Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge-Homestead

on 12/06/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability	
1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management	
2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management and Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petitiion Process	Satisfactory
2.07 Youth Records	Satisfactory

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

Standard 3: Shelter Care	
3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Satisfactory
3.04 Log Books	Limited
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:87.50%
Percent of indicators rated Limited:12.50%
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:96.30%
Percent of indicators rated Limited:3.70%
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

Keisha Dunn-Pettis, QM Manager, Children's Home Society West Palm Beach

Paula Friedrich, Program Monitor, Department of Juvenile Justice

Carline Jean, Case Manager, Center for Family and Child Enrichment

Sonia Santiago, VP Clinical Director, Sarasota YMCA

Persons Interviewed

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

0 Case Managers
1 Program Supervisors
1 Health Care Staff

1 Maintenance Personnel
1 Food Service Personnel

2 Clinical Staff
0 Other

Documents Reviewed

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

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

Surveys

3 Youth 3 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Posting of Abuse Hotline
- [ ] Staff Supervision of Youth
- [ ] Program Activities
- [ ] Tool Inventory and Storage
- [x] Facility and Grounds
- [ ] Recreation
- [x] Toxic Item Inventory and Storage
- [x] First Aid Kit(s)
- [ ] Searches
- [ ] Discharge
- [ ] Group
- [x] Security Video Tapes
- [ ] Treatment Team Meetings
- [x] Meals
- [ ] Social Skill Modeling by Staff
- [ ] Youth Movement and Counts
- [x] Medication Administration
- [x] 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. Funding through CINS/FINS allows the agency to serve 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 special populations 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 run away and homeless youth.

Miami Bridge is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through August 31, 2021. 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 of 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 March 2017 as follows:

· The agency's paperless Electronic Medical Record (EMR) system utilizing Lauris, an online automated system, is fully implemented in the Non-Residential program. This system was implemented in July 2016 to optimize the organization's service delivery and information management processes as well as afford the ability to automate workflow and manage all aspects of services. The goal is to complete implementation in the Residential program in the near future.

· The agency added a new position, Director of Philanthropy/Volunteer Development, to support its resource development, fundraising and donor activities. The position was filled by a current Miami Bridge employee. In addition to the Directory of Philanthropy position, a new Chief of Programming position was also added to the organizational structure.

· Direct oversight of clinical services at each Miami Bridge location was created with the addition of a Clinical Supervisor for each site.

· Steve Hope, Deputy CEO and CFO of Miami Bridge was recently appointed by the Governor to the Juvenile Justice Prevention Committee. Mr. Hope has over 20 years management experience in for and non-profit and has been employed by Miami Bridge for the past 3 years.

· With the help of the community through a social media campaign which raised $3300, all the youth in the shelter were able to go to Disney World. GL Group provided a match of about 60% of the cost for 20 youth to go on the one day trip.

· The program implemented use of E-logbooks in July 2017.

· The agency received financial support from the CRA Homestead to provide extended recreational activities such as fishing and art.

· Since the last QI visit, the agency has made improvements to the shelter with the addition of LED lighting on the exterior and throughout the facility. Plans are underway for the addition of a Reception area utilizing a portion of the current front porch. The new 300 square foot space will include an ADA bathroom and serve as a single point of entry and greeting area for all guests. The project will be funded by Braman Foundation.

· The agency reaches out to the community by hosting multiple events throughout the year. Over 270 attended the annual luncheon. A Christmas luncheon was also scheduled for the Homestead community.

· The Program Committee, a subcommittee of the Board of Directors, was formed to address issues impacting youth. The committee came up with 20 key areas including education and recreation services. The committee's goal is to leverage their relationships in the community to obtain tangible resources to support the programs and bridge the gap in support services.

Standard 1: Management Accountability

Overview

Narrative

MB Homestead, located at 326 NW 3rd Ave, Homestead, Florida, is under the leadership of a Board of Directors, Chief Executive Director, Deputy CEO/ Chief Financial Officer, Chief Administrative/Compliance Officer, Chief Facilities and Construction Officer, Chief Programming Officer, Director of Shelter Services, two Clinical Directors, Director of Philanthropy, Director of Human Resources, Director of Admissions, Director of Residential Services, Director of Non-Residential Services, and a Shelter Supervisor. 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 Shelter Supervisor and the Director of Shelter Services who supervises the clinical component. During the onsite visit, the current RN Nurse Scott was also designated as interim Shelter Supervisor as a result of the recently vacated Shelter Director's position. Nurse Scott is responsible for the day-to-day operations of the shelter and supervision of 2 Health Care Specialists (Central and South shelter) as well as 3 Shift Leaders, 8 YAW, and Cook. The Residential Counselor (1) and Case Manager (2) positions are supervised by the Director of Residential Services.

MB Central office handles all fiscal, administrative, and personnel functions for both locations. 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 part time YAW vacancies. The MB Homestead facility is licensed by the Department of Children and Families for 20 beds, which is displayed in the facility, effective through 2/28/18.

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 Homestead has a policy and procedures, 1.01 that was last revised on 7/01/17, to address the background screening of all employees, volunteers, and interns prior to any offer of employment or volunteer service.

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.

The most recent submission of the Annual Affidavits of Compliance with Level 2 Screening Standards was sent via email to DJJ BSU on 1/9/17 prior to the January 31st deadline.

A total of eleven (11) applicable personnel files were reviewed for three (3) new staff, seven (7) interns, and one (1) staff eligible for 5-year re-screening. The three new staff were hired after the last onsite QI visit in April 2017 and all three received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. Similarly, the one staff that was eligible for 5-year re-screening had the re-screening conducted prior to the staff's five-year anniversary date.

The program has seven interns providing volunteer service during the review period. All seven received eligible screening results from DJJ prior to their service start dates.

In addition, electronic submissions of Department of Homeland Security E-Verify for the three new employees were verified confirming the employees' work eligibility and date of hire.

No exceptions to this indicator were noted at the time of the visit.

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has a policy and procedure # 1.02-Provision of an Abuse Free Environment and, 1.02.01 Grievance Process. The policies were last revised on 9/30/16.

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. Staff are required to adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. The code of conduct clearly communicates the agency's behavioral expectations of staff that prohibits the 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 personnel file.

Policy #1.0201 addresses 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 hotline number is included in the resident handbook.

The program has a current grievance procedure (1.02.01) 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 a grievance box for depositing grievances. Per the program's procedures, youth are instructed to put their grievance in the box.

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

During the tour of the facility the Reviewer observed posters with evacuation and emergency procedures, important telephone numbers including the Florida Abuse Hotline and DJJ CCC, client rules, and behavioral expectations. The signs are visibly posted in both dorm room areas as well as in the counseling hallway. The abuse hotline and DJJ CCC numbers are included on the posters.

The program maintains both a Monthly Abuse Registry Log and a Client Grievance Monthly Log. A total of 4 Abuse Registry calls were made since the last onsite visit that were accepted by the Hotline. None of the abuse calls were institutional. Youth receive an orientation guide and grievance procedures during admission. The program documents the calls on Abuse Registry Log Sheets that are maintained in a binder. Per the agency's policy and procedures, the program will document in the program log and document an abuse report in the client's case file.

