



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge-Central

on 03/22/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/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 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

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

Rating Definitions

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

Satisfactory Compliance	Non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Review Team

Members

- Marcia Tavares, Lead Reviewer, Consultant-Forefront LLC**
- Joan Jordan, Clinical Supervisor, Children's Home Society West Palm Beach**
- Ben Kemmer, Co-CEO, Florida Keys Children Shelter**
- Gabriel Medina, Regional Monitor, Department of Juvenile Justice**
- Felicia Wells, Program Director, Youth Advocate Programs**

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Fire Drill Log | 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 type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Table of Organization | 16 # Personnel Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 6 # Training Records |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 1 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | 5 # Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 0 # Other |

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

- | | | |
|--|--|--|
| <input type="checkbox"/> Intake | <input checked="" type="checkbox"/> Posting of Abuse Hotline | <input checked="" type="checkbox"/> Staff Supervision of Youth |
| <input checked="" type="checkbox"/> Program Activities | <input checked="" type="checkbox"/> Tool Inventory and Storage | <input checked="" type="checkbox"/> Facility and Grounds |
| <input checked="" type="checkbox"/> Recreation | <input checked="" type="checkbox"/> Toxic Item Inventory and Storage | <input checked="" type="checkbox"/> First Aid Kit(s) |
| <input type="checkbox"/> Searches | <input type="checkbox"/> Discharge | <input checked="" type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <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 Youth and Family Services, Inc. contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in two locations, Miami Bridge Central Shelter (MB Central) located in North Miami and a south shelter located in Homestead, Florida. Through this funding, the agency serves both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to youth who meet the criteria for Staff Secure Shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence and probation respite. MB is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to runaway and homeless youth.

Miami Bridge is currently accredited by the Council of Accreditation (COA) and has maintained 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 at both locations. In addition, there is a Registered Nurse who works at both facilities to oversee the referral for health care services and medication management of youth in care.

During the onsite visit, the CEO reported several accomplishments the agency has achieved since the last onsite QI Review in October 2015 as follows:

- Effective July 20, 2016, the agency implemented an Electronic Medical Record (EMR) system utilizing Lauris, an online automated system, to optimize the organization's service delivery and information management processes. This system gives the agency the ability to automate workflow and manage all aspects of services. The goal is to become a paperless agency by July 1, 2017.
- The Central shelter now boasts a new pavement that covers the entire perimeter of the shelter, creating an appealing walkway that encourages youth and staff to walk on the grounds. Funding is provided by CINS/FINS Maintenance and Update account.
- Grant funding from Galleria Farms allow the agency to offer music therapy to youth using iPods as well as professional music lessons by Evolution Karaoke and Motivational Edge.
- A computer lab of 6 computers, desks, and chairs was donated and installed by Braman Foundation and One World Properties. Youth has access to technology to assist with homework, research, and other internet related activities.
- Twenty-eight new metal beds, mattresses and new bedding was donated by Braman Foundation to replace the former wooden beds.
- The agency purchased a Zapper for each campus, which allows staff to 'zap' and destroy bedbugs by placing all of the child's belongings in a heated box and 'baking' them. Youth are provided scrubs so even the clothes they wear into the shelter can be placed into the zapper as well.
- The agency upgraded its camera system to include increase storage capacity and improved video quality; upgrade was partially funded by CINS/FINS Maintenance and Update account.
- A full alarm system was added, funded by Miami-Dade County CDBG.
- Miami Bridge elected a new Board President in 2016.

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, Chief Executive Director, Deputy CEO/ Chief Financial Officer, Chief Operations/Technology Officer, Chief Administrative/Compliance Officer, Director of Shelter Services, two Clinical Directors, Director of Human Resources, and a Director of Admissions. The Chief Executive Director oversees the Miami Bridge agency and the services provided in Central Miami and Homestead, Florida. The residential component is managed by the Director of Shelter Services who supervises the Shelter Supervisor for the Central shelter as well as seven Shift Leaders. The clinical component for each location is under the supervision of two Clinical Directors, one for each site.

MB Central office handles all fiscal, administrative, and personnel functions for both locations. This site is the location of the offices for all the Administrators; however, the CEO also has an office at the Homestead location and a few other staff positions operate agency-wide requiring these staff to visit the Homestead program regularly. The HR office processes all state and local background screenings and human resource functions. Annual training is tracked according to the employee's date of hire.

At the time of the quality improvement review, the program reported two vacancies for an on-call Youth Activity Worker and a full-time Receptionist. 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, 2017.

An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates. 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. Each employee has a separate training file that contains a training attendance form and corroborating documentation for training received.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

Miami Bridge has a policy and procedures, 1.01, in place that address the background screening of all employees, volunteers, and interns prior to any offer of employment or volunteer service. The policy was last revised on 9/30/16.

The agency requires all staff and volunteers to complete a DJJ Background Screening (DJJ BSU) 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. Prior to completing a Live Scan, Human Resources will check the clearinghouse database to see if the applicant has a current background screening on file. If the prospective employee's record is not found, the agency will proceed with the submission of a Live Scan. Upon receipt of an eligible screening result, the agency will formally make an offer of employment. 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. All employees are re-screened every 5 years from the initial date of hire.

A total of twenty-five (25) applicable personnel files were reviewed for seventeen (17) new staff, seven (7) staff eligible for 5-year re-screening, and one (1) Intern. The seventeen new staff were hired after the last onsite QI visit and all seventeen files maintained evidence of eligible screening results prior to hire.

Seven (7) staff were eligible for their 5-year re-screenings; all seven had the re-screenings conducted within the required time frame prior to the staff's five-year anniversary dates.

The program has one Intern providing service during the review period. An eligible screening result was received from DJJ background screening for the Intern prior to the volunteer service start date.

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 seventeen new employees were verified, confirming the employees' work eligibility.

Since the last onsite QI visit, the agency submitted two Annual Affidavits of Compliance with Level 2 Screening Standards via email to DJJ BSU on 1/6/16 and 1/9/17 prior to the January 31st deadline.

No exceptions are noted for this indicator as of the date of the QI visit.

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has policies, # 1.02-Provision of an Abuse Free Environment and 1.02.01 Grievance Process, and procedure that addresses the components of this indicator. The policies were last revised on 9/30/16.

The agency requires staff to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. Miami Bridge's Employee Handbook includes information about the required code of conduct in two sections: 1) Code of Business Conduct, and 2) Anti-Harassment. The two sections combined clearly communicates the agency's behavioral expectations of staff conduct that prohibits use of any kind of abuse (verbal, sexual, or physical), threats, intimidation, and use of profanity. The handbook includes an acknowledgement of receipt for the employee to sign and the signed copy goes in the employee's file.

The policy also requires staff training on Child Abuse reporting to the Florida Abuse Hotline. There are comprehensive procedures regarding the reporting of abuse as well as information about signs of abuse/neglect, licensure requirements, and code of conduct which includes dress code expectations. The program requires that calls made to the Abuse Hotline be documented in the program logbook for residential clients.

The program has a current grievance procedure that is utilized by youth to file a complaint. The procedure is reviewed with youth during intake. A copy of the grievance procedures is included in the resident handbook and the program has two grievance boxes for depositing grievances. Per the program's procedures, youth are instructed to put their grievance in the box.

