Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge – Homestead, Florida
Residential Program

November 6-7, 2019

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

Miami Bridge Homestead– November 6-7, 2019
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Limited
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: 85.71%
Percent of indicators rated Limited: 14.29%
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 & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/ Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	N/A

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

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 92.86%
Percent of indicators rated Limited: 7.14%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Paula Friedrich – Regional QI Monitor, Department of Juvenile Justice

Shelia Dixon- Clinical Director, Lutheran Services Florida Southwest

Hilda Reyes – Clinical Supervisor, Children's Home Society Osceola

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

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Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

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

Documents Reviewed

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

Surveys

- **3** # Youth
- **3** # Direct Care Staff
- **0** # Other: ____

Observations During Review

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

Comments

Additional Comments regarding observations, other important findings of interest, etc.

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, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). 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.

Since the last Quality Improvement visit in November 2018 Miami Bridge has implemented new programs and has continued to enhance services to youth and families as follows:

Facilities:

- ML20 Leadership organization donated over $30,000 to replace all the mattresses with new superb quality Tuft and Needle mattresses spent a day of service at the shelter and paint murals “strength and joy theme” in each dormitory
- Renovated volleyball area
- Installation of new tetherball/punching bag; lessons taught by experience youth
- New roof in First Stop for Families (FSFF)
- FIU renovation and planting of fruit trees (mango, limes, and oranges)
- LED lighting installed to the exterior for added safety

Programming

- Miami Bridge successfully completed the first year of its Nurturing Parenting Program (funded by the Children's Trust). The grant serves 60-80 families/year through 12-week cohorts who participate 3 hours/week. Last year a total of 72 families were served
- MB received $50k grant to hire full time specialist to work with the LGBTQ youth and families who will provide groups in home and offsite to educate families and prevent out of home placements
- Youth and families had their second annual overnight trip during the summer to Orlando, FL, by way of Batchelor Foundation Grant and donations in kind
- Batchelor Foundation and Miami Foundation provided funds for youth to have a summer program
- New science, technology, engineering, and math (STEM) equipment consisting of 2 virtual reality machines to support the education of youth
- Project young a Florida International University/Pepsi program conducts groups twice a week with topics such as nutrition, self-preservation, and fitness.
- Equestrian therapy

General

The agency continues to reach out to the community by hosting multiple events throughout the year and has earned success with the following events held during the current FY:

- Annual Gala - April 2019, more than 600 guests attended Miami Bridge's Poseidon's Night Gala to celebrate its mission of providing lifesaving services to local youth and families in Miami-Dade County.
- Physicians Fishing Tournament Florida Keys – July 2019
- Annual Luncheon - October 2019

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, Director of Finance, Chief Programing Officer, Chief Operations Officer, Chief Administrative/Compliance Officer, Director of Admissions, Director of Shelter Services, Director of Community Based Services, and 2 Shelter Supervisors, one of which is also the Registered Nurse. The Chief Executive Director oversees the Miami Bridge agency and the services provided in Central Miami and Homestead, Florida. The Director of Shelter Services, intended for a licensed professional who oversees the clinical component for both shelters, was vacant during the visit. Other vacant positions included a book keeper and 2 part time YCS.

MB Central office handles all fiscal, administrative, and personnel functions for both locations. The Central location has offices for all the Administrators; however, the CEO and other agency-wide administrative staff split their time at both locations and visit the Homestead program regularly. The HR specialist processes all state and local background screenings and human resource functions.

The program experienced significant turnover in several positions since the last onsite review and reported a total of 18 staff members resigned since last audit. Some of the key positions involved in the turnover include the following:

- HR Generalist resigned January 2019
- CFO/Deputy CEO resigned in May 2019
- Finance Manager resigned in June 2019
- Chief Program Officer resigned in June 2019 but decided to stay on until year end
- Recreational Coordinator/Administrator resigned July 2019, but returned as weekend YCC
- LCSW - Clinical Director of Residential Services, both Miami and Homestead resigned August 2019
- Chief Administration and Compliance resigned in September 2019

Miami Bridge has a Performance Quality Improvement (PQI) plan that describes the structure and protocols involved in the monitoring, evaluation, and improvement of its processes and outcomes. 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. To support PQI processes, the organization will analyze data in relation to the following:

• 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 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 program has not reported any major incidents since the last QI visit but indicated a management review was conducted by the Florida Network earlier in the year. One of the indicators in standard 1 was rated limited and two were rated satisfactory with exceptions. The indicator rated as limited is 1.01, Background Screening due to having an exception for 5-yr rescreening for two consecutive years and hiring an employee that did not meet the provider’s pass rate criteria for employability on the Berke assessment.

The two indicators rated as satisfactory with exceptions include:

- 1.04, Training: two first year staff did not complete two mandatory trainings (one each) required during first 120 days of hire and two in-service staff did not complete the annual DJJ Skill Suicide Prevention training. Additionally, one in-service staff was not on target for completing annual/biannual training.
- 1.05, Data Analysis and Reporting: the provider has not conducted a peer record review for the 4th quarter 2018-2019 and 1st quarter 2019-2020

The remaining indicators were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Miami Bridge Youth and Family Services is contracted to provide both shelter and nonresidential services for youth and their families in Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week for youth who meet the criteria for CINS/FINS, Staff Secure, DV and Probation Respite, DMST, and FYRAC. 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. For the Homestead location, a total of three non-residential counselors and two residential counselors are responsible for providing counseling and case management services and linking youth and families to various community services.