Surveys were completed with three youth on-site during the QI visit. All three youth were knowledgeable about the abuse hotline and 1 of 3 knew the location of the number. None of the youths surveyed stated

they had attempted to call the hotline while in the shelter. The three youth surveyed indicated staff is not respectful when talking with youth and 1 stated sometimes staff is rude and aggressive to the youth and yells at each other.

During the tour of the facility, the grievance box and forms were observed to be mounted on a wall adjacent to the intake office. Eleven grievance reports for the current review period were reviewed. Eight of the grievances were related to staff's behavior toward youth and three were youth related. Four of the eleven grievances were not resolved because the youth were already discharged upon accessing the grievances. The remaining seven grievances submitted by youth were all addressed by the QI Coordinator or Program Supervisor but the section of the form that allows youth to indicate satisfaction with the outcome were not completed in any of the 7 grievances filed. All three youth surveyed stated they were not familiar with the grievance process.

Exceptions:

None of the four abuse calls reported to the Hotline were documented in the program logbook as required by the program's policy and procedure.

As required by the indicator, the Grievance Policy/Procedure does not clearly state that direct care workers will not directly handle complaint/grievance documents.

None of the 7 grievances addressed by the program staff indicated whether or not the youth was satisfied with the resolution.

The three youth surveyed indicated staff is not respectful when talking with youth and 1 stated sometimes staff is rude and aggressive to the youth and yells at each other.

All three youth surveyed stated they were not familiar with the grievance process.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Miami Bridge program has a policy and procedures in place regarding reporting of incidents. The policy was signed and approved by the CEO and Chief Administrative Compliance Officer on 10/31/2017. The policy states that when a reportable incident occurs, staff must notify the Department's Central Communication Center within two (2) hours once the staff has knowledge of the incident. The policy also states that staff must write up the incident after the occurrence and before leaving the shift. Follow up procedures are included in the policy regarding any instructions required by CCC in order to close the case and to be sure that the incident has been attended to as needed.

Once an incident occurs, several staff are included in implementing the procedures outlined in the policy, including the Clinical Director, Shelter Supervisor, and staff who became aware of the incident either by witnessing it or being made aware of it. Specific forms for the reporting are used, along with the importance of time frames being practiced. Staff report the incident to supervisory staff, write up the incident, and when appropriate a call to the CCC, Law Enforcement and Parent/Guardians is made. Witness statements are gathered along with appropriate signatures needed. The incident is reported in the log book as well. Incidents are kept in files and can be viewed by staff and residents. The Shelter Supervisor is responsible for making sure the procedures are complied with.

This policy assists the program in developing risk management strategies to minimize incidents regarding safety issues, provides a frame work for corrective action and serves to reduce the severity and number of incidents occurring. The program is highly aware of the risks the incidents bring and use the incident reporting as a tool to bring safety and quality of service to youth.

Six (6) CCC reports made during the review period were reviewed. All reports contained the appropriate information, including witness statements. All signatures were in place including staff, youth and

witnesses as well as supervisory personnel. The report filing occurred within the 2 (two) hour time frame as stated. Reports consisted of medication issues and behavioral issues of youth. Appropriate authorities were notified including Supervisors, Law Enforcement, Parent Guardian and CCC. The documentation was noted in the log book and a copy is attached to the incident report for ease of checking.

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

1.04 Training Requirements

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Miami Bridge Program has a clear policy, number 1.04, on training requirements approved and signed by the CEO and Chief Administrative Compliance Officer on 10/31/2017. The policy clearly states the expectations for staff for training that meets the requirement of the indicator.

All employees are subject to 80 hours of training within the first year of employment based on their date of hire. Additionally once completing their first year, staff will need to have 40 hours of training. Staff can meet this requirement by providing documentation of training hours. Community, on line, conference, workshops can be used to meet the training requirements. The training requirement states staff will need to complete 80 hours of training according to their date of hire in their first full year of employment and 40 hours will be required yearly. The procedures identifies a list of training that are to be completed within 120 days of employment as well as a list of training to be completed within the first year. The procedures also list specific training to be completed in the DJJ-Skill Pro System. There is also specific training that will be provided during in service. Each staff will have an individual training file with written documentation of training hours. The file will include the start dates for each employee. Supervisor will review the file annually.

The program has an organized training file for each staff member that includes required training, and employment start dates. As staff completes training, a copy of the training certificate is placed in their file. The training hours completed are noted and the total number of hours is written as well. The program encourages staff to meet the required hours of training through their new hire orientation which covers many areas that staff needs to be informed about to do their job. This is well organized and provides new staff with a well-rounded level of information that will assist them in meeting training requirements.

A total of 6 files were reviewed for this indicator for 3 first year staff and 3 in-service staff. The 3 first year staff were under their one (1) year anniversary dates of hire (DOH) and 2 (DOH 3/29/17 and 5/16/17) had surpassed the first 120 days of hire. For these 2 staff, all of the mandatory trainings required during the first 120 days were completed with the exception of one topic (Youth/Adolescent Development) for one of the two staff. A third first year staff (DOH 8/29/17) had 2 weeks remaining to attain 120 days of hire and had not yet completed 6 of the 10 mandatory training topics required to be completed during that time frame.

Three in-service training files were reviewed for staff with DOH 1/6/15, 2/22/16, and 11/23/15. One of 3 staff had completed all but one of the required training (PREA) which was due by 11/23/17. A second staff had one topic remaining (Suicide Prevention) and was lacking 22 of the required 40 hours of training with only 30 days remaining in the current training year. The third staff's training file selected (DOH 2/22/16) did not have any evidence of on-going training, including a valid CPR/First Aid certification in their file.

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

Exceptions:

One first year staff (DOH 3/29/17) did not complete Youth Adolescent Development training during the first 120 days of hire as required.

One of 3 in-service staff did not complete the PREA training which was due by 11/23/17.

The third in-service staff's training file selected (DOH 2/22/16) did not have any evidence of on-going

training, including a valid CPR/First Aid certification in their file.

The policy states that the Supervisor will review the training file, but there is no indication that this is completed.

Skill Pro training will need to be added to the list of training required on staff forms as well as Information Security Awareness.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program has 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, walkthroughs),

• 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 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 workgroup/committee meeting and documented on the agenda and meeting minutes.

The last two quarterly CQI Committee meeting agendas and minutes were reviewed for meetings held in May and November 2017 (September was not held due to Hurricane Irma). A sign in sheet agenda and minutes is maintained for each meeting. Agenda items include: incident reports, risk prevention, training update, clinical subcommittee update, health care and medication management, client satisfaction surveys (if applicable), review of NetMIS report analysis, and case record review report.

The provider conducts monthly Clinical CQI Subcommittee meetings (except for months when case record reviews are conducted) and quarterly peer record reviews. Clinical CQI Subcommittee meetings during the review period were held in the months of June, August, and November; September was not held due to Hurricane Irma. Agenda items include: CQI, Client and Program Outcomes, Review of NetMIS Data, Client

Satisfaction Surveys, Case Record Management and Reviews, Incident Reports, EMR, and Behavior Modification System. Case record reviews for Q4 FY 2016-2017 and Q1 FY 2017-2018 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 regular 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 April, June, July, September, and October 2017. The provider tracks the types of incidents and monitor trends, reporting 65 incidents at the Central location for the current FY.