A random sampling of 3 personnel files verified acknowledgement of receipt of the Miami Bridge's Employee Handbook which includes information about the required code of conduct.

Signs are posted in the main recreation room, intake office, and both dorm room areas that include the abuse registry hotline number on large posters. The posters also include other emergency numbers as well as a listing of program rules. A total of 12 Abuse Registry calls were made since the last onsite visit and 9 were accepted. The program documents the calls on Abuse Registry Log Sheets that are maintained in a binder. Surveys were completed with three youth on-site during the QI visit. Two of the three youth were knowledgeable about the abuse hotline and knew the location of the number. None of the youths surveyed stated they had attempted to call the hotline while in the shelter.

During the tour of the facility, the grievance boxes and forms were observed to be mounted on a wall adjacent to the common area, at the entry to the girl's dorm, and in the lobby. Five grievance reports for the current fiscal year were reviewed; three of the five grievances were resolved successfully. Three of the grievances were related to staff's verbal tone/behavior toward youth and two were client related. One of the three staff related grievances resulted in a disciplinary action and the youth left prior to resolution of

the other two grievances. All three youth surveyed were familiar with the grievance process.

Per the HR Director, the agency took disciplinary actions and terminated one staff for disruptive behavior and inappropriate physical aggression toward youth and another staff who was aware of the incident was written up for not informing their supervisor.

Exceptions:

A review of the logbook found 2 of the 6 calls made to the Abuse Hotline for shelter youth were not documented in the logbook as required by the program's policy and procedure.

The follow-up section to be completed by the client's assigned Counselor was blank in 4 of the 12 abuse reports.

One of three youth surveyed indicated no knowledge of the abuse hotline or location of the number in the facility.

The provider's grievance policy and procedure states staff will advise youth that it may take longer to deal with grievances placed in the grievance box. However, as required by the indicator, it does not clearly state that direct care workers will not handle complaint/grievance document.

Three of the five grievance reports reviewed were not signed by the youth submitting the grievance and/or staff involved on 9/23/16, 10/24/16, and 1/2/17. In addition, two youth and one staff did not sign acceptance of the resolution on 3 grievance reports (two on 10/1/16 and 1/2/17).

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all the key elements of the CQI indicator. The policy manual was last updated 9/30/16 and was signed by the Chief Executive Officer and Chief Administrative and Compliance Officer.

The provider's policy requires that whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two (2) hours of the incident, or within two (2) hours of becoming aware of the incident.

Provider's procedure requires staff to comply with DJJ, CBC Agencies, Florida Administrative Code and Florida Network Risk Management requirements. The Clinical and Shelter Directors are responsible for compliance with this policy. Incident report time frames will be strictly adhered to ensure compliance with DJJ, CBC Agencies and Florida Network standards.

Provider's procedures also state that the program will maintain separate confidential files of all incident reports, electronically and hard copies. The provider also provides procedure/practice for the following situations:

1. General Information
2. DJJ Incident Reports
3. Community Based Care Incident Reports
4. Riots, Major Disturbances and Hostage Taking Incidents
5. Runaway/Lost Youth: "Crisis" Youth Reporting Procedure
6. Court Ordered/Civil Citation "Crisis" Runaway Youth
7. Threat of Actual Harm or Violence

8. Assaultive Behavior

For the past six (6) months there were a total of eight (8) DJJ CCC Incidents reported of the following types: four (4) abscond; one (1) youth injury resulting from youth on youth altercation; one (1) contraband/medical; one (1) youth injury; and one (1) traffic accident. All but one incident was reported within the two-hour time frame and documented with follow-up communications tasks/special instructions as required by the CCC. All incidents were documented on incident reporting forms and all incident reports were reviewed and signed by program supervisors/directors.

Exception:

One (1) of the eight (8) incidents reported was not reported within 2 hours. The incident was documented on 11/9/16; however, the Shelter Supervisor reported it to CCC on 12/10/16. The time documented in the log book was inconsistent with the time on the report. An Incident Report form was completed on 11/29/16 with the date of the incident, incident time 7:15 pm, report time 9:26 pm; however, log book states at 2020 client reported the incident to staff.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure (1.04) that addresses all of the key elements of this indicator. The policy was last updated 9/30/16.

Direct care staff in residential programs licensed by DCF is required to have 40 hours of training per year after the first year. All direct care staff at Miami Bridge (full-time, part-time, and on-call) shall have a minimum of 80 hours of training for the first full year of employment and 40 hours of training each year after the first year. Required Training meets the standard of the Florida Network.

The Quality Improvement coordinator and Shelter Directors are responsible for ensuring that new staff orientations are completed and documented in the employees' or volunteers' training file. Other supervisors are responsible for ensuring that all their direct reporting staff training needs are met, including orientation. New staff members are required to sign the orientation and training form once they have completed orientation/training.

The provider has a comprehensive list of training topics that is offered throughout the year. Records are kept of all applicable training for each employee in order to monitor their compliance with the minimum of 80 hours of training during the first year of employment. Training records are maintained by the Quality Improvement Coordinator.

The Provider's Annual Training and Development Plan and Process for 2016 - 2017 states Orientation Training staff are required to complete this orientation training within 2 - 4 weeks depending on the department and workforce needs at the time.

The program has individual training files for each employee that are kept separate from the personnel files for the purpose of making them accessible for updating and monitoring. The files are organized by training year and include a cover page with a training log documenting all of the training completed. The supporting documentation for training completed is kept in the file.

A total of 6 files were reviewed for this indicator. Two (2) files were under their one (1) year anniversary (dates of hire (DOH) 11/1/16 and 7/5/16), one (1) file was at its one (1) year anniversary (DOH 3/21/16), and three (3) files were for in-service staff (DOH 4/24/15, 2/12/97 and 1/29/12). One file did not have a completion date on the training log sheet nor on the "New Hire Orientation Training Clinical and Program Staff".

All three first year staff were on target or had completed the 80 hours of training required. Completion of mandatory training topics during the first 120 days is applicable to two of the three first year staff who were hired after July 1, 2016. During the first 120 days of employment the following trainings were

completed by the 2 applicable staff:

- One of two (2) staff completed Managing Aggressive Behavior
- Two (2) staff completed Suicide Prevention
- Two (2) staff completed CINS/FINS Core Training
- One of two (2) staff completed Signs and Symptoms of Mental Health and Substance Abuse
- Two (2) staff completed Behavior Management
- One of two (2) staff completed CPR & First Aid
- Two (2) staff completed Child Abuse Reporting
- Two (2) staff has time remaining to complete additional training required in the first year.

The three in-service training files reviewed demonstrated evidence of on-going training. All three staff had current valid CPR/First Aid certification in their files. As of the date of the review, all three had completed the mandatory Fire Safety, PREA, and MAB and 2 of three completed Suicide Prevention; one still has time to complete the Suicide Prevention training prior to the 4/24/17 anniversary. Two of the 3 in-service staff had completed or was on target for completing the 40 hours of training required.

The provider did not have any applicable first year non-licensed clinical shelter staff during the QI review.

Exceptions:

All three first year staff completed Program Orientation; however, the Provider's Annual Training Plan and New Hire Orientation states the Program Orientation should be completed within four (4) weeks and none of the 3 files showed orientation was completed during this time.