The agency completed a full year of utilizing Lauris, an online automated case management and counseling system, for the residential and non-residential CINS/FINS program. This system was launched 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. There has been significant progress in made to customize the system as well as integrate closed files subsequent to the launch.

All but one indicator in standard two was rated satisfactory without exception. Indicator 2.09, Special Populations, had an exception due to one of the 2 applicable DV files reviewed not having a case plan developed and/or evident in the electronic medical record (EMR) during the youth's stay for 26 days.

Standard 3: Shelter Care

Overview

Rating Narrative

Miami Bridge South is licensed by the Department of Children and Families (DCF) for twenty (20) beds and primarily serves youth from Homestead and the surrounding areas of south Miami Dade County. The shelter building includes a large day room, girls' and boys' sleeping rooms, dining room, kitchen, laundry, staff offices and a conference room. During the Quality Improvement review, the shelter was found to be in good condition, the furnishings in good repair, and the rooms and common areas were clean. The bedrooms are separated into two separate areas, one for the boys and one for the girls. There are 2 large bathrooms, one on each dorm wing. Each bathroom consists of three sinks, three showers and three toilets. The bathroom floors are tiled and the plumbing appeared functional. The sleeping rooms house ten (10) youth each. The sleeping room is equipped with bunk beds and each youth has a locker, individual bed, bed coverings and pillows. Youth have access to a computer lab equipped with updated computers, recreational games, a volley ball court and basketball.

Staff members in the residential program include: a shelter supervisor/RN, 2 counselors, 8 fulltime and 5 relief youth care coordinators, a health care specialist, a recreation specialist, and a food specialist/cook. The provider also employs a maintenance person who is responsible for facility repairs and maintenance for both the central and south Miami program facilities. The youth care coordinators are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. During the current review period, the agency utilized the manual logbook but transitioned over to the electronic logbook in October 2019.

Miami Bridge utilizes a Behavior Management System (BMS) that is based on a system of rewards, privileges, and consequences. The system encourages positive behavior and discourages negative behavior.

For standard 3, the provider received a limited rating for indicator 3.07, Video Surveillance and a satisfactory rating with exceptions for indicators 3.01 (Shelter Environment), 3.04 (Logbooks), and 3.05 (Behavior Management Strategies).

Indicator 3.07 was cited as limited as a result of multiple cameras (12 out of 36) not working due to a reported power supply failure as well as discovery of bed checks documented in the log book that were not verified while reviewing the video footage,

which resulted in CCC being contacted during the onsite review and the report was accepted.

The finding of exceptions for the following indicators is as follows:

- Indicator 3.01 exceptions are due to missing quarterly mock emergency drills on the first and third shifts as well as observation unsecured chemicals in the laundry room for which there were not material safety Data Sheets.
- Indicator 3.04 was found to have errors recorded in the logbooks where the corrections were not consistently struck through with a single line or initialed by the staff with the date and several instances of overwriting.
- Indicator 3.05 exceptions are due to inconsistent details of the behavior management system in the handbook that differs from the number of points actually in used at the program and interviews with 3 youth who were unaware of how many points they needed to earn to “make” their day how many points they had earned so far in the week.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

The residential counseling services in the shelter are overseen by a licensed clinical director; however, this position was vacant during the visit and was temporarily being conducted by the CEO who is a LCSW. Trained direct care staff completes screening and CINS/FINS Intake assessment. All case management and/or counseling staff are trained on the suicide risk screening process and utilize the CINS Intake form to initially screen for potential risks prior to placing all youth on sight and sound supervision status.

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. 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. An initial assessment occurs to determine the most appropriate room and module assignment, Module A or Module B, given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Room assignment is documented on the CINS/FINS Intake Assessment page 2. Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Director and Residential Coordinator are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The agency is storing all prescribed medications in the Pyxis Med-Station 4000 cabinet and has several staff members as regular users and more than 2 Super Users. The provider has a RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility including: oversight of the general practice of distributing medication to residents in the shelter; oversight of medication inventory and storage practices; training of all staff authorized to distribute medication; and completion of health screenings and medical follow ups on an as needed basis. Topical and injectable medications are stored separately from oral medication in the Pyxis Med Station. 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.