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 programs' 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 during the current FY.

Staff meeting minutes were reviewed for the review period and were held during July, August, September, and November 2017. October was canceled due to Hurricane Irma. The QI Coordinator and/or Chief Compliance Officer participate in the staff meetings to share information related to CQI and program monitoring.

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 exceptions were noted for this indicator as of the date of the QI visit.

1.06 Client Transportation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a clear policy and procedure in place for indicator 1.06 approved by the CEO and Chief Administrative Compliance Officer on 10/31/2017. The transportation policy developed by Miami Bridge is intended to avoid situations that may put youth in danger of real or perceived harm and keep staff and clients safe. It meets the requirements identified in the standards of the Florida Network and DJJ.

The procedure outlined in the policy clearly provides guidance for the safety of youth and staff. A list of approved agency drivers with valid driver's license is maintained along with and approved agency vehicles to be used. Staff ratios are to be maintained. If a third party is needed to transport youth, they must be an approved volunteer, intern, or other youth. The policy states that best practice is to have a 3rd party present while transporting youth. If a 3rd party is not available for transport, an evaluation of the client's history and present behaviors is considered. The agency driver is also evaluated to ensure appropriate behavior. If transporting a single client of any gender in a vehicle, the program supervisor is made aware prior to the transportation and consent is documented accordingly. Youth may not be transported in personal vehicles.

Documentation regarding the vehicle in use includes name of the driver, date, time mileage, number of passengers, purpose of travel and location.

The staff will comply with all company policies and procedures regarding the use of the vehicle. The program will provide a list of approved drivers that will be visibly posted in the Intake Office. The program

will have adequate transportation to meet the needs of their clients.

The acquisition of vehicles and their maintenance is under the responsibility of the Operations Department and Chief Operations and I/T office. Planned inspections and maintenance are scheduled to keep the vehicles safe and clean. A clean safe vehicle for clients and staff is essential to the program for successful management. Planned inspections and preventive maintenance is essential and is regularly scheduled. The need for appropriate insurance is part of the safety practices and procedures.

The Agency has transportation log books of the 2 vans used, one red and one white van. Included in the log book are: the insurance forms, vehicle registration, and a thorough check list of the vehicle. The transportation log contains time of travel, driver name and signature, purpose of the trip, odometer readings, number of passengers and a check off for pre/post inspection. Transports are noted in the program log book.

The policy and procedure states ratios will be maintained when transporting youth. On 12/1/17 a transport occurred with one driver and 8 youth with no indication on the transport log of additional staff being present. A late entry in the program log book indicated that another staff accompanied youth in the transport. Additional staff present during the transport was not always listed on the transportation log.

Exception:

Staff who transport youth is not consistently listing other staff person present on the transport sheet.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The Agency has a written policy and procedure 1.07 that is approved and signed by the CEO and Chief Administrative Compliance Officer on 10/31/2017. This policy recognizes the importance of outreach services for the community and the population served. The targeted outreach serves to increase public awareness of the services available to the community, the referral process to further assist their clients and enables collaboration and partnerships.

The procedure states efforts to engage with community agencies who provide a wide array of services with the opportunity to further enhance services for the youth they serve. These include medical, educational, therapeutic and other services available in the community. It also enhances the opportunity for referrals for youth. Formal Inter-agency agreements help to develop a continuum of services for the community and support the coordination of services for clients. The community partnerships and collaborative efforts assist in the service delivery to maximize the utilization of existing resources.

Miami Bridge staff is to participate in the local DJJ board and circuit board meetings. Staff are to provide outreach and participate in community audiences and groups in many areas including low performing schools, crime zones and siblings of youth in the DJJ system.

The agency has a Targeted Outreach Plan and has a lead staff member to coordinate outreach and attend DJJ board meetings. They provide outreach in high crime zip codes and schools. They have a plan for community events and provide information on CINS FINS services as well as the Shelter services available for youth. The program maintains a binder with a list of Inter-agency agreements and evidence of contact with community partners for referrals to assist the youth and families they serve. There are 45 MOUs and Inter-agency agreements listed. The lead staff that participates in outreach activities is posted on the list. These MOUs and Interagency agreements cover a vast array of community partners which is used to enhance services for clients.

In practice Miami Bridge follows the outreach practices identified in their policy and procedures. Outreach events are documented on the Florida Network Outreach form and maintained in a binder. The event is identified as is the staff and the number of participants. Outreach activities are filed monthly in the outreach binder. There is a list of the events attended for the month as well.

The Agency is invested in connecting to other community partners by participating in local meetings. They also reach out to high risk zip code areas and low performing schools as evidenced through the outreach form.

Staff also participates in local DJJ Circuit 11 meetings monthly with documentation contained in a separate binder that includes meeting minutes and agendas.

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

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 the 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 were 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

The agency has a written policy and procedure 2.01 that addresses all of the key elements of the QI indicator. The policy manual was last revised on September 30, 2016 and was signed by the Chief Executive Officer and Chief Administrator and Compliance Officer. Per the policy and procedures, Centralized intake services are available through the shelter program and are accessible 24 hours and 7 days a week.

The agency has written procedures that states initial screening is completed within seven days of a client

being referred to the program to determine the client eligibility is completed within seven days of first initial contact. The agency conducts the screening to determine the needs of the client. The agency also ensures that the parents/guardians and youth will receive the following in writing during intake:

- **Available service options;**
- **Rights and responsibilities of youth and parents/guardians**
- **Grievance Procedures;**
- **Behavior management and Intervention Systems, including incentives;**
- **Possible actions occurring involvement with CINS/FINS services (i.e. case staffing Committee, CINS petition, CINS adjudication).**

A total of 6 files were reviewed for 3 residential and 3 non-residential cases. All 6 files contained screenings that were completed within 7 calendar days. All files contained a signed document stating that parents and guardians received the residential handbook as well as the CINS/FINS brochure which includes information for parents and youth regarding available service options, rights and responsibilities of youth and parent, parent/guardian brochure, possible actions through CINS/FINS Services, and grievance procedures.

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

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure for Needs Assessment, Indicator 2.02 that includes all of the required elements of the QI indicator. The policy was last revised on September 30, 2016 and signed by both the Chief Executive Officer and Chief Administrative and Compliance Officer.

The agency requires a Bachelor's or Master's level staff member to initiate or attempt the Needs Assessment within 72 hours of admission for residential client, and to be completed within two to three face-to-face contacts following the initial intake for non-residential client. The provider requires the counselor/case manager to sign and date the Needs Assessment form corresponding to the date of completion. The supervisor is then required to review and sign the completed document.

A suicide risk assessment will be included in the needs assessment to determine existing mental health issues that may require immediate action by the agency and must be reviewed by a licensed clinical staff if determined. The staff will ensure that appropriate and necessary referrals/recommendations are made to address the client's needs.

Three residential and three non-residential files were reviewed. Of those files, all the residential files were completed within the time frame of the agency. However; in two of the three non-residential files, the Needs Assessments were not initiated at the first face to face with the family.

All the 6 files were completed and by a staff with a Bachelor's or Master's level and all 6 cases were signed by a supervisor.

None of the files reviewed were identified as having elevated suicide risk screening. No additional suicide risk screening needed to be completed.