As required, during the first 120 days, none of 2 applicable new staff completed the required Understanding Youth/Adolescent Development training and one of two staff did not receive Managing Aggressive Behavior, CPR & First Aid, and Signs and Symptoms of Mental Health and Substance Abuse. Although beyond the first 120 days, both staff still have time to complete trainings not yet completed before the end of their first year.

One staff who just completed the first year had not received LGBTQ Youth training as required.

One (1) in-service employee with an anniversary date of 2/12/17 had only completed 33 of the required 40 hours of training.

Understanding Youth/Adolescent Development is not a listed training in the Provider's Policy and Procedures, Annual Training Plan, New Hire Orientation or Training Log.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedures, # 1.05, that was last revised/reviewed on 9/30/16. Policy 1.05 describes the process for the collection and review of several sources of information to identify patterns and trends for analyzing and reporting information.

The agency has a PQI plan for FY 2016-2017 that describes the structure and protocols involved in the monitoring, evaluation, and improvement of its processes and outcomes. To support PQI processes, the organization will analyze data in relation to:

- Consumers (Client Outcomes, Demographics),
- Program/services (Outcomes, Medication and Behavior Management, Service Delivery),
- Performance (Client and Employee Satisfaction),
- Risk management (Incident Reports, walk-throughs),
- Financial management, integrity viability

The agency has a CQI Steering Committee that meets regularly. Sub-committee membership includes staff of various levels from both the Central and Homestead location. A copy of the updated committee membership list for 2017 was reviewed.

The Case File Record Review is conducted quarterly to analyze and evaluate clarity, content and continuity of open/closed records and to determine if youth's needs and strengths are being assessed appropriately. The MIS Manager produces a random list of youth from each program to be reviewed. This list will represent no less than 40% of youth each quarter in each of the programs. Assignments are given to each community and shelter-based counselor and Shelter Director who act as peer reviewers for case file records. For credibility of the process, the Peer Reviewers will review only those cases with which they have not been directly involved or for which there is no conflict of interest. All records reviewed will be subject to the Confidentiality Policy of Miami Bridge Youth and Family Services, Florida Department of Juvenile Justice and the Florida Department of Children and Families.

The Risk Prevention Review is conducted via periodic management meetings to assess areas that pertain to Miami Bridge's administration. The Risk Prevention Review consists of representatives from human resources, performance quality improvement and Shelter Directors who will review processes and specific documents to identify patterns/trends in need of attention. Recommendations and suggestions will be discussed and documented in the PQI report and submitted quarterly.

The following is included in the information gathered via the formal CQI risk management process:

Flammables Control- The agency operates in an area that risk must be contained to a minimum for clients, staff and the physical plant. The agency has an active no smoking policy that is adhered to via its staff policy and client information brochure. All chemicals and potential flammables are strictly controlled via an inventory of acceptable items and ensuring that all flammables are accounted for daily. An active review is conducted each year to make that we are in compliance of storage, retention and information such as the active use of MSDS sheets and pro-active policy that ensures the health and safety of all parties.

Client Intakes/Exits- Admissions Director retrieves aggregate data monthly from NETMIS and CIS programs. This data is circulated to all management team members and is reviewed by the committee members and included in minutes as produced from CQI committee meetings.

Incident/Accident Reports- Incident reports from all Miami Bridge programs will be reviewed daily by the Shelter Director and collected and tabulated weekly regarding the total number of incidents, number of incidents reported to Department of Children and Families (DCF) and DJJ Central Communications Center, number of incidents per program and actions taken and developing patterns/trends.

Medical and Medication- Medication errors are examined and focus is on the client, medication, type of error and developing patterns/trends. Medication errors are evaluated and the client, medication, and type of error are reviewed. Miami Bridge employs Healthcare Specialists at both shelter locations and reviews of administrative practices and procedures are conducted weekly.

Manual Restraints- A report of manual restraints (MAB) conducted and follows up with the client and staff during the quarter is provided by the Shelter Directors using a MAB Debriefing Report. This information is compiled and discussed during the CQI committee meetings as part of the incident reporting process.

Client Grievances- Client grievances are submitted according to Miami Bridge policy. The Shelter Directors and others in authority are required to submit all grievance documentation to the CQI Department after grievances are resolved; these are documented and reported on accordingly.

Client Satisfaction- At each discharge the parent and/or guardian and youth are given a survey to complete anonymously and place in the MIS Manager's mail box. The survey addresses satisfaction with services, safety, respectful treatment, unmet needs and recommendations for improvement. The MIS Manager and CQI Coordinator compile data and develop an annual report for the management team and the BODs.

Employee Satisfaction Survey- Annually, the HR Director distributes an Employee Satisfaction Survey to all staff to identify areas of satisfaction and areas in need of improvement. Components of the survey include: mission and purpose, quality of services, compensation, and respect for employees, staff satisfaction, and communication, opportunities for growth, workplace resources, personal expression and diversity. This data is collected and shared with all staff. Program Directors address areas of needed improvement with individual programs and develop an action plan. This process is included for discussion at management team meetings, CQI meetings and staff meetings and reported at BOD meetings. 4 Client User Satisfaction Survey: these are conducted when each client leaves the shelter or when they stop using the FSFF community based services. A thorough survey about the overall service rating is entered into the NETMIS system.

Client outcomes are assessed using specific measures to evaluate their success in the program. Outcome measure forms are completed by the counselor and are submitted for data entry into a tracking spreadsheet. These are tallied, analyzed and reported on at the CQI meetings, to our stakeholders and funders as part of the agency outcome measure goals, primarily for grants.

The provider has a MIS staff who is responsible for data entry and reviews of NetMIS data. NetMIS data reports are addressed at each CQI work group/committee meeting and documented on the agenda and meeting minutes.

The last three quarterly CQI Committee meeting agendas and minutes were reviewed for meetings held in August and October 2016, and February 2017. A sign-in sheet agenda and minutes is maintained for each meeting. Agenda items include: incident reports, risk prevention, training update, health care and medication management, client satisfaction surveys, review of NetMIS report analysis, and case record review report.

The provider conducts monthly and quarterly peer record reviews. Case record reviews for Q1 and Q2, FY 2016-2017, were reviewed. Each report documents the committee members involved, methodology, results for each program, findings, and a tabulated summary. Case record reviews include cases from both Miami Bridge locations.

The Risk Prevention Subcommittee reviews incidents, accidents, and grievances on a monthly basis with a written report which includes data in tables and graph form. The meeting agenda includes a review of: incidents, grievances, medication, health and safety, flammable control, technology, surveys results when they are completed during the period. Trends and issues are discussed at the quarterly meetings. Each meeting is accompanied by a sign-in sheet and minutes. A review of meetings held for the past 6 months was conducted and were found to be held regularly.

During the October 1, 2015 meeting, the QI Manager reported on incidents at the Central and Homestead locations during FY 2014-2015. The provider tracks the types of incidents and monitor trends, reporting an increase by 163 in critical incidents from the past FY but a decrease in grievances.

Outcome data is reviewed quarterly. The reports are separated by Emergency Shelter and First Stop for Families (FSFF). The outcome measures translate directly to contract measures from the program's funders. Demographic data on clients served is also included. Program outcomes for FSFF, Emergency Shelter, and CINS/FINS Contract were discussed at the CQI meetings held and reviewed.