All indicators in standard four were rated satisfactory with no exceptions.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) Policy and procedure 1.01 addresses the background screening of all employees, volunteers, and interns prior to any offer of employment or volunteer service. The policy was last revised 10/24/19 by the CEO and Chief Program Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	A total of eight (8) applicable personnel files were reviewed for five (5) new staff (one re-hired as a consultant), one (1) staff eligible for 5-year re-screening, and two (2) interns. Four of the five new hire files maintained evidence of eligible screening results obtained prior to hire. The original background screening for the re-hired consultant dated 9/22/15 is still valid as separation from the agency was only 3 days from 8/2–8/5/2019. The primary role of the consultant is to supervise the college interns; however, it was observed that a signed contract/agreement for services has not yet been executed. E-verify for the four eligible new employees were reviewed confirming the employees' work eligibility. The program has two interns providing service during the review period. The provider has evidence of eligible screening results obtained prior to the interns' start dates. One staff met the criteria for 5-year re-screening during the review period; the 5-year re-screening was due by 5/14/2019 but was not yet completed by DJJ as of the date of the onsite visit. Per the HR	**Exception-Limited rating** One staff met the criteria for 5-year re-screening during the review period; the 5-year re-screening was due by 5/14/2019 but was not yet completed by DJJ as of the date of the onsite visit. Per the HR Specialist, the agency submitted the 5-year re-screening request on 1/31/2019 but it was not processed due in part to a pending follow-up request by the background screening unit and turnover in the agency's HR position. The information requested was submitted by HR to DJJ on 11/5/2019. All three applicable new hires completed the Berke Assessment; however, one of the staff received a "low" rating which does not meet the provider's pass rate criteria for employability.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Specialist, the agency submitted the 5-year re-screening request on 1/31/2019 but it was not processed due to a pending follow-up required by the agency due in part to a turnover in the HR position. The information requested was submitted by HR on 11/5/2019. The most recent submission of the Annual Affidavit of Compliance with Level 2 Screening Standards was sent via email to DJJ BSU on 1/14/2019 prior to the January 31st deadline.	As a result of the findings of this indicator in addition to not fully addressing the repetitive issue of completing 5-year re-screenings on time, as similarly cited during last year's QI review, this indicator is rated a limited compliance.
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) Policy and procedure 1.02-Provision of an Abuse Free Environment and 1.02.01 Grievance Process address the abuse free environment requirement of indicator 1.02. The policies were last revised and signed by the CEO and CPO on 7/01/18.	No exceptions
RATING	☒	☐	☐	☐	☐	The provider's policy and procedure for Provision of an Abuse Free Environment is that "Miami Bridge strives to provide a safe, therapeutic environment in which you feel safe and secure" for all youths especially the ones who allege abuse and/or have been victims of physical, sexual, or emotional mental abuse, neglect or abandonment. The staff working at Miami Bridge must create a safe environment for youth and be prepared to immediately respond to these issues and become familiar with the signs of abuse and the legal implications and reporting requirements. The reviewer found evidence indicating that the program has a code of conduct that prohibits the use of physical abuse, profanity, threats, or intimidation. The reviewer also verified there is a signage that reflects that all youth are accepted regardless of sexual orientation, gender identity, or gender expression. Postings of the Florida Abuse Hotline were observed throughout the facility. The program has a process in place for documenting child abuse hotline calls, as observed by this reviewer.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable		
						Reviewer observed that the program provides accessible and responsive grievance process for youth to provide feedback and address complaints. Evidence of this was found in the HMSTD Grievances Binder through observation and examination of reports made by youth. The facility has a couple of locked grievance boxes available to youth in a common area. Documents reviewed demonstrated direct care workers do not handle the complaints/grievance documents. There is documentation that grievance is resolved within 72 hours by management and that when the issue was not resolved, there was documentation explaining the reason. The program maintains grievances on file for a minimum of 1 year. There were 3 youth surveys reviewed for 1.02, with 12 items specifically targeting the indicator. None of the youth reported needing to contact the abuse hotline or being stopped from calling the abuse hotline. All of the youth indicated adults showed respect and feeling safe at Miami Bridge.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) Policy and procedure 1.03 addresses the requirement of incident reporting. The policies were last revised and signed by the CEO and Chief Administrative and Compliance Officer (CACO) on 7/01/18.	No exceptions
RATING	☐	☒	☐	☐	☐	Seven (7) CCC reports between May 1st and November 5, 2019 were reviewed. The breakdown of the reports is as follows: • Absconding (2) • Program Closure (1) • Medical Incident/Youth Injury (2) • Contraband (2) All 7 incidents were documented in the program log and on the incident reporting forms. All of the reports had follow-up communication and	**Exception** One of the 7 CCC reportable incidents dated 11/1/2019 related to youth injury and transport offsite for medical treatment was reported outside the 2-hour notification timeframe.

Quality Improvement Indicators	Rating: Explain — Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: Interview/Surveys, Observation, and/or Type of Documentation — Summarize Findings Based on Completed Worksheets	Notes — Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						were signed by program administrators. Six of the 7 incidents were reported within the required 2-hour required notification timeframe. This reviewer saw evidence that the program completes follow up communication tasks/special instructions as required by CCC in the Incident Log CCC Reports Binder and incidents are documented in the program logs. Also, incident reports are reviewed and signed by program supervisor/directors.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) Policy and procedure #1.04 addresses the requirement of training. The policy was revised on 7/1/18 and signed by CEO and CACO on 7/1/18.	No exceptions
RATING	☐	☒	☐	☐	☐	A total of 6 employee training files were reviewed for three 1st year direct care staff and three in-service direct care staff. Each staff has an individual training file that includes a training plan/log and supporting documentation. Training is maintained annually based on the individual's date of hire. All 3 of the 1st year direct care staff have completed the minimum 80 hours required and all 3 in-service direct care staff have completed a minimum of 40 hours of training during their recently completed training year. The reviewer found that after the first 120 days of employment, only one of the 3 employees completed all of the required training.	**Exceptions** **2 Trainings not completed within 120 days** Two new staff were missing mandatory trainings required within 120 days: • One staff did not complete the Signs and Symptoms of Mental Health and Substance Abuse training • Other staff did not complete the DJJ Skill Pro Training for Suicide Prevention Parts 1 and Part 2. **Trainings to be completed before end of training year 11/19/2019:** One staff DOH 11/19/18 has a couple weeks remaining in the current training year and has a few mandatory trainings to complete before end of training year