Exception:

According to agency's policy and procedure, it is required for the needs assessment to be initiated during the first face to face visit/session with the family. In two of the three non-residential files reviewed, the Needs Assessments were not initiated at the first face to face with the family.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure 2.03 that includes the key elements of the CQI indicator. The policy manual was last revised in September 30, 2016 and was signed by the Chief Executive Officer and Chief Administrative and Compliance Officer.

The agency's procedures require that the service plan to be initiated within 7 working days of the initial intake. The service plan will be developed with youth and family to ensure their active participation in this process and support if the identified goals. The service plan must be reviewed 15, 30, 45, 60, 90, 180, 360 days whenever appropriate and depending on the program type, shelter or community based services.

The 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.

Altogether, the 6 case files reviewed contained case service plans that were developed within 7 working days of the completion of the needs assessment. All three residential and the three non-residential service plans were individualized suitable to the client/family based needs identified during the completion of the Needs Assessment. All service plans included goals, realistic time frames, service type, frequency, and location. All 6 service plans reviewed contained person(s) responsible, actual target dates, signatures of parent/guardian, youth, counselor and supervisor. All 6 plans reviewed contained the date that it was initiated. However; the files did not contain actual completion dates due to ongoing services provided to the family. Service plan were reviewed and completed within 15, 30, 45, 60, 90 days as applicable and modifications were made when needed to.

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

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has multiple written policies and procedures: 2.04 that address Case Management and Service Delivery, and 2.04.01, Service plan Follow Up/Aftercare. Both policies address all the key elements of the QI indicator. The policy manual was last revised on September 30, 2016 and was signed by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

The written policies for Case Management and Service Delivery provides procedures for counselor assignment, external referral establishment and assessment of ongoing family needs, coordination for service implementation, progress monitoring, referrals for case staffing and referrals for additional services when appropriate. The assigned counselor is responsible to ensure that service delivery and case management services are completed through direct provision or referral. The process of Case Management includes:

1. Establishing referral needs and coordinating referrals to service based upon the ongoing assessment of the youth's/family's problems and needs;

2. Coordinating service plan implementation;

3. Monitoring youth's/family's progress in services;

4. Providing support for families;

5. Monitoring out of home placement, if necessary;

6. Referrals to the case staff committee; as needed to address the problems and needs of the youth/family;

7. Recommending and pursuing judicial intervention in selected cases;

8. Accompanying youth and parent/guardian to court hearings and related appointments, if applicable;

9. Referral to additional services, if needed;

10. Continued case monitoring and review of court orders; and case termination follow up;

11. Actively identify and adapt new and innovative service and mage diligent efforts to increase diversity of services within the service delivery process;

12. Being responsive to the needs of the community and individual clients it services and will seek out culturally competent service providers to meet these needs.

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.

All 6 files reviewed include evidence of delivering case management and services. All were completed within the time frames established by the agency. The plans outline services that would assist the youth and family. The case files were monitored by both the counselor and the supervisor at least monthly. Supports were provided to the youth/family in helping to achieve outlined goals in the service plan. Referrals were made to assist the family with additional services that were not provided by the agency. All 6 files reviewed are still opened, with completed service plan reviews. Thus far, no case staffing was recommended for any of the 6 files reviewed.

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

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.05 and 2.05.01, that address and exceeds all of the key elements of the QI indicator. The policy manual was last revised on September 30, 2016 and was signed by the Chief Executive Officer and Chief Administrator and Compliance Officer.

The policy and procedure state that the staff will be responsible for meeting with clients and families to assess progress toward improving their goals. The agency provides youth and families with counseling services in accordance with youths' case/service plans, to address needs identified during the assessment process. The counselor ensures that family conference, family outreach and access to family counseling are provided to address family issues and prepare the youth to return to the community. The program maintains individual case files with chronological case notes on youth's progress and adhere to all laws regarding confidentiality.

In addition to individual and family counseling, the agency provides group counseling sessions held a minimum of five days per week. The staff makes extensive efforts to engage families, guardian, and significant other in the planning and service activities. One of the agency's primary goals is to prevent family separation and/or reunify family by strengthening and supporting families.

The Non-Residential program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, protect the family structure, minimize

out of home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. Services are provided at youth's home, community location, or the local provider counseling office.

2.05.01 Group counseling

The group counseling sessions are conducted five days per week in the residential program. Group counseling will be documented in the youth's case file and other agency logs or forms utilized for this purpose. Group counseling will be determined by assessing the client's current needs and issues based on available curriculum and materials provided by counselors or other employees trained in group counseling. These employees will be qualified based on specific education, degree status, training certification and/or licensure. The shift leaders and other staff may provide counseling session on the weekends or when necessary or indicated. Staff performing these serviced will be trained in-group counseling skills.

A total of 6 files were reviewed, three residential and three non-residential. All files reviewed, were well written and detailed individual meetings with the youth and families as well as the specific issues they were addressing with them. Each file included youth/family signatures, counselor signatures as well as signatures of supervisors noting that the service is being provided. Counseling services were in accordance of the developed goals listed on the service plan.

No exceptions.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.06, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on September 30, 2016 and was signed by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

The policy states that services managers can use Case Staffing Committee for cases that cannot be resolved through services provided by assigned counselor. Staff will notify all parties within five working days (this includes family, youth, guardian, school personnel and any/all providers). The notification will be sent out via certified mail to the guardian. If a guardian makes a written request for case staffing, then service manager has seven days to convene a meeting. The case staffing will be recorded.

In addition, the program works with the circuit court for judicial intervention for the youth or family, as recommended by the case staffing committee. The program's Case Manager or designee completes a review summary, prior to hearing, informing the court of the youth's behavior and compliance with court orders and providing recommendations for further dispositions.

A listing of the case staffing committee members includes a representative from the youth's school district, representative from the Department of Juvenile Justice, Court Liaison Staff, and if necessary the youth and the parent, State attorney representative, mental health and social health providers, a supervisor of the department's contract provider and any person recommended by youth, family or CINS/FINS program.

There were three non-residential files reviewed. All three of the files had a case staffing completed. The program held case staffing meetings monthly on the third Thursday of every month, unless rescheduled due to unforeseen reasons. The parents/family and the Case Staffing Committee were notified more than five days in advance. The Case Staffing Team also had more than five working days' notice. All three cases are currently under the court supervision with ordered recommendations made by assigned Circuit Court Judge.

No exceptions.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.07, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on September 30, 2016 and was signed by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

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 files reviewed were marked confidential. All 6 files are kept in a safeguarded locked room within a locked cabinet. When in transport the case managers carry a locked box marked confidential which also has the agency's name and contact information on it. All of the files were very neat with typed documents. The files are organized and were able to be located in a timely manner.

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

Standard 3: Shelter Care

Overview

Rating Narrative

Miami Bridge Homestead Shelter program provides temporary residential shelter care for male and female youth identified to be at-risk. The facility is comprised of three buildings: the main shelter building, an onsite school building and the First Stop for Families building for non-residential counseling. The shelter is currently licensed by DCF as an emergency shelter for twenty beds. The program has adequate space for all activities and is equipped with one dormitory for male youth and one for female youth. The dormitories, kitchen, restrooms and common areas were clean during the tour of the facility. Each dormitory is further differentiated into Module A and Module B which is used to classify youth based on risk factors identified during intake. Youth are assigned lockers to store their personal belongings. Beds and lockers are numbered and youth are assigned to individual beds furnished with bed coverings and pillows. Youth have access to a large yard for outdoor activities.