The client and employee satisfaction surveys are completed bi-annually and discussed at the quarterly CQI meeting. The results are compiled and shown in relation to the last results. The most recent satisfaction survey was completed for the current FY2016-January 2017.

NetMIS data reports are presented at the CQI quarterly meetings. Meeting minutes from the last CQI quarterly meetings specifically reflect discussion on NetMIS data.

No exception to this indicator as of the date of this QI review.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all the key elements of the CQI indicator. The policy manual was last updated on 9/30/16 and signed by the Chief Executive Officer and Chief Administrative and Compliance Officer.

The provider's transportation policy is intended 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. The best practice to prevent such situations is to have a 3rd party present in the vehicle while transporting a client. In the event that a 3rd party cannot be obtained for transport, the clients' history, evaluation, and recent behavior is considered. The agency approved driver's work performance and history indicates no inappropriate behavior is likely to occur. If driver is transporting a single client of any gender in a vehicle, staff is required to obtain a program supervisor's approval (prior to the transportation) and consent is documented accordingly.

Three (3) Daily Van Accountability Logs were reviewed along with the corresponding log book date and time. The Van Accountability Logs include: name of driver, number of passengers, date and time, mileage, purpose of travel, and location. The HR Director provided the Reviewer with a list of staff who are approved as having a valid driver's license and are covered under the company insurance policy.

On 1/13/17, the Daily Van Accountability log was completed excluding the number of passengers for the commute from bowling to the shelter. The log book documented the youth's exit for bowling; however, there was no documentation of the return.

On 3/6/17, a new Daily Van Accountability log was completed. The driver signed for the vehicle; however, there was no trip purpose documented, number of passengers or last 4 numbers of cell phone number. At 10:40 staff signed out vehicle for client home; however, there is no number of passengers yet the log book documents two (2) staff transported youth, the log book also has staff return. The date of this event took place 3/6/17 but the log book documented 5/6/17. The log book was reviewed by the shelter supervisor after these entries on 3/6/17.

Exception:

The Daily Van Accountability log was completed on 2/11/17. It was noted there was a one (1) staff to one (1) client ratio. The log book had no documentation of the client leaving or returning to facility. Also, there was no documentation that supervisor's approval was given prior to the 1:1 transport that took place.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all the key elements of the CQI indicator. The policy manual was last updated on 9/30/16 and was signed by the Chief Executive Officer and Chief Administrative and Compliance Officer.

The agency policy states the program builds strong community partnerships and collaborations to ensure

youth and families receive medical, educational, therapeutic, and other supports that are identified in the service plan. The program maintains written agreements with community partners that include services provided and the referral process.

The provider participates in local DJJ board and council meetings to ensure CINS/FINS services are represented in a coordinated approach. The provider will also maintain and provide minutes to DJJ Board and Council meetings and provide verification of attendance at these Circuit 11 meetings; also provides support and accommodation for representative to participate in assigned meetings.

The Outreach Coordinator and Directors will actively recruit collaborative partners for inter-agency agreements based on currently identified needs. These needs will be established by agency or community based needs assessments.

Outreach services are delivered throughout the defined service area (Miami-Dade County). The target audience includes those youth most likely to become delinquent as identified by research.

Miami Bridge has an outreach plan in place that includes targeting identified high crime zip codes and low performing schools. The CEO, Management, and other agency staff participate in large community events to provide information about its programs and services. During the review period, the agency participated in numerous community events to advocate for the effective use of CINS/FINS services and ensure that community partners are aware of Miami Bridge scheduled events.

The agency has three (3) binders for this indicator: Outreach, 11th Judicial Circuit Advisory Board Meeting, and Current MOU Agreements.

11th Judicial Circuit Advisory Board Meeting contains minutes for the past 12 months of meetings, agendas and presentation information.

Current MOUs includes 32 MOUs with various agencies to meet the needs of their clients. There are ten (10) MOUs documented as pending. Outreach Binder documents twenty (20) outreach events within the last six (6) months.

No exception to this indicator as of the date of this QI review.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Miami Bridge Youth and Family Services is contracted to provide both shelter and non-residential 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 for youth who meet the criteria for CINS/FINS, Staff Secure, DV and Probation Respite, and DMST. 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 and family counseling, 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.

The clinical component of the program is under the supervision of a licensed Clinical Director; the clinical director has placed a copy of her Florida internship license on her office wall. The CEO is also a Licensed Clinical Social Worker. A total of two Non-residential Counselors, one non-residential Case Manager, and two Residential Counselors are responsible for providing counseling and case management services and linking youth and families to various community services.

Youth entering Miami Bridge enter services through First Stop via the Director of Admissions. FSFF Counselors work with youth both in the First Stop office as well as in the community. Youth are referred to Miami Bridge by a family member, school, or a community partner. Upon referral, the youth goes through an intake screening process, followed by an intake, and a needs assessment. A service plan is developed within a week of the completion of the service plan. Case Management and counseling services are provided to meet the needs and goals developed through the intake/service plan process. Counseling and supportive services are offered to parents/guardians/family members as well. The First Stop offices seem to provide a safe and nurturing environment for youth and families to meet with counselors.

Residential counselors have offices adjacent to the primary common area where residential clients spend time, thus allowing youth to have easy access to counselors. Staffing of cases is done on a weekly basis and file reviews are done quarterly.

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.

The agency has implemented electronic files through the Lauris system. As of the onsite visit, there are still some documents that need hardcopy signatures. In addition, it appears that only 3 individual service plan goals can be opened initially, restricting staff to up to 3 goals on the Service Plans.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Agency policy 2.01 provides for and reflects requirement of the QI Indicator 2.01 while including all necessary elements. The policy was last updated on 9/30/16.

The provider has procedures that include the following requirements:

1. Eligibility screening within 7 calendar days of referral.
2. Available service options

3. Rights and responsibilities of youth and parents/guardians

4. Parent /Guardian Brochure

5. Possible actions occurring through involvement with CINS/FINS services

6. Grievance procedures.

The following required standards were met for the 3 residential and 3 non-residential files:

1. Eligibility screening was completed within 7 calendar days of referral for all 6 files reviewed. In two non-residential files, one contained an eligibility screening dated 12/13/16 and the intake was completed on 12/28/16. Another non-residential file was screened on 8/29/16, and the intake was completed on 9/8/16. In both cases, there was sufficient documentation in the files indicating attempts to contact the families for the intakes.

2. All 6 files received the following:

- Available service options
- Rights and responsibilities
- Parent/Guardian Brochure
- Aware of possible options
- Grievance Procedures.

No exception to this indicator as of the date of this QI review.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

Agency policy 2.02 provides for and reflects all the requirements of Indicator 2.02. The policy was last updated on 9/30/16.

The agency's procedures include the following requirements:

- 1. Needs Assessment to be initiated within 72 hrs of admission**
- 2. Needs Assessment must be done within 2-3 face to face contacts**
- 3. Needs Assessment should be completed by a Bachelors or Masters level staff**
- 4. Needs assessment includes a supervisor's review signature**
- 5. Youth identified with an elevated risk of suicide as a result of the needs assessment**
- 6. As a result of above (#5), Suicide Risk Assessment will be conducted by/under the direct supervision of a licensed mental health professional.**

The Needs Assessment was completed within 72 hours in 2 of the 3 residential files reviewed and within 2 to 3 face-to-face contacts in all 3 non-residential files reviewed. All six files had evidence of completion of the Needs Assessments by staff who have either a Bachelor's or Master's degree and all six were signed and reviewed by a supervisor upon completion.