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
							11/19/2019: Fire Safety Equipment, Serving LGBTQ, DJJ Skill Pro Information Security Awareness, DJJ Skill Pro Equal Employment Opportunity, DJJ Skill Pro Sexual Harassment, DJJ Skill Pro Suicide Prevention Part 1 and Part 2, and DJJ Skill Pro Human Trafficking 101. Note: This last training was completed on 5/24/18 through DCF. **In-service staff missing SkillPro trainings:** Two in-service staff were also missing SkillPro trainings: • One has not completed the mandatory DJJ Skill Pro training Suicide Prevention Parts 1 and Part 2. • One has not completed DJJ Skill Pro mandatory training Suicide Prevention Part 2.
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) Policy and procedures 1.05 addresses the requirement of the indicator. The policy was last reviewed on 7/1/18 and was approved on 7/01/18 by the CEO and CACO.	No exceptions
RATING	☐	☒	☐	☐	☐	Peer 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	**Exception** As of the date of the QI visit, the provider has not conducted a peer record review for the 4th quarter 2018-2019 and 1st quarter 2019-2020.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						quarter in each of the programs. Case record reviews for Q3 and Q4, for the period October 2018-March 2019, was completed on June 20, 2019. A total of 130 cases 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. Incident/Accident/Grievance 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. The Risk Prevention Subcommittee meets monthly (except when quarterly meetings are held) to review incidents, accidents, and grievances. 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. A review of meetings held for the past 6 months was conducted and were found to be held April, July, two in August, and September 2019. 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. The client and employee satisfaction surveys are completed annually and discussed at the quarterly CQI meeting. Client satisfaction data is retrieved from the Netmis and the employee satisfaction surveys are distributed and compiled by the program. The most recent satisfaction surveys completed for the current FY 2018-2019 was completed with	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						226 youth respondents. No employee surveys have been distributed since the last QI visit. 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. Florida Network Report cards are emailed to the management teams and are discussed during the management morning calls held daily and at the quarterly CQI meetings. 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 June and August 2019. 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. Evidence of strengths, weaknesses, improvements: 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	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						suggestions will be discussed and documented in the PQI report and submitted quarterly. Last meeting addressing audit findings was conducted in August 2019. Netmis data reports are presented at the CQI quarterly meetings. Meeting minutes from the last CQI quarterly meetings specifically reflect discussion on Netmis data. Staff and management meetings held in 2019 for April (training), May, June (luncheon), July, and August during the QI period provided minutes for each meeting that incorporates findings reviewed at the quarterly CQI meetings. The QI Coordinator and/or Chief Compliance Officer participate in the staff meetings to share information related to CQI and program monitoring.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) **Indicate policy number, authorized signee, date(s) of last review/revision/approval, and exceptions in notes.** Policy and procedure 1.06 addresses the requirement of client transportation. The policy was approved and signed by the Chief CEO and Chief Facilities and Construction Officer on July 1, 2018.	No exceptions
RATING	☒	☐	☐	☐	☐	MBC maintains a list of approved drivers with valid Florida Driver's licenses and who are covered under the agency's insurance policy. Also, all third-party participants must be approved. There is not one reporting tool that captures all the information specified in the indicator. The agency uses a Department of Transportation application and log that maintains mileage, but does not document all of the other information required by the indicator. The electronic log does not record the mileage of each youth transport.	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						Reviewer observed that the agency has Transportation Logbooks and that their transports are recorded every time a youth is transported. The transports are written in different colors - color coded, depending on the type of transport. The agency has implemented a transportation policy that prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip. Reviewer was assisted by a few agency staff members in searching the Transportation Logbook for any one on one transport (one staff, one youth) and was not able to find one within the past 6 months. This reporter was informed that since the agency's last audit they have been very conscious about not doing this. Reviewer was able to verify this in the electronic van transportation spreadsheet. Reviewer was informed by various agency staff that volunteers do not transport. The agency's transportation policy includes exceptions in the event that a Third party is NOT present in the vehicle while transporting. Evidence showed through observation of written policy, that staff transportation of youth must be specific to gender when one youth is to be transported.	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) **Indicate policy number, authorized signee, date(s) of last review/revision/approval, and exceptions in notes.** Policy and procedure 1.07 addresses all key elements of the indicator for outreach services and interagency agreements. The policy was reviewed and approved on 7/1/18 and was signed by the CEO and CACO.	No exceptions
RATING	☒	☐	☐	☐	☐	The Program participates in local DJJ Board and Council Meetings to ensure CINS/FINS services are represented in a coordinated approach	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						to increase public safety by reducing juvenile delinquency though effective prevention, intervention and treatment services. Targeted outreach services increase public awareness of services available, enhance the referral process, enable collaboration and partnerships and improve access to services for community members. The Chief Program Officer is designated to attend the DJJ Board and Council Meetings. Evidence showed that in the last 6 months, 3 DJJ Board and Council Meetings took place and the CPO attended during the months of May, July, and September 2019. There were no meetings scheduled for the months of April, June, August, and October and the November meeting was cancelled. Per the minutes, the meetings will resume in January 2020. Evidence of meeting minutes for 1 of the 3 meetings recorded was reviewed. The CPO explained that she is attending meetings has not been provided with the meeting minutes on all occasion. It was explained and verified though observation that the meetings were taking place every other month. Documentation supported evidence that the provider participated in 46 outreach events within the last 6 months, including Telemundo 51, a local Hispanic channel. The outreach events are logged in the Florida Network of Youths and Families Outreach Event Forms and entered in NETMIS.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) Policy and procedures 2.01 addresses the screening and intake requirement. The policy was last reviewed, signed, and dated by the CEO and CPO on 7/1/18.	No exceptions
RATING	☒	☐	☐	☐	☐	For indicators 2.01-2.05, a total of 5 residential files (2 closed, 3 open) and 5 non-residential files (2 opened, 3 closed) were reviewed. All 5 residential files and 5 non-residential files contained screenings that were completed within 7 calendar days of the referral and were completed upon admission to the program. Overall, all 10 files contained signed documents stating that parents and guardians receive the resident/client handbook as well as the CINS/FINS Brochure which includes information for parents and youth. The reviewer also reviewed the documents personally which included information for parents and youth regarding available services options, rights and responsibilities of the youth and parent/guardian brochure, through CINS/FINS Services, and grievance procedures.	No exceptions
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Policy and procedure 2.02 addresses the requirement for needs assessment. The policy was last revised on 07/01/18 and signed by the CEO and CPO.	
RATING	☐	☒	☐	☐	☐	A total of ten (10) files were reviewed for 5 residential and 5 non-residential youth. In all five residential files, the needs assessments were completed within 72 hours of admission and were signed by the supervisor. All 5 non-residential files met the requirements for this indicator and the needs assessments were completed within 2-3 face to face visits. All 10 Needs Assessments were conducted by a Bachelor's or Master's level staff member. None of the files reviewed were identified with an elevated risk of suicide.	No exceptions