Staff members in the Residential Program include: Interim Shelter Supervisor/RN, Director of Admissions, 1 Residential Counselor, 2 Case Managers (1 funded by HHS), three Shift Leaders, eight Youth Activity Workers, a LPN Health Care specialist, a Food Specialist/Cook, a Recreation Specialist, and a Facilities Coordinator that is shared between the two shelters. The Direct Care workers are responsible for completing all applicable admission paperwork during intake, orientating youth to the shelter, and providing necessary supervision 24 hours per day, 7 days per week.

Health and medication related activities are the responsibility of the RN and Licensed Practical Nurse who maintain inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administer 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 Med-Station 4000.

All youth admitted to the program receive a copy of the Client Handbook and an orientation to the facility. A parent handbook is also available for the parent/guardian of the youth. The program provides individual, group and family counseling, as needed. Group sessions are conducted five times per week and include: anger management, substance abuse prevention, nutrition, life skills, and social skills. Youth also receive formal on-site education from a Miami-Dade County Public School teacher and tutorial services. The program encourages family members to visit and to take part in the development of the youth's service plan. The program utilizes a variety of local medical facilities for emergency services. Miami Bridge Homestead also admits youth from the Department of Children and Families (DCF). The shelter is designated by the Florida Network to provide Staff Secure services, Domestic Violence Respite, Probation Respite, and Domestic Minor Sex Trafficking services.

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedures, 3.01, that address all of the key elements of this indicator regarding maintaining a safe, clean and neat shelter environment. The policy was last revised on 9/30/16 and was signed by the CEO and Chief Administrative and Compliance Officer.

Policy 3.01, Shelter Environment, requires the facility to be kept clean, landscaped, and well maintained. The agency employs a Chief Operations and Technology Officer (COTO) whose responsibility include the governance of facility procedures and schedules to ensure a safe, clean, and attractive environment. Cleaning and daily maintenance of the facility is implemented through the youth activity workers along with youth who are assigned daily chores as part of their life skills training under the supervision of staff. In addition, repairs and building inspections are completed by the maintenance personnel as needed. The

maintenance staff maintains documentation of repairs in log. Per the agency's policy and procedures, weekly and monthly inspection checklists are to be conducted; however, there is no documentation of these inspections between June and November 2017. Per the COTO, quarterly walk-throughs are conducted to inspect the building to identify any safety hazards or disrepair. The inspections include verification of current health and fire inspections as well as valid inspections of the fire safety equipment. Needed repairs must be requested within 24 hours and documented on the Maintenance Request form. Completed repairs are maintained in a log accessible to staff responsible for maintenance.

During the tour of the facility, an inspection of the shelter environment was conducted. The facility appeared to be clean overall, neat, and well maintained. The agency has a policy and procedures that include a comprehensive safety and emergency disaster preparedness plan updated 5/18/16. The emergency response plan includes all forms of emergencies, special considerations for residential program, hurricane preparedness, emergency kit inventory, bomb threat, and checklists.

Documentation for the last six months of fire drills and mock drills were reviewed. The drill logs were all well documented and the agency met requirement by successfully completing fire drills on at least a monthly basis within 2 minutes for 4 of the 6 drills reviewed.

All health and fire safety inspections are current as of 11/17/17 when the Department of Health completed the last Group Care inspection and the Miami Dade Fire Rescue issued Fire Permits for all three buildings onsite effective through April 2018. There were no violations cited in these inspections. The agency has a current Department of Health Sanitation certificate issued through 9/30/2018.

A two week menu is posted in the kitchen that is approved and signed by licensed dietitian whose license is valid through 5/31/19. All fridges/freezers are equipped with thermometers and are maintained at required temperatures. All food is properly stored, marked, labeled and pantry area is clean.

Agency has a current DCF Child Care License for 20 beds, which is displayed in the facility, effective through 2/28/18.

All furnishings appear to be in good repair. The program is free of insect infestation and no findings of droppings were observed while touring the facility.

The facility's washer and dryer are operational and general lint collectors were clean upon review.

All youth dorms are in compliance with agency policy. Beds are numbered and labeled with module A or B. Linen is cleaned weekly and youth are able to wash linen upon request. The dorm bathrooms and public restrooms observed were well maintained and functional. There is adequate lighting throughout facility. Youth have lockers equipped with locks to keep personal belongings secure.

The program hires a Recreation Specialist to ensure that youth are engaged in meaningful, structured activities during wake hours. A monthly activity/recreation calendar is developed and posted in the intake office. Idle time is minimal. The daily schedule reflects at least one hour of physical activity as well as opportunities for youth to complete homework, use the computer, and access books in the facility library that have been approved by the agency. The library of books is kept next to the computer lab adjacent to the day room.

Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities are offered to youth as an alternative to youth who do not choose to participate in faith-based activities. Faith based services were documented on the calendar for November 26 and December 3rd.

All shifts are assigned a set of keys. All doors are secure, in and out access is limited to staff members, and key control is in compliance.

The facility has detailed egress plans throughout facility; client rules, grievance forms, abuse hotline info, DJJ incident Reporting number and other vital information posted in common areas such as the dormitories and counseling hallways.

During the review, the agency vehicles were observed and were secured, clean, and had working seat belts. The vans had first aid kits, fire extinguishers, current registration & insurance, a multi-task tool (able

to use as a seat belt cutter, glass breaker, flash light) and airbag deflator tool.

No exceptions.

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy 3.02 for Program Orientation. The last date reviewed and signed by the CEO was on 9/30/16. The policy is in line with Florida Network's indicator 3.02 (Program Orientation) and details the importance of orientation for new youth to the shelter within 24 hours of admission, if not immediately, upon completion of the intake.

The procedure documents that employees will be trained on how to develop rapport with youth using Positive Action techniques. Staff are expected to do a thorough review with youth of the orientation checklist, including the date and signature of the staff and the youth. The orientation includes a review of the below (not all-inclusive): agency's policy on contraband and unauthorized items; rules governing youth conduct and the disciplinary actions or consequences; dress code; access to medical, mental health and substance abuse services; visitation schedule, mail and telephone procedures; grievance procedure; disaster preparedness and emergency evacuation plans; and room and bed assignment. Once completed, staff are required to provide the youth a tour of the facility.

Three residential files were reviewed for compliance. The following areas were reviewed: providing orientation and a handbook within 24 hours; review of disciplinary action; grievance procedures; emergency/disaster procedures; contraband rules; physical/facility layout map; room assignment; suicide alert, if applicable; signature of youth with parent/guardian obtained; daily activity; and provision of the Abuse Hotline number. All areas are covered in the provider's orientation checklist for the youth as well as through their facility tour.

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 acknowledging receipt of introduction to services 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 a policy for Youth Room and Bed Assignment-Client Safety 3.03. The last date reviewed and signed by the CEO was on 9/30/16. The policy is in line with Florida Network's indicator 3.03 Youth Room Assignment. The policy details the significance of ensuring the safety of clients and staff when assigning clients sleeping arrangements.