None of the 3 residential files was identified as elevated risks of suicide; however, one residential youth required a suicide risk assessment to be completed 11 days later when a youth reported that she wanted to kill herself. This was completed by Banyon Mobile Crisis on 3/14/17. A follow-up was completed within the 24-hour requirement by a Miami Bridge Central counselor.

One (1) of the 3 non-residential completed a suicide risk assessment at intake and without the need for the client to be further assessed.

Exception:

One residential file intake was completed on 3/2/17; however, the needs assessment was completed on 3/8/17 and outside the 72-hour requirement.

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

Agency policy 2.03 provides for initiation of the case/service plan and that it be developed within 7 working days of the Needs Assessment. The policy was last updated on 9/30/16.

The provider's policy and procedures include the following requirements of the indicator:

1. Case/Service Plan
2. Development within 7 working days of needs assessment
3. The Case Service plan includes: Individual and prioritized needs and goals identified by the needs assessment, Service Type, frequency, location, Persons responsible, Target Dates for completion, Actual Completion dates, Signature of youth, Signature of parent/guardian, Signature of counselor, Signature of supervisor, the Date the plan was initiated and the progress reviews every 30 days for the first 3 months and every 6 months after.

All three residential and three non-residential case service plans reviewed were developed within 7 working days of the completion of the Needs Assessment and reflected the needs presented at the time of intake and any subsequent counseling sessions. All six case/service plans included the following: service type, frequency, and location; person(s) responsible; target completion date(s); actual completion date(s); signature of youth and parent(s)/guardian(s); signature of counselor and supervisor; and date the plan initiated. Service plan reviews were applicable for only 2 (non-residential) of the 6 files reviewed.

Client surveys of 3 youth indicate all 3 stated they have a counselor. Two of the 3 youth were able to state the goals established by their counselors.

Exceptions:

A service plan was completed for 1 non-residential client on 1/6/17. The 30-day review was due by 2/4/17, but wasn't completed until 2/9/17.

A service plan for another non-residential client was created on 9/19/16. Both the 30- and 60-day reviews were completed within the required time frames; however, neither were specifically documented in the progress notes. For that same youth, the 90-day service plan review was not attempted. The 12/6/17 progress note is too early to be considered for the 90-day review.

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 policy was last updated on 9/30/16.

The agency's procedures provide for and reflect the requirements of 2.04 and further describe the agency's protocol for the following:

- Assigned counselor/case manager
- Establishes and coordinates referrals to services based on youth/family on-going needs
- Coordinates service plan implementation
- Monitors progress
- Provides family support
- Monitors out-of-home placement
- Referrals to case staffings
- Accompanying youth to court hearings
- Referrals for additional services
- Case monitoring/court order reviews
- Provides 30- and 60-day follow ups.

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.

The 3 residential and 3 non-residential youth received counselor/case management services. Also, 5 of 6 files contained coordinating referrals and service plan implementation. There were 5 of 6 youth requiring substance abuse treatment and all 5 of them received referrals for substance abuse treatment.

All 6 youth progress were monitored. None of them required referrals for case staffings. And 1 of 6 files required a court hearing, which the counselor attended with the youth and parent on 3/20/17. Only 1 file was closed, and it contained a case termination note.

No exception to this indicator as of the date of this QI review.

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 policy was last updated on 9/30/16.

The provider's procedures require that non-residential programs provide and/or coordinate 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.

The 3 residential and 3 non-residential reviewed indicate that all 6 youth were receiving individual/family counseling services relevant to the youth's needs identified. Presenting problems were addressed in the 6 case files in the Needs Assessments, case/service plans, case notes, and through clinical reviews with the supervisor.

Group notes are kept in a separate binder with a sign-in sheet for all of the youth who participated in group and the 3 residential files reviewed demonstrated the youth also participated in groups at least 5 times/week but not on consecutive days.

Exception:

Group participation sign-in sheet for 3/21/17 is present, but not signed by any of the youth.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures 2.06 in place that describes the Case Staffing process. The policy was last updated on 9/30/16.

The provider's procedures describes protocol for referral to the case staffing committee notification, time-frames, committee members, committee recommendations and revision of the service plans. If the parent or staff initiates the case staffing, it must be held within 7 days. Notification to family and committee will be no less than 5 working days. The provider's case staffing committee includes the following: School representative and DJJ (or CINS/FINS representative) and may include the following representative(s): district attorney; mental health; substance abuse; law enforcement; DCF representative; others requested by youth/family. Meeting notes and agendas are maintained for the CINS/FINS case staffing in a CINS/FINS Petition binder with monthly tabs in which communication - via email- with the various committee members is kept.

Per the QI Specialist, Miami Bridge Central had no case staffing requests initiated during the 2016-2017 fiscal year; therefore, there is not practice for this indicator.

No exception to this indicator as of the date of this QI review.

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. The policy was last updated on 9/30/16.

A tour of the facility included the storage of youth records. Current residential records are kept locked in the main shelter facility and transferred to the First Stop building for locked storage once the youth has been discharged. Non-Residential records are kept locked in a file cabinet in the First Stop building. When youth records are being transported from one building to another or to Miami Bridge South they are transported in an opaque messenger type bag and is marked as being used to transport counseling or medical records for youth, with clear instructions as to how the records are to be handled.

All 6 youth records reviewed were marked "Confidential." All records were observed kept in a secure room or locked in a file cabinet marked "Confidential." All of the records are maintained in a neat and orderly fashion consistently with each section of the file clearly labelled with the contents for that section. In transport, all files are carried in an opaque container marked "Confidential."

Exception:

In transport, the files are in opaque carrying cases marked "Confidential." Neither of the carrying cases reviewed had a feature that allowed them to be locked.

Standard 3: Shelter Care

Overview

Rating Narrative

Miami Bridge Central 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 large bathrooms, one on each dorm wing. The bathrooms consist of three sinks, six showers and three toilets. The bathroom 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 computer lab with 6 computers, recreational games, a volley ball court and basketball.

Staff members in the Residential Program include: a Shelter Supervisor, 2 Counselors, 4 Shift Leaders, 7 Youth Activity Workers, a PT Registered Nurse, a Health Care specialist, a Recreation Specialist, and a Food Specialist/Cook. The provider also employs a Maintenance person 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 Registered Nurse and Health Care Specialist who maintain 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 the Pyxis 4000 Med Station in the Nurse's office.

3.01 Shelter Environment

Satisfactory

Limited

Failed

Rating Narrative

The agency has two policies that address Indicator 3.01 including Miami Bridge Policy 3.01 Shelter Environment and 3.09 Shelter Programming. These policies were last reviewed and approved in September 2016 and signed by the CEO and the Chief Compliance Officer.

Miami Bridge Policy 3.01 relates to the cleaning and maintenance of the building and outlines the organization policies as to how repairs are to be made and documented, when weekly and monthly inspections are completed, and the Youth Activity workers' responsibilities. The policy also covers client visitation, correspondence, telephone use, youth hygiene practice, youth dress code, religious practice, and expulsion and re-admittance procedures. Policy 3.09-Daily Programming ensures that all youth engage in meaningful, structured activities, counseling services, life skill groups (seven days a week) and that idle time is minimal. The policy also includes procedures related to physical activity, faith-based activities as well as homework and education procedures.