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) Policy and procedures 2.03 addresses the requirement for case/service plan. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency provides the most appropriate and least restrictive or intrusive service alternative to the person or family served. The agency provides an effective service plan and ensures the highest quality of services at Miami Bridge. A total of ten (10) files were reviewed for 5 residential and 5 non-residential youth. All the requirements of this indicator are addressed with this policy. In reviewing the 5-residential and 5-non-residential files, the service plans were all completed in the files within the required time frames. All signatures and dates were documented in all but 1 residential youth file missing some signatures. The service plan only had the youth and staff signature and the service plan review	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						only had staff signature – no signature for the youth and parent. There was no documentation explaining the missing signatures.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) Policy and procedures 2.04 addresses the requirement for case management and service delivery. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	Total of ten (10) (5 residential and 5 non-residential) files were reviewed. All 10 files showed evidence that a counselor was actively involved with delivering services to clients and families. In each individual case file reviewed, the communication between services provided, sharing information and following up on services provided by outside sources to provide continuity of client care was documented. The procedure assured that staff is involved in the service delivery process for the identified client at the same time of service. The consistent and effective intra-agency and inter-agency communication ensured effective service delivery management. The activities and services were documented in the case chronological and or progress notes.	No exceptions
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) Policy and procedures 2.05 addresses the requirement for counseling services. The policy was last revised on 11/05/2019 and signed and dated by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	Total of ten (10) (5 residential and 5 non-residential) files were reviewed. All applicable files have case notes documenting counseling services and youths' progress. The supervisor has an ongoing internal process that ensures clinical reviews of case records	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						and staff performance. Youth and families receive counseling service in accordance with their case/service plan, and the program provides individual/family counseling. The (FSFF) First Stop For Families services provide therapeutic community based services designed to deliver the intervention necessary to stabilize the family in the event of crisis. Also to keep families intact and minimize out of home placement, it provides aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. Group counseling logs were reviewed from June – November 2019 including sign in sheets for groups topics: Hygiene, Life Skills, Safety & Coping Skills, Importance of Fire Safety, Motivational Edge and House Meeting on Weekend Schedule. The logs met the requirements of having groups at least 5 times a week and notes included: topic, date, duration, participants, and facilitator. Group schedule and topics are posted with the program's color coded activity schedule.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) Policy and procedures 2.06 addresses the requirement for adjudication/petition process. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☐	☐	☒	☐	☐	There were no applicable case staffing conducted by the provider since the last QI review. However, the provider has a standing case staffing committee made up of a DJJ representative, CINS/FINS provider, school representative, and Court Liaison. The committee may also include state district attorney, health, mental health representatives, or any person requested by the guardian(s), youth, or CINS/FINS staff. A signed, written report of the findings of the	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						committee will be provided to the family at the conclusion of the meeting, or it can be mailed to them within 7 days after the Case Staffing. If requested, the family and committee will be notified of the case staffing date no less than 5 days prior to the staffing.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) Policy and procedures 2.07 addresses the requirement for maintaining confidential records. The policy was last revised on 07/01/18 and signed and dated by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	All of the agency records are found in their EMR "Lauris". From staff interviews it was gathered that there are no more paper charts. In the field, staff use tablets to access their EMR and the tablet is kept in a locked pouch. Former hard copy files are kept on-site in the secured, non-residential FSFF office building. The file cabinet is locked and marked "Confidential".	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) Policy and procedures 2.08 meets the requirement for ensuring a safe and therapeutic environment for youth regardless of sexual orientation, gender identity, and gender expression. The policy was implemented and last reviewed on 07/01/2018 and was signed and dated by the Chief Executive Officer and the Chief Program Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	During a tour of the facility, "safe zone" rainbow flags were posted throughout the facility indicating that all youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The stickers were visibly observed on the entry window, two on intake office window, on a poster board in each dorm,	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Explain Deficiency Identified	Explain No Eligible Items For Review	Explain No Practice	Explain Not Applicable		
						posted on boards in the dorm hallways, on the counselors' and administrative office doors/windows, and throughout the First Stop Non-residential office building. The program has four different types of brochures providing education and information about LGBTQ; two from the Alliance for LGBTQ, 1 in Spanish from the National Runaway Switchboard, and 1 from pridelines. Alliance occasionally conducts groups for the provider. The program served six youth who met the criteria for the indicator. None of the youth identified as a non-biological gender but five of the six youth indicated bisexual sexual orientation and one as gay. Documentation reviewed demonstrated the youth were addressed according to their preferred name and pronouns and preferred name and pronouns were used in the e-logbook records as well as case notes, and other client information. Youth preference was considered and documented for room assignment for two of the three youth on the CINS/FINS intake form but was blank for one of the youth. Although the room assignment documented on the CINS/FINS Intake form does not identify which gender dormitory the youth are assigned (just the module and bed number), room assignments are also documented on the Client Daily Point Sheet Log and in the e-logbook during bed checks. None of the youth were identified as needing hygiene products and other items needed by the youth to support their gender identity or gender expression. The program has documentation to support all 4 new staff and 2 interns being made aware/having knowledge of Florida Network policy #5.08.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Policy and procedure 3.07 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and Chief Administrative and Compliance Officer.	
RATING	☐	☒	☐	☐	☐	The provider did not serve any youth who met the criteria for Staff Secure, DMST, Intensive Case Management, or FYRAC since the last QI review. Four (4) closed DV Respite files were reviewed for this indicator. All four files had documentation of youth pending DV charges and had evidence of being screened by JAC/Detention and did not meet the criteria for secure detention. One of the four youth in the program had a length of stay in DV Respite placement for 21 days and evidence of transfer to CINS/FINS was documented in NETMIS and in the file on the DV progress report that states case has been transferred and youth will continue to receive shelter services. The case plans reflected goals consistent with the issues identified regarding aggression, coping skills and effective communication in 1 of the 2 file. The needs assessment was completed for the other two youth but they were discharged prior to the timeframe required for development of the case plan. Documentation was provided that is recorded in NETMIS to support services were provided consistent with all other general CINS/FINS program requirements. One applicable probation respite file was reviewed. Documentation in the file demonstrated the referrals came from DJJ Probation; the length of stay was less than 30 days, there is evidence that all case management services and counseling needs were considered, and services are provided to the PR youth are consistent with all other general CINS/FINS program requirements.	**Exception** One of the 2 applicable DV files reviewed did not have a case plan developed and/or evident in the EMR during the youth's stay for 26 days.
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☐ NO (explain) ☒ N/A (explain)	Miami Bridge is not a SNAP provider.