The process includes awareness of any safety or security risks associated with the youth's placement. As such, the following items are to be documented when placing a youth in a multi-occupancy room: review of youth's history and status (delinquency and/or dependency); initial collateral contacts; initial interactions and observations of youth's behavior; separation of older from younger youth using module system (when possible); identification of youth susceptible to victimization using module system (small, young or immature); presence of medical, mental or physical disabilities using module system; potential suicide risk using module system; history of sexual aggression or predatory behavior using module system; and

potential suicide risk using module system. Alerts are to be placed in the program's medical and mental health alert system. In addition, a photograph of each youth is to be maintained for identification purposes.

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. All trained agency direct care staff that conduct intakes evaluate the youth on the aforementioned traits and circumstances (age, gender, height, weight, build, history of assault or aggressive behavior, history of mental health/substance use issues and attitude scale of 1-10) prior to documentation of the placement. The document captures the designated module (A or B) and the actual bed number assignment (1-14). 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 three had completed CINS Intake Forms with Youth Room Assignments with a comprehensive assessment of the youth's history, status, and alerts to determine classification. This form captures all required documentation for room classification. They also have a written policy on Medical and Mental Health Alerts. Two of the three files had alerts which were appropriately documented.

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

3.04 Log Books

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a policy for Log Books 3.04. The last date reviewed and signed by the CEO was on 10/31/17. The policy is in line with Florida Network's indicator 3.04, Log Books.

The procedure specifies that all entries in the log book should be brief and legible and include: date and time of the incident, event or activity; names of youth and staff involved; brief statement providing relevant information; name of the person making the entry with the date, time and signature; and errors are to be struck through with a single line and void written by the error. The use of white out is prohibited. The Shelter Supervisor or their designee must review the log book weekly, dating and signing as verification of review. The shift lead or supervisor and all direct staff are required to review the last two shifts, which is documented in the log (date, time and signature). In addition, staff must date the top of each page; document shift changes, resident care or behavioral information, and planned intakes/discharges; and highlighted or color code other critical program operational issues.

Miami Bridge requires each residential facility to maintain either a paper or electronic daily logbook to document general program operational information. Random dates in the months of July 1-24 and November 1-18 were reviewed. In line with the agency's policy and practice, staff are writing in complete sentences; including the who, what, when and where. Documentation regarding activities, significant incidents, individuals entering/leaving the shelter is evident. There is a great practice of obtaining and maintaining copies of ID's of individuals entering the facility.

Reviewer also viewed the electronic log book for random days during the review period. Electronic log books document routine daily activities, events and incidents. Electronic log book entries that could impact the security and safety of the youth and/or program are highlighted. Entries include: date and time of the incident, event or activity; names of youth and staff involved; a statement providing pertinent information; the name and signature of the person making the entry. All recording errors are struck through with a single line. The staff person initials or sign for the deleted entry. The program director or

designee reviews the facility logbooks every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date entry.

It is also noteworthy to mention the agency's P&P page 1 reads: All recording errors are struck through with a single line and void written by the error. The staff person must sign the correction. Page 3 states: Errors must be corrected by drawing a single line through the entry; void should be written by the error, and initial above the error. After speaking with the PD it was clarified that the language on page 3 is accurate. Therefore, page 1 requires a revision.

Exceptions:

Policy asks for the date to be on the top of each page. This is not occurring. However, each entry does have the date and time of the specified action/activity.

The Agency documents the retention period as three years; however, the Florida Network's Policy and Procedure Manual #4.14, Revision Date 7/1/2017, lists the retention period as seven years.

Program's Policy and Procedure (P&P) reads that staff should be reviewing the last 2 shifts and documenting their review. This is not occurring. It is important to note that this area was an exception during the last QI visit as well.

Although minimal, there are inconsistencies with staff striking through errors, writing void, and initialing. Some errors are struck through and initialed (void not written), and some are struck through, void written and staff initials are documented. There are also some errors that did not follow policy and instead were consistently written over.

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy 3.05 for Behavior Management Strategies and Intervention. The last date reviewed and signed by the CEO was on 10/31/17. The policy is in line with Florida Network's indicator 3.05. The agency's policy requires a detailed written description of the behavioral management strategies includes: a wide variety of rewards, appropriate consequences and sanctions, application of consequences immediately and consistently that matched the level of the severity of the behavior, and ensures that rewards outnumber consequences. Consequences are to be applied logically and consistently.

The program uses a variety of rewards/incentives to encourage participation and completion of the program. Rewards are to be administered fairly and consistently. The agency utilizes the Florida Network Managing Aggressive Behavior training curriculum and all staff is trained in the practice of administering appropriate consequences and rewards. There is a protocol for providing feedback to staff regarding their use of positive and negative consequences. Supervisors are trained to monitor the use of rewards and consequences. Staff performance evaluations include an evaluation of this skill.

The agency utilizes a Behavior Management System (BMS) that is based on rewards, privileges, consequences that encourage positive behavior, discourage negative behavior, and sets clear behavioral expectations. The BMS is administered by Youth Activity Workers (YAW) under the supervision of the Shift Leaders and Shelter Supervisor. As a result of directly observing youth's behavior during their shift, YAW will document and report on the youth's behavior through the BMS. The BMS consists of a point and level system that rewards positive behavior by increasing privileges and incentives (positive reinforcement) and provides consequences for negative behavior (negative reinforcement).

Information about the BMS was observed to be present in the client hand book and is also reviewed with the youth at intake. The process requires the youth's signature as acknowledgement. The interim Shelter Supervisor described the point system and how points are tracked for each youth in a binder. Youth are able to use points earned at the agency's point store. The agency also has ties in the community to

various vendors who supply items for the youth, example Nike. Youth are also recognized by their teachers and/or other youth. Weekly, teachers are asked to rate the youth in the following categories: best helper, most improved, most initiative, most respectful, most school participation, leader, therapeutic improvement, and group discussion participation. Youth are recognized in front of their peers and are given a certificate.

Privileges are lost for non-adherence to rules and regulations. Consequences include not attending an outing, non-use of the computer tech lab, or not being able to select the movie watched on movie night.

No exceptions found.

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy 3.06 for Staffing and Youth Supervision. The last date reviewed and signed by the CEO was on 9/30/16. The policy is in line with Florida Network's indicator, 3.06. The agency also has policy 3.06.01, One on One (1:1) Staff/Client Supervision to ensure there is a 1:1 staff to client ratio that will provide a higher level of supervision.

The agency's procedures state that at all times they will have an adequate staff to client ratio that provides consistent supervision of clients to ensure a safe and secure environment. To do this the following will be maintained: 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during the sleep period. There is always at least one staff on duty of the same gender as the youth. If a program accepts both males and females, there should always be both a male and a female staff present, including the overnight or sleep period. Overnight shifts must always provide a minimum of two staff present. The staff schedule is provided to staff or posted in a place visible to staff. There is an on call or overtime rotation roster which includes the home telephone numbers of staff who may be accessed when additional coverage is needed. All room checks are documented in the log book in real time.

Staff observe youth every 15 minutes while they are sleeping in their room, or when sick. Youth on suicide watch are placed on Constant Sight and Sound until clinically assessed and formally removed.

In practice, the agency implements a staff schedule that provides adequate supervision of clients and ensures the safety and security of all youth and staff. The schedule includes a system that considers staff training requirements, regular days off, holidays, vacation and sick leave, diversity issues, budgetary issues, and other service delivery issues.

Each shelter has at least one Youth Activity Worker (YAW) on duty for every six clients in the shelter during wake hours. One YAW is on duty for every twelve youth during hours of sleep. During the sleep hours, one YAW of the same gender will be assigned and stationed at each of the dormitories to provide adequate supervision and conduct bed checks. Dormitories will be locked during the day. Youth will not be allowed access to the dormitories without adequate supervision.

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 20 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 when 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 found.

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

Miami Bridge has a written policy and procedure 3.07 in place signed by the CEO and the Chief Administrative and Compliance Officer to serve special populations. These include staff secure, domestic minor sex trafficking youth, probation respite, and domestic violence respite youth. The intent of these services is to prevent and or reduce the incidents that create /contribute to more at risk behaviors. The policy states these special populations have clearly defined procedures to be followed by staff.

The policy states these youth will be served at a higher level of supervision with assigned staff to monitor all movement. 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.

Youth served as staff secure must have been formally court ordered into staff secure and specific criteria for placement. Probation and Domestic Violence Respite youth have pending or adjudication withheld charges and must have been screened by the DJJ Probation/JAC but not eligible for secure detention. Length of stay does not exceed 14 days for DV youth and up to 30 days for Probation Respite youth.

The procedures for staff secure youth includes specific staff identified to provide the one on one service for each shift as dictated by the standard and will need to be documented in the log book. The procedures also outline any court service (reports) that may be needed.

Domestic Violence Respite and sex trafficked youth require more enhanced services to encourage remaining in the shelter. Domestic Violence youth need prior approval for placement and services reflect the issues youth is experiencing. The procedures also outline the transition to CINS status within 14 days.

During the review period, there were no youth placed in the program for Staff Secure, Probation Respite, or for Domestic Minor Sex Trafficking status. Two youth were placed for Domestic Violence Respite. Procedures are complied with and reflected in the notes in youth files. The services reflected the need to address anger management, improved communication and family sessions. Discharge planning reflected appropriate services in place. The files contained a clearly visible form reflecting the change of status for the youth from Domestic Violence Respite to CINS services.

No exceptions noted.

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy 3.08 for Video Surveillance. The last date reviewed and signed by the CEO was on 9/30/16.

The agency's policy and procedures requires that the system be able to capture and retain video

photographic images which must be stored for a minimum of 30 days. The system records date, time, and location and maintains resolution that enables facial recognition. The locations of the cameras placed in interior and exteriors (general locations of the shelter where youth and staff congregate and where visitors enter and exit). Only designated staff will review the program.

Cameras are never placed in bathrooms or sleeping quarters. Video surveillance system is only accessible to designated personnel (Chief and Deputy CEO's, Chief Operations and Technology Officer, Chief Compliance Officer, QI Coordinator, Clinical Directors, Shelters Directors/Coordinators). The policy requires overnight bed check logs to be reviewed weekly by the shelter director and the QI Coordinator against footage from the video surveillance system and entered into agency log book, per DJJ QI expectation.

During the tour of the facility, Reviewer observed all cameras to be visible to persons in the area (no covert cameras) and a written notice is conspicuously posted on the premises for the purpose of security. All cameras are easily visible both internally and externally. The Miami Bridge camera system is new and consists of 32 cameras, 16 inside the facility and 16 outside. 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. The camera system can be viewed off-site and is limited to the viewing by 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.

No exceptions.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

MB Homestead has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate Room Module assignment, Module A or Module B, given the youth's needs and issues, the current population at the facility, physical space available, and staff's assessment of the youth's ability to function effectively within program rules and expectations.

Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Director and Shelter Supervisor are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color coding system. Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The provider has a RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility. Medications are stored in the Pyxis Medication Unit; 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 ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

The program's health services are very organized and well documented. Additionally, the program received an award from the Florida Network for medication management excellence on October 31, 2017 for not having any medication errors in 2016-2017.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintained policy and procedure number 4.01 to address health services. The policy was last reviewed and revised on 9/30/16 and last approved on 9/30/2016.

At initial intake the residential nurse, if available, or residential staff will complete the intake form using information obtained from the youth, parent/guardian, the placing agency case manager and other interested parties. The completed intake form is to be reviewed by the residential nurse, if available, or if unavailable the assigned residential staff. Youth are to receive preliminary physical and mental health screening at shelter admission. The preliminary physical health screening is to include current and past medications, allergies, existing medical conditions, report or evidence of recent injuries or illnesses, presence of pain or signs of physical distress, observation for evidence of illness, injury, physical distress or mobility issues, as well as presence of scars, tattoos, or other skin markings. Youth admitted with ongoing medical care needs due to chronic conditions will receive ongoing medical care. Follow up is required for any youth with asthma, recent head injuries, hemophilia, seizure cardiac disorders or blackouts, tuberculosis, diabetes, or pregnancy. Additionally other identified conditions may result in ongoing medical care. Staff are to document and highlight needed medical referrals in the log book and the youth appointment book. Weekly review of the log book is to be conducted by the residential coordinator

to ensure youth medical information is entered and highlighted, and any omission is to be entered via a corrected log entry.

The program performs a preliminary physical health screening for each youth at the time of admission to the shelter. The agency nurse or direct care staff conducts the screening dependent upon who is available at the time of the youth's intake. The preliminary screening addresses current medications, existing acute and chronic medical conditions, allergies, recent illnesses or injuries, the existence of current pain or other physical distress, observations for evidence of illness, injury or physical distress the presence of scars, tattoos or other skin markings.

Three youth records were reviewed and each contained a completed preliminary healthcare screening which identified each youth's healthcare concerns. Each youth admitted to the shelter received a health screening completed by the shelter nurse or direct care staff. The program's health screening form addresses chronic medical conditions inclusive of diabetes, pregnancy, seizure disorders, cardiac disorders, asthma, tuberculosis, hemophilia and recent head injuries as well as high blood pressure; chronic pain, cough or headaches; eating disorders; gynecological, vision, hearing, kidney, skin, and digestive problems. Documentation evidenced youth on current medications, with allergies, with existing medical conditions and observed with a tattoo. No youth in the program during the review period had any chronic conditions requiring follow-up medical care. However, the program nurse was able to state the program's procedure for referring youth for follow up medical care for chronic conditions.

No exceptions noted at the time of the visit.

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintained policy and procedure number 4.02 to address suicide assessment and precautions. The policy was last revised on 9/30/16, and last approved by the program's CEO and Chief Administrative & Compliance Officer on 9/30/2016.

The program's policy references the Florida Network's standardized, statewide Suicide Risk Response Protocol, as the basis for the program's suicide response policies to address elements of suicide assessment, precautions and prevention. The suicide risk screening is to be completed as part of the intake process with additional assessment as warranted. The assessment of suicide risk is to be conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the supervision of a licensed mental health professional. Youth in shelter awaiting an assessment are to be placed on constant sight and sound supervision. All observations of any youth on heightened supervision are to be documented in the program's observation log. The program's referral system for youth at high risk of suicide includes law enforcement or licensed professionals (Banyan Health) qualified for Baker Act screening related to suicide prevention/response.

A total of three residential records were reviewed. All three applicable youth were screened for suicide risk during the initial intake and screening process and were placed on sight-and-sound supervision until assessed by a licensed professional or a non-licensed professional under the supervision of a licensed professional. Documentation evidenced the three youth were placed on the appropriate level of supervision based upon the results of the suicide risk assessment. Staff documented the applicable youth's behavior more frequently than every 30 minutes on the precautionary observation log sheets.

Exception:

The program's policy and procedure continues to differ from the requirements of the Florida Network (on page 3 of 4.02 under Assessment of Suicide Risk: Residential) in that screenings of suicide risk occurring over the weekend (after 5:00 p.m. Friday through 9:00 a.m. Monday) may have the assessment of suicide

risk completed within seventy-two hours, rather than requiring those assessments to be completed on the morning of the first business day as required by the Florida Network.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintained policy and procedure number 4.03 to address medication administration and storage. The policy was last reviewed on 9/30/16 and last approved by the program's CEO and Chief Administrative & Compliance Officer on 9/30/2016.The program maintained policy and procedure number 4.03 to address medication administration and storage. The policy was last reviewed on 9/30/16 and last approved by the program's CEO and Chief Administrative & Compliance Officer on 9/30/2016.

The program's written procedure requires the program to:

· Store all medications, including narcotics and controlled medications, in the Pyxis med-station which should be inaccessible to youth.

· Maintain at least two site-specific super users for the med-station

· Have the licensed healthcare staff conduct medication pass when on duty

· Perpetually inventory controlled substances via witnessed shift-to-shift counts.

· Verify and document the verification of prescription medication via telephone contact with the pharmacy.

· Allow only staff delineated with user permissions to have access to secured medication and allow only limited access to controlled substances.

· Secure syringes and sharps and document weekly inventory counts of same.

· Conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports.

All medications, including controlled mediations, were stored within the Pyxis med-station and the med station is stored in the locked medical office which is inaccessible to youth. The agency verifies youth medications via telephone contact with the pharmacy inclusive of the name of the pharmacist with whom the verification was conducted. The program has two super users for the med-station consisting of the nurse and a direct care staff. Only eighteen staff designated with user permissions have access to the Pyxis med-station and limited access to controlled substances is maintained via a required electronic staff witness log in to the station. Oral medications are stored separately from both injectable and topical medications. The program maintains a secured refrigerator which is used only for the storage of medication. The program maintains a thermometer in the refrigerator to ensure adherence with storage temperature requirements and the refrigerator has a built in lock.

When on duty, the nurse conducts medication pass. Controlled substances are perpetually inventoried as well as documented via witnessed shift-to-shift inventory counts. A perpetual inventory is maintained for OTC medication in both the Pyxis med-station and via a hand written log. OTC medications are inventoried weekly by the nurse. Sharps are secured and documentation of weekly inventories is maintained. The program does not maintain any syringes on-site. The Individual Client Medication Distribution Log form is used to document distribution of medication by all staff to each youth. Monthly medication management practice reviews are conducted by the program via the knowledge portal or med-station reports as required by network policy and the printed reports are maintained in a binder for the calendar year.

No exceptions.

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintained policy and procedure number 4.04 to address the programs medical and mental health alert process. The policy was last revised on 9/30/2016, and last approved on 9/30/2016.

Information concerning a youth's medical condition, physical activity restriction, allergies, common side effects of prescribed medications, food and medication contraindication are to be effectively communicated to all staff through an alert system. The system is to include precautions concerning prescribed medication and medical/mental health conditions. Staff are to be trained on how to recognize and respond to emergency care and treatment as a result of identified medical or mental health problems. Suicide risk alerts are to be utilized to inform staff of needs which may require emergency care, assessment and treatment.

The program maintained a binder of the Daily Youth Alert sheets from each day as a reference of alerts active for each youth on each date of their stay in the shelter. Observation and an interview with the nurse indicated staff are informed of youth alerts via a wall-mounted board in the intake office which confidentially identifies each youth through the use of a color-coded dot system. Additionally, alert information is posted in the staff communication binder for each staff to review. Each staff initials their assigned box at the bottom of each communication page to document their review and understanding of the information contained on the page.

Three applicable records were reviewed and found to have medical/mental health conditions, dietary alerts, and/or history of victimization noted within their records. All three youth were correctly placed on the program's alert system, which identified all precautions concerning allergies and special dietary restrictions, substance abuse, histories of sexual assault victimization, and medical/mental health conditions through a color-coded dot system. Additionally, staff are provided information and instructions through emails sent by the nurse/center director as communication reinforcement for staff to recognize/respond to youth issues. Medication distribution records include all medication side effects, precautions and allergies.

No exceptions noted.

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintained policy and procedure number 4.05 to address episodic and emergency care. The policy was last reviewed on 9/30/16 and last approved by the program's CEO and Chief Administrative & Compliance Officer on 9/30/2016. The program's written emergency procedures manual, which also addresses health emergencies, was last reviewed and approved by the program's CEO and Chief Administrative & Compliance Officer on 10/30/2016.

The program's written procedure for emergency medical care requires the program to obtain off-site emergency services for youth in need of urgent medical or dental care. The program's written emergency procedures manual includes procedures for medical emergencies, established formal interagency agreements with Jackson Memorial Hospital and the transportation of persons served for the program to obtain off-site emergency services for youth in need of urgent medical care. Youth may be transported for off-site care via emergency transport accessing Miami-Dade County Emergency Medical Services.

All direct care staff are to be trained in CPR, first aid, utilization of the knife for life, and AED. Notification of the need for medical attention is to be made to the youth's parent/guardian by the nurse or shift leader/supervisor. Documentation is to be maintained of the details of each crisis, emergency or off-site

care as well as all staff responses and responses to each situation. Notification of the need for medical attention is not specifically addressed in the program's health emergency procedures; however, all off-site medical care is documented by an incident report and the incident reporting procedures include parental notification within that procedure for to be made to the youth's parent/guardian as soon as possible. The program's policy outlines incident reporting requirements, which requires incidents meeting the criteria of DJJ reportable critical incidents to be reported to the Central Communications Center within two hours.

The program had only one instance of emergency/off-site care during the review period of youth requiring off-site urgent medical care; therefore, the one additional incident occurring since the last annual QA review was reviewed in order to increase the sample size for this indicator. It is the program's practice to complete an incident report for any incident requiring off-site care although that is not specifically required by the program's written policy. Incident reports were completed and maintained for each of the two reviewed records.

Additionally, the program attached a photocopy of the related facility logbook page to each incident report to evidence the program's documentation of the episodic/emergency care in the logbook. Notification of the need for medical attention was made to the youth's parent/guardian in both instances of off-site care. The program maintained a log to document all off-site care, which included the date and time of the parent/guardian notification. Reviewed documentation revealed all direct care staff completed the required training in CPR, first aid, utilization of the knife for life, and AED. An inspection of the automated external defibrillator (AED) revealed the battery installed in the AED had an expiration date of April 30, 2024. The AED electrode pads were maintained in a sealed pouch within a built-in storage compartment on the AED, and the pouch is only opened should the AED actually be used. The electrode pads had an expiration date of March 31, 2019. The program's registered nurse powered on the AED during the review demonstrating it was functional.

No exceptions noted.