a separate, secure (locked) area that is inaccessible to youth (when unaccompanied by authorized staff);
2. Oral medications are not stored with injectable or topical medications. There is a separate drawer for the storage of injectable or topical medication. There was no injectable medication on site at the time of the visit;
3. Medications that require refrigeration are stored in a secured, locked refrigerator inside the Nurse's office that is used for medication only. The room is secure and inaccessible to youth;
4. Narcotics and controlled medications are stored behind three locks- in a locked room, behind a locked cabinet, in a locked metal box;
5. Only designated staff delineated in writing have access to secured medications, with limited access to controlled substances (narcotics). A listing of the approved staff is posted in the Nurse's office. All staff on the list were verified as receiving medication training;
6. For controlled substances, a perpetual inventory with running balances is maintained on the youth's MDR, and daily shift-to-shift inventory counts are conducted by YCS as well as daily counts by the Nurse. All counts are documented;
7. Over the counter medications that are accessed regularly are inventoried daily by the Nurse and a perpetual inventory is maintained;
8. Sharps (razors) are secured in a locked cabinet in the Intake office and counted and documented weekly. There were no syringes in the

facility at the time of the visit. There is a container for biohazard sharps as well as a biohazard waste basket located in the Nurse's office. The facility has a Bio-medical waste permit effective through 9/30/15 that approves their collection of biohazard waste. An agreement is established with Steri Cycle to pick up biohazard waste for disposal as needed.

Three youth medication records were reviewed. The three records contained: the youth's names; date of birth; allergies; medication side effects and/or precautions; picture of youth; staff initials and youth initials for medication record; full printed name and signature of youth receiving medication; and full printed name, signature, and title of staff members who distributes medication.

No exceptions noted at the time of the visit.

4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

Rating Narrative

Agency has a written policy and procedure to ensure that information concerning a youth's medical condition, physical activity restrictions, mental health, Alert, Emergency Mental Health and Substance Abuse Services that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, food and medication contraindication, and other pertinent treatment information is effectively communicated to all staff through the alert system. The alert system is a color coded system that is communicated to staff through the program logbook, the alert board located in the Intake Office, and documented in the youth's individual case file. The Client Alert System identified medical, substance abuse, victimization, nutritional and mental health issues and the color codes are as follows: Red=Medical; Blue= Substance Abuse; Green= Victimization; Yellow= Nutrition; and Orange= Mental Health.

The program has established interagency agreements with Camillus Health Concern, Here's Help, Miami Behavioral Health Center, New Horizons Community Mental Health Center, Narcotics Anonymous, Psych Solutions Inc., The Village South, and the University of Miami to assist with the provision of medical, mental health, and substance abuse services as needed.

Medical, nutritional, substance and mental health alerts are identified on the Census board kept in the intake officer. Each file reviewed contained a Youth Alert System Form which identifies applicable alerts.

One of the three youth files reviewed had 3 alerts identified for medication, substance abuse, and mental health. Only two of the alerts codes were documented by way of a red and blue dot (medical and substance abuse) on the alert form in the file. Similarly, the alert board in the Intake office did not reflect the mental health alert.

Agency Policy and Procedure states that the alert will be documented on the inside label of the front of the client's case file; however, this is not evident in the three files reviewed. Alerts and coded colored dots are documented on the alert form in the files.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The agency has policy and procedures to address episodic/emergency care. The program's written procedures address the provision of emergency medical and dental services through Memoranda of Understanding with various off-site emergency services sites. Protocol ensures that proper parental notification is provided and noted on the program's "Client Transported Offsite Due to Emergency Medical Attention" form. Upon return to the facility, the provider documents the Hospital/Doctor's recommendations and the entire incident is critiqued by the program supervisor. The provider is also aware of the requirements to contact CCC should there be any reportable incidents. An Emergency Medical Care Log is maintained to log all medical client offsite transportation.

A review of three applicable youth files demonstrated the provider's adherence with its policy and procedures. The provider noted the medical services on its "Client Transported Offsite Due to Emergency Medical Attention" form for the three youth and notified each parent. Similarly, the Emergency Medical Care Log documented the date of transportation, names of the youth, nature of illness, and name of medical care provider for each youth. A record of the incident was also noted in the program's logbook.

Staff are trained in CPR and First Aid and were up-to-date on the training. The program has a knife-to-life and wire cutters in the Intake Office, school, and Nurse's office. First aid kit and supplies are located in seven locations: Intake office, one in each of two vans, school location, First Stop office, the kitchen, and nurse's office. First aid kits are checked weekly by the Nurse who maintains the weekly records in a binder.

No exceptions noted at the time of the visit.