Miami Bridge Homestead– November 6-7, 2019
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☐	☐	☐	☒	**N/A** Miami Bridge is not contracted to provide SNAP services.	**N/A**

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Explain — Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) Policy and procedure 3.01 addresses all the key elements of the QI indicator for shelter environment. The policy was last updated on 7/1/18 and was signed by the CEO and Chief Program Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	Reviewed documentation revealed the program maintains a general housekeeping and maintenance plan which outlines the cleaning and maintenance for the facility. Youth Activity Workers are responsible for the daily inspections and cleaning of the shelter. A tour of the shelter facility was completed during which the program was observed to be clean, neat, and pleasant smelling. Ongoing maintenance of the facility was observed including a drywall repair caused by a previously repaired plumbing leak. The program maintains a full-time maintenance staff person on-site to complete routine maintenance and needed repairs. The shelter has adequate space for the scheduled daily activities. The facility maintains a clean and organized laundry room with two operational clothes washers and two operational dryers which had clean lint collectors. All observed furniture was in good repair. The program recently recovered the common room couches in an attractive green patterned vinyl which is more easily cleaned. Each youth is provided an assigned bed with new Tuft and Needle memory foam mattresses, a pillow, attractive bed linens and comforter. All bathrooms were observed to be clean and functional. No graffiti was observed and there was no evidence of	**Exceptions** • Mock emergency drills are to be conducted once a quarter on each shift; however, reviewed documentation indicated emergency drills were conducted once a quarter only on the second shift. • Observations on the program tour included several chemicals in an unaccompanied wheelbarrow in the laundry room for which there were not material safety Data Sheets, including Clorox Outdoor bleach, Behr paint, Zep Mold Stain & Mildew Stain Remover, Zep Commercial neutral floor cleaner, and WD40.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						insect infestation. Chemicals approved for use were listed and maintained in the kitchen storage closet under three locks. Observed garbage cans and the dumpster were all covered. The facility has detailed egress plan maps posted throughout facility, Detailed egress maps were posted in each room of the shelter indicating facility exit paths. Additional postings included client rules, grievance forms, Florida Abuse Hotline information, and the Department's Central Communications Center incident reporting number. The annual food hygiene sanitation inspection was completed, and the certificate was issued on October 1, 2019 with no restrictions. The current active CCA-Emergency Active license was issued on March 1, 2019 for 20 beds, is valid through February 2020 and was posted in the program's common area. Annual facility fire inspection was conducted by the Miami-Dade Fire Rescue Department and was approved March 19, 2019. A satisfactory county Health Department inspection was completed 10/29/2019 for the group care and food inspection of the facility. The program is required to conduct a minimum of one fire drill per month with evacuation in two minutes or less. Reviewed documentation indicated the program conducted three fire drills each month, one on each shift, during the six-month review period, with the exception of May, which had two fire drills conducted. All fire drills documented evacuation was completed in less than two minutes. Documentation reviewed indicated the fire alarm system was last inspected and tested on January 14, 2019. The program's weekly activity schedule is posted in each dormitory and in the common room. The program's schedule engages youth in meaningful, structured activities seven days a week during waking hours. Daily programming includes opportunities for youth to complete homework and access books provided in the facility library. Youth are provided the opportunity to participate in weekly faith-based activities. Non-punitive activities are optionally offered as an alternative for those youth who do not choose to participate in faith-	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						based activities. The daily schedule includes at least one hour of physical activity/recreation. Activities include outdoor large muscle activity and exercise, playing pool, or various field trips, including equine therapy. Idle time is minimal. All staff are assigned keys individually. All doors are secure, in and out access is limited to staff members, and the front door entry is controlled by the office assistant or accessible only with key access. The program's two vans and staff vehicles were found to be securely locked. The vans were equipped with inspected fire extinguishers, first aid kits which are inspected weekly and emergency kits.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.02 for program orientation that addresses the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and Chief Program Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The review of two active and two closed youth records indicated each youth received a program orientation and a copy of the youth's program handbook within the first twenty-four hours after each youth's admission to the program. Each orientation included an explanation of the daily activities, disciplinary actions, program's grievance procedure, emergency and disaster procedures, contraband rules, room assignment, suicide prevention, Florida Abuse Hotline number, and suicide prevention/alert notification. In addition, a tour of the program was provided to each youth which noted the postings of the Florida Abuse Hotline, emergency egress	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable		
						maps, and the daily activity schedule. Each reviewed orientation was acknowledged by the youth's dated signature as well as that of a staff. The program maintains a professional-looking printed youth and guardian handbook and orientation guide for emergency shelter services.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.03 for room assignment that addresses the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and CACO.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of two active youth records and two closed youth records validated each youth completed intake an initial classification and which included the review of the youth's history, status and exposure to trauma, age, gender, history of violence, disabilities, physical size/strength, gang affiliation, suicide risk, sexually aggressive or reactive behavior, gender identification, alerts, collateral contacts. A review of the youth's initial interactions and observations of any markings were also documented.	No exceptions
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.04 for logbooks that addresses the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and CACO.	No exceptions
RATING	☐	☒	☐	☐	☐	A review of the program's log books for the prior six months confirmed the program utilizes a color-coded log book ledger system to documents daily activities, events, and other major occurrences. Logbook documentation included issues related to safety and security, incidents, youth supervision, movement and counts, visitation and home visits, transportation, grounds and facility checks,	**Exceptions:** Recording errors were observed in the logbook in that corrections were not consistently struck through with a single line or initialed by the staff with the date. Several instances of overwriting were