The grounds of the facility are nicely landscaped and well maintained. Common areas are very organized and clean. Documentation reviewed indicated that the program has a general housekeeping and maintenance plan in place to ensure the regular maintenance of all the program's physical plant and equipment.

The agency has record of the annual agency fire permit that is valid through 9/30/17. The agency's last satisfactory Food Service Inspection conducted on 3/21/17 did not require a re-inspection. Similarly, the agency received a satisfactory Group Care Inspection on 3/21/17 with 4 citations but also did not require a re-inspection.

The tour of the program also confirmed that the program is equipped with adequate lighting throughout, bathroom facilities that are clean and functional, furnishings are in good repair and in each dormitory youth has an individual bed, clean cover mattress, pillow, linens and blanket, as well as a secure footlocker to keep personal belongings. The bedrooms in the facility are "Bay Style" furnished with new bunkbeds and are very organized, clean and functional. There was no evidence of graffiti on walls, doors, or windows and the facility appear to be free of insect infestation.

Shelter daily schedules are accessible to youth and staff and are posted by the staff office. The schedule includes time for counseling, recreation, at least one hour of physical activity daily, and groups/social skill training. The youth are given opportunities to participate in religious activities.

The counselors and staff offices are located in the main shelter, off the common area. Additional rooms/buildings in the facility and on grounds include a family meeting room, a laundry room, and a Nurse's station, Community Based Services (First Stop For Families) building, and a separate school house. Artists have painted new murals on the outside of the building since the last review. The agency recently purchased "BUG ZAPP", a machine that eradicates bed bugs from clothes and linens. All health and fire inspections are current.

No exceptions to this indicator as of the date of this QI review.

3.02 Program Orientation

Satisfactory

Limited

Failed

Rating Narrative

The agency has one policy that addresses all elements of Indicator 3.02- Miami Bridge Policy 3.02 Program Orientation. The policy was last reviewed and approved in September 2016 and signed by the CEO and the Chief Compliance Officer.

Miami Bridge Policy 3.02 Program Orientation requires that all youth entered into the program "within a 24 hour period" receive an in-depth orientation which includes a review of philosophy, goals and services, building evacuations procedures, policies on contraband, a review of the daily schedule, room assignments, abuse hotline and or DJJ CCC hotline numbers, grievance procedures, suicide prevention, procedures to access medical care, visitation schedule, telephone policy, behavior management, youth development and an introduction to staff. All orientation forms and the orientation checklist will be signed by both the staff completing the orientation and the youth and will be filed in the youth's record.

A review of three client files contained documentation that the Orientation process was initiated within 24 hours each on the date of intake and each client and staff signed the orientation checklist sheet. Each youth was given a list of contraband items and a layout of the facility as well as an explanation of: disciplinary actions, the grievance procedure, emergency disaster procedure, and rules on contraband. They were oriented on room assignments and suicide prevention precautions, including alerting staff of their feelings or awareness of others having suicidal thoughts. Additionally, they received a review of daily activities and were given and shown postings of the abuse hotline and a tour of the facility.

The Miami Bridge Emergency Shelter Handbook provides valuable information which includes policies regarding behavior management and consequences for non-compliance, key staff, rights and responsibilities, privacy of information, grievance procedures, consumer rights and responsibilities, behavioral procedures at school, abuse registry and DJJ CCC phone numbers, in addition to client

information technology and Tec lab procedures. The youth and parent sign a document attesting that the introduction to services were explained and that they understand the information contained within.

No exceptions to this indicator as of the date of this QI review.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has one policy that addresses all elements of Indicator 3.03- Miami Bridge Policy 3.03 Youth Room and Bed Assignment. The policy was last reviewed and approved in September 2016 and signed by the CEO and the Chief Compliance Officer.

Policy 3.03 states staff must take the following into account prior to making a room assignment: clients physical characteristics, observed level of maturity, gang affiliation, current alleged offenses, previous delinquency history, levels or degrees of previous violent behavior, suicide risk, sexual aggression history, runaway history, substance abuse, and requires the separation of violent from non-violent youth.

The dormitories are broken down into two separate modules. Module A is for the younger, more vulnerable client while Module B is for the better adjusted youth. There is an island containing lockers, separating the two sides in the dorm and the staff supervising the unit is stationed on the Module A side for maximum supervision whenever youth are in their sleeping quarters. During the Orientation Process, the youth are informed of their bed assignments. The provider uses the CINS Intake Form for gathering information and observations of the youth at intake.

Three open residential files were reviewed and all had completed CINS Intake Forms with Youth Room Assignments and classifications detailed. This form captures all required documentation for room classification. They also have a written policy on Medical and Mental Health Alerts. All three files had appropriate alerts.

No exceptions to this indicator as of the date of this QI review.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

Standard 3.04 Log Books is addressed in Miami Bridge Policy and Procedure 3.04 Log Books. The Miami Bridge policy requires accurate and concise written documentation to enhance staff's ability to provide appropriate supervision and ensure youth safety. The policy was last reviewed and approved in September 2016 and signed by the CEO and the Chief Compliance Officer.

The agency maintains a permanent daily bound log book, bound with sequential pages, that includes entries from each shift. They have a color-coded system for log entries which include Red, Green, and Blue/Black. All Red items are considered critical to the continued safety of the shelter or the youth in the shelter. It includes information on incidents, medications, medical appointments, grounds and facility checks, and alerts to staff/administrator for calls to CCC. All Green information pertains to shift changes and current status/condition of shelter. It is also used to show supervisor's review of the log. Blue/black items are for head counts, visitors and general log entries.

A review of the logbook showed where recording errors were struck-through with a single line. The entries

were legible and captured the overall shelter operation. The quality program director reviews the facility logbook weekly and makes a note in the logbook indicating the date reviewed and if any correction, recommendations and follow-up are required, and signs/dates the entry. The oncoming supervisor and direct care staff review and sign the log book.

No exceptions to this indicator as of the date of this QI review.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The facility has policies in place, 3.05 Behavior Management Strategies and 3.05.01 Behavioral Interventions for the Behavior Management System. The policy states clear direction and expectation of the Behavior Management System and meets the requirements for this indicator. These policies were last reviewed and approved in September 2016 and signed by the CEO and the Chief Compliance Officer.

Miami Bridge utilizes a BMS that is based on a system of rewards, privileges, and consequences that encourage positive behavior and discourage negative behaviors. The Shelter Director and/or Clinical Director are responsible for training, monitoring and supervising staff in the implementation of the behavior management system. The program has a detailed written description of the BMS that is included in the youth's handbook. The program's BMS consist of a point and four levels system that includes an orientation level that youth receive upon admission to the program.

Information about the BMS was observed to be present in the client handbook; it is also explained to the youth at intake. The process requires youth review and signature as acknowledgement. The Behavioral Management System (BMS) being used by Miami Bridge-Homestead is a positive reinforcement model that accentuates and promotes acceptable behaviors by the youth. The system consists of four levels. Orientation, Level I, Level II, and Level III. Point logs are kept and a client has to accumulate 100 points to advance to each level (i.e. it takes 100 points to advance from orientation to level I 200 points from I to II and 300 points to advance to level III). An advancement in levels means the client receives more incentives. The Miami Bridge rewards each youth that excel with clothing items, special food items, and an assortment of items that the youth can use.

In addition, special outings are used as an added reward/incentive within the behavior management system. Staff are oriented and trained in the theory and use of the BMS and evaluated in its use. Supervisors are trained in its use and to monitor staff's use of the BMS. Grievance reports are posted in the common area for easy access. Managing Aggressive Behavior (MAB) is the training curriculum that is currently used for physical intervention for personal safety and self-defense.

No exceptions to this indicator as of the date of this QI review.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

The facility has policies in place, 3.06-Staffing and Youth and Staff Supervision and 3.06.01-One on One (1:1) Staff/Client Supervision, to ensure adequate staffing is provided to ensure the safety and security of youth and staff. These policies were last reviewed and approved in September 2016 and signed by the CEO and the Chief Compliance Officer.

The Miami Bridge will at all times have adequate staff to youth ratios that provides consistent supervision

of clients, which is essential to maintaining a safe and secure environment. This level of supervision applies whether clients are on outings or within the shelter facility. Maintaining accurate count of the number, location and activities of the youth is critical to providing effective supervision of youth.

The agency has a weekly staff schedule that is developed by the Program Manager and is posted in the staff office in the shelter. The schedule includes youth care staff work hours/days over three shifts. The three shifts run from 6:30 AM to 3:00 PM, 2:30 PM to 11 PM, and 10:30 PM to 7 AM. This provides for a 30-minute overlap between shifts to facilitate the transfer of information between staff working on different shifts. The shelter is licensed for 28 beds and the staff schedules reviewed for the review period reflect a minimum staffing ratio of 1 staff to 6 youth during the afternoon shift and 1 staff to 12 youth during sleep period. The program had at least two staff working during the evening shift and always had a male and female on shift. The program has an on-call roster that includes the names and telephone numbers of staff who may be accessed for additional coverage.

A review of the program logbook shows that 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 when youth are in their sleeping rooms.

No exceptions to this indicator as of the date of this QI review.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a written policy and procedure that addresses all the key elements of the CQI indicator. The policy manual was last updated on 9/30/16 and was signed by the Chief Executive Officer and Chief Administrative and Compliance Officer.

The provider has specific procedures in place for providing services for Staff Secure, Domestic Violence Respite (DV Respite), Probation Respite, and Domestic Minor Sex Trafficking (DMST) youth. Strategies are in place to prevent and/or manage runaway incidents involving court ordered, staff secure or any other category of youth. All youth will receive a standard CINS/FINS Intake and Needs Assessment within 72 hours of intake. Service plans will be developed within 7 days of the intake or admission. Staff Secure youth will receive a higher level of assessment, supervision, intervention, and services.

Prior to intake, it is the provider's responsibility to ensure that referrals for special population meet the admission requirement. Where required, the provider will obtain the necessary approval from the FN and ensure that stays exceeding the contracted days are also approved. Case management and counseling services will be established to address the needs of the youth and issues presented.

The provider did not serve any youth who met the criteria for Staff Secure, Probation Respite, or DMST.

Six (6) DV Respite files were reviewed for this indicator. All six (6) client files had documentation of youth pending DV charge and had evidence of being screened by JAC/Detention and did not meet criteria for secure detention. All six (6) youth did not have a length of stay in DV Respite placement that exceeded 21 days.

Four (4) files provided documentation in file of transition to CINS/FINS placement. The remaining two (2) were discharged prior to the 21 days.

Exception:

Three (3) of the six (6) Domestic Violence Respite files did not have case plans. The 3 clients had a length of stay 1 day, 10 days and 20 days.

3.08 Video Surveillance System

Satisfactory

Limited

Failed

Rating Narrative

Standard 3.08 Video Surveillance is addressed in Miami Bridge Policy and Procedure 3.08 Video Surveillance System. The policy covers all elements of Indicator 3.08. The policy was last reviewed and approved in September 2016 and signed by the CEO and the Chief Compliance Officer.

As an extension of the Risk Prevention Program, the video surveillance system monitors the Miami Bridge facility both internally and externally. The Video Surveillance System operates 24 hours a day, 7 days a week to monitor and capture recordings of agency happenings to assure the safety of all youth, staff, and visitors to the residential shelter.

The Miami Bridge camera system is new and consists of 32 cameras, 16 inside the facility and 16 outside. All cameras are easily visible both internally and externally. The video footage is high resolution and the system can store footage for a minimum of 30 days. Supervisor staff reviews the footage from a designated laptop computer. The Surveillance System has its own battery back-up supply for electrical outages. Written notices of video surveillance are posted and no audio from the video cameras is enabled to ensure some level of privacy. The camera system can be viewed off-site and is limited to the viewing of only authorized employees. Personnel authorized to review Surveillance System footage are Chief and Deputy Chief Executive Officer, Chief Operations and Technology Officers, Chief Compliance Officer and the QI Coordinator. A review of the program video surveillance system shows that staff observes youth at least every 15 minutes while they are in their sleeping room.

Exception:

Only one video surveillance supervisory review, logged from 1/1/2017 to 2/10/2017, was observed. Per the requirement, supervisor must conduct reviews once every 14 days. Miami Bridge Policy 3.08 states supervisor's reviews will be documented weekly and documented in the log book.

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 and 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 Clinical Director and Residential Coordinator 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 agency stores all prescribed medications in the Med-Station 4000 cabinet and has several staff members as regular users and more than 2 Super Users for the Pyxis Med-Station 4000. The provider has a RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility. Topical and 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 and 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 had policy, procedures and practice to ensure the completion of a preliminary health screening for each youth at the time of admission to the shelter. The policy was revised in September 2016 by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

The shelter utilizes health screening forms that include: CINS/FINS Intake Form; Health-Related History Form; and Medical Services Consultation Form and has a thorough referral process and mechanism for necessary follow-up medical care as required or needed. The provider's aforementioned preliminary health screening process 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 program maintains one individual healthcare record for each youth.

All general client information is entered in the agency's client information system (CIS). When the RN is not on duty, the CINS/FINS Intake is completed by the Youth Activity Workers. The agency also captures screening information that includes markings scars, tattoos, and piercings; findings are documented in the CIS system.

The agency's nurse utilizes the Health-Related History Form after the Intake process. This information is then used to develop a health or medical summary for each client. The agency nurses also use a Medical Services Consultation Form. The latter is documented in the agency's CIS system and a copy is printed and placed in the youth's file.

The agency has a partnership agreement with a local health care entity, Camillus Health Concern. Camillus provides initial health exam on all clients generally on Wednesdays and Fridays every week. The agency also requires that all parents be involved in routine medical follow-up treatment.

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 now utilizes a Registered Nurse (RN) to manage all medical care for youth in the program. The RN is responsible for overseeing documenting any follow-up care provided to clients.

A review of three youth healthcare records found that each contained a preliminary health screening that include current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or physical distress, observation for evidence of illness, injury or physical distress, and observation for presence of scars, tattoos, or other skin markings. All the screenings reviewed were completed by counselors and reviewed and approved by the supervisor. When applicable the parent/guardian was actively involved in the coordination and scheduling of follow-up appointments. The program documented all medical referrals on a daily log.

No exceptions to this indicator as of the date of this QI review.

4.02 Suicide Prevention

Satisfactory

Limited

Failed

Rating Narrative

The program had policy and procedures related to suicide prevention. The policy was revised on September 30, 2016 by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

The program ensures all youth are screened for mental health, substance abuse and suicide risk issues at intake. Documentation reviewed revealed that in the applicable case(s) youth are referred to the appropriate professionals or agencies or Baker-Acted due to identified mental health issues. The shelter has a Suicide Prevention policy that is current. This policy includes the agency's suicide prevention and response procedures. The agency's suicide risk assessment policy has been approved by the Florida Network of Youth and Family Services. The policy requires that each resident admitted to the shelter will be screened for suicidal risk by the utilizing the six (6) suicide risk questions on the CINS/FINS Intake form. The agency executes the policy by administering the questions to all residents.

The Direct Care staff are trained to ask each resident the risk screening questions. If the resident answer "yes" to any of the 6 questions, the policy requires that resident be placed on elevated supervision (Constant Sight and Sound supervision) until a full suicide assessment can be completed by a qualified mental health professional. If the qualified mental health professional is not available, the youth will be placed on Constant Sight and Sound supervision until the counselor is available to conduct a full suicide assessment. Following this action, Direct Care Staff will immediately refer the youth to the agency's licensed mental health professional. The agency's CEO is a qualified Licensed Clinical Social Worker. The agency's Clinical Director oversees all non-licensed counselors.

A review of three youth records indicated that suicide screening results were reviewed and signed by the supervisor and documented in the youth's case records. One of the three youth was placed on sight and sound as a result of the suicide risk screening and Assessment of Suicide Risk. The supervision level was not changed/reduced until the licensed professional completed a further assessment. The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.

Exception:

The Precautionary Observation Log that documents the youth's suicide risk behavior while on sight and sound status was not documented for the 3 hours the youth was on sight and sound.

4.03 Medications

Satisfactory
 Limited
 Failed

Rating Narrative

The program had extensive policy and procedures for the safe and secure storage, access, disposal and distribution of oral medications and pharmaceutical products, including over-the-counter (OTCs) medications. The policy was reviewed on September 30, 2016 by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

The tour of the program, procedures reviewed, and interview with the registered nurse (RN) revealed that the program has a Pyxis Med-Station 4000, and all oral medications were stored in the Med-Station. The program had four Super Users for the Med-Station. Inspection of the program's medical nurse station validated that oral medications are stored separately from injectable and the topical medications located in the intake office. Although the program does not have any medications requiring refrigeration at the time of the review, the program had one small refrigerator available only for medication use. The program does not have any narcotics, and had only one youth on controlled medication.

The controlled medication for applicable the youth was stored in the Med-Station. The review of the medical distribution logs verified the shift-to-shift counts. The Med-Station documentation reviewed confirmed that the program staff conducted perpetual inventory for controlled substances. Documentation reviewed also indicated that the program had 18 staff members delineated in User Permissions to have access to secure medications, with limited access to controlled substances. The program does not have any syringes and all the sharps are secured in a locked medical storage cabinet, and documented in the sharps log. OTCs are accessed regularly and inventoried weekly through the Med-Station. The program conducted monthly review of medication management via Knowledge Portal or Pyxis Med-Station Reports. The program cleared medication discrepancies every day within 24 hours and/or in each shift to shift practice.

The agency completes weekly sharp counts. All sharps are secured in a locked cabinet in the Intake Office. The agency does have a red bio-hazard container for sharps disposal. The facility has a Bio-medical waste agreement with Steri Cycle for bio-hazard waste.

The Registered Nurse performs 40 hours of nursing services divided across both the Miami Bridge Central and South locations. The Registered Nurse oversees the documentation, storage, and distribution practices executed at both Miami Bridge youth shelter locations.

No exceptions to this indicator as of the date of this QI review.

4.04 Medical/Mental Health Alert Process

Satisfactory
 Limited
 Failed

Rating Narrative

The program has two comprehensive written policies, procedures and practices related to the medical and mental health alert process and the emergency mental health and substance abuse services provided by the program. Both policies were revised on September 30, 2016 by the Chief Executive Officer and the Chief Administrative and Compliance Officer. The written procedures ensure that information concerning youth's medical condition, physical activity restrictions, allergies, medication side effects, food and medication is effectively communicated to all staff, and a process to access the required services, that includes the referrals.

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 identifies medical, substance abuse, victimization, nutritional and mental health issues and color-codes as follows: Red=Medical; Blue= Substance Abuse; Green= Victimization; Yellow= Nutrition; and Orange= Mental Health. Medical/Mental Health/SA/Allergy/Victim/Nutrition alerts are included in the program log, posted on the whiteboard located in the Intake Office, documented on "Youth Alert System" form included in each of the files reviewed, and food allergy alerts are posted on a clipboard in the kitchen.

Training documentation reviewed indicated that staff is provided with sufficient training that allows them to recognize and respond to medical and mental health emergencies as a result of identified problems.

A tour of the program and observation revealed the program had a medical alert board in the kitchen, and each applicable youth alert was also documented inside the youth's records. Services provided by the program include screenings, youth's classification system, appropriate placement, medical care, close youth supervision, crisis intervention and emergencies management, and notification and on-going communication with parents/guardians and others. The review of the program's Memorandum of Understanding (MOUs) log confirmed the program maintained several community agreements with local organizations to obtain the provision of the applicable services to all youth in the program. Three youth records reviewed validated the program practices.

Three (3) youth files were reviewed to validate practice of medical/mental health alert process as outlined in the procedure. Initial medical/mental health screening is conducted during the admission screening. If the RN is not on site to conduct the screenings, the medical/mental health alerts are reviewed by the RN within 72 hours of admission. All three youth were appropriately placed on the program's alert system and precautions regarding medication were communicated in one applicable file. Staff are provided sufficient information/instructions to recognize and respond to emergency care if needed.

No exceptions to this indicator as of the date of this QI review.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

The program had written policy, procedure and practice related to episodic and emergency care to effectively respond to the emergency health or medical needs of youth. The policy was revised on September 30, 2016 by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

The program's written procedures address the provision of emergency medical and dental services through Memorandum 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.

The review of the program's emergency drills log found that the program staff has been conducting emergency drills as required. The program had several inter-agency agreements for the provision of the appropriate referrals for additional emergency medical services to the youth in the program. Emergency medical and dental services are provided by accessing Miami-Dade County Emergency Medical Services (EMS) by calling 911 at any time 24 hours a day. The program has an Emergency Medical Care Log that was reviewed. Documentation reviewed confirmed that the program provides 1:1 staff to youth supervision during a mental health emergency. Law enforcement officials from Miami-Dade Metro Police Department regularly and consistently provide secure transportation to and from emergency care facilities. The program utilizes the Jackson Memorial Hospital Holtz Children Unit for medical emergencies and Citrus Health for mental health emergencies.

Training documentation reviewed found that the program staff received training in emergency procedures, including CPR and First Aid. The program had six knife-for-lives and six first aid kits (located at the intake office, kitchen, school, 1st Stop, and the two vans).

The program has a knife-for-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. First aid kit/supplies are located: 2 vans, the school, kitchen, Intake Office, First Stop program. The First Aid kits are inventoried and the supplies are restocked weekly. This is documented on the weekly check list reviewed.

No exceptions to this indicator as of the date of this QI review.