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						distribution of medication, and other significant events. All entries were brief and generally legibly written in ink, and included the date, time and name of each youth and/or staff involved. Oncoming staff documented review of the previous two shifts Supervisory reviews were conducted weekly, dated and signed at the top of the page. All entries included statements related to who, what, when and where. Each applicable log book page had a photocopy of visitor's photo identification with the date and time of arrival written in red on the photo which was attached to the top of the entry page. The program transitioned to the Note Active digital logbook entry system two weeks prior to the start of the annual compliance review.	observed, including on August 24, 2019 when the times of thirteen dormitory checks were overwritten for the period of 2:45 am to 5:45am.
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, 3.05 for behavior management strategies that address the requirement of the indicator. The policy was signed and dated on 7/1/2018 by the CEO and CACO.	No exceptions
RATING	☐	☒	☐	☐	☐	Reviewed documentation confirmed the program has in place a behavior management system (BMS) which is appropriate and relevant to the youth served, the type of program, and the average length of stay for youth. The design of the program's BMS includes clear boundaries and expectations for the youth which promote order, safety, security, respect, fairness, protection of the youth's rights, constructive discipline dialogue and peaceful resolution, and minimizes separation of youth from the general population. The program's BMS is designed to encourage compliance with the program rules, influence positive behavior, and increase accountability using incentives and rewards to encourage participation and completion of the program. Incentives include social activities, extra leisure time, adult recognition, special outings, and purchasing items from the incentive closet.	**Exceptions:** The program's BMS information is outlined in the Youth and Guardian Handbook and the youth's orientation guide however, the details of the system in the handbook differ from the number of points actually in use at the program. Reviewed documentation and an interview with the CQI coordinator revealed the BMS system was revised effective June 2019 and the handbook needs to be revised. Interviews with three active program youth indicated the youth understand how the system works, which behaviors can earn or

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						BMS is administered by the Youth Activity Workers (YAWs) under the supervision of the shift leaders and shelter supervisor. YAWs document youth behaviors on individual youth points sheets. The consequences for behavior are logical and related to the promotion of skill-building for the youth. The shelter supervisor and/or clinical director is responsible for training, monitoring and supervising staff in the implementation of the BMS. Staff are evaluated on their use of the behavior management system utilizing the Youth Activity Worker Feedback Form.	deduct points, as well as the rewards which can be earned by adhering to the BMS. However, none of the youth knew how many points they needed to earn to "make" their day and the youth said there was no way to know how many points they had earned so far in the week. Youth said the points sheets are not posted for them to see how many points they earned.
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The provider has policies in place, 3.06-Staffing and Youth and Staff Supervision and 3.06.01-One on One (1:1) Staff/Client Supervision, to ensure adequate staffing is provided to ensure the safety and security of youth and staff. These policies were last reviewed and approved 7/1/18 and signed by the CEO and the CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	Reviewed documentation validated the program maintains a process to ensure adequate safety and security of youth and staff and a policy and procedures which meet the minimum staffing ratio requirements. A review of the program schedules for the previous six months revealed the program maintained a minimum staffing ratio as required by Florida Administrative Code and the program's contract. Staffing schedules consistently maintain coverage with at least two staff present on each overnight shift. Overnight work shifts consistently maintain a minimum of two staff present of the same gender as the youth on each work shift including all overnight work shifts. A review of the program log books for the six months prior to the annual compliance review supported staff observing youth at least every fifteen minutes while they were in the dormitory overnight. The	No exceptions

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	Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable		
						staff schedule is posted in the intake office accessible to staff. The program director directly texts staff to alert them to any schedule changes, when applicable. An interview with the program director indicated the program has a list of staff available for holdover or additional shifts if additional coverage is needed. Observation confirmed the program has thirty-six surveillance motion cameras, which were all well positioned and working during the annual compliance review. Captured video footage is maintained for at least thirty days.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) Policy and procedure 3.07 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CACO.	No exceptions
RATING	☐	☒	☐	☐	☐	The program maintains a digital surveillance video system with thirty-six cameras, twenty-four of which were working during the week of the annual compliance review. The video system was observed to have clear, crisp images in which faces are easily identifiable. Four agency staff are designated to have access to the cameras including the COO, the North and South shelter supervisors and the CQI Coordinator. As the program does not maintain security cameras in either dormitory, it is the program's practice for staff who elect to remain in one of the dormitories for more than fifteen minutes to come to the door of the dormitory within sight of the security camera at least once every fifteen minutes. A review of security video footage in comparison with the program logbook and the Note Active electronic logbook reports for two other	**Exception – Limited rating:** Twelve of the thirty-six surveillance cameras were not working due to a reported power supply failure in one of the two digital video recorders which powers half of the systems cameras. The program was in the process of having both power supply packs to the program's surveillance system replaced. A review of security video footage in comparison with the Note Active electronic logbook reports indicated on October 30, 2019 that bed checks documented for the

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						dates indicated the checks were conducted as documented at least every fifteen minutes as required	male dormitory at 4:29a.m. and 4:45a.m. did not actually take place, as the staff was observed exiting the dormitory at 4:12 a.m. and no staff re-entered the male dormitory again during that time period. The program was advised to secure a digital copy of the video footage of this incident and report the finding to CCC. CCC was contacted and report was accepted.

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.01 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of four residential client files were reviewed including two open and two closed client files. Healthcare Admission Screening Forms were completed at the time of intake by direct care staff for all files reviewed and were completed in its entirety. The program has an alert board that reflects current client alerts and corresponds with the client's electronic medical record. Client alerts are indicated in several areas in the client's electronic medical record including the general information page, the Youth Alert System, and client record note. All client files reviewed reflected that a review of Health Care Admissions Screening/Intakes were completed by the Nurse or designated staff. None of the client files reviewed needed medical follow up; however, interview with the program's RN reflected that medical follow up referrals are documented in the electronic medical record on the Medical Documentation form, staff communication binder, and client medical file which was also observed. The program strives to provide adequate screening and referral for any health related issues or concerns.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.02 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of four residential client files including, three closed files and one open file were reviewed. The program utilizes the Suicide Risk Screening on the CINS/FINS intake form. Youth who answers 'yes' to risk factor questions 1-6 on will be placed on sight and sound and referred to a licensed staff or non-licensed staff with the required training for a suicide risk assessment. Suicide Risk Screening forms were completed in their entirety and completed in the required time frame at intake. The client files reviewed demonstrated that youth answering 'yes' to risk factor questions were placed on constant sight and sound supervision. Sight and sound supervision forms were reviewed and documented as required. Youth placed on sight and sound remained on this supervision until assessed by a mental health professional. Removal from sight and sound supervision is documented on observation logs. One of the assessments reviewed was completed immediately after intake. Suicide Risk Assessment utilized by the program is approved by the FL Network. All Suicide Risk Assessments reviewed were completed	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						by a Licensed Clinical Social Worker or a non-licensed mental health clinical staff member whose documentation of training was verified. Assessments are also completed by a Licensed Clinical Social Worker who did have an active license at the time suicide risk assessment was completed. Documentation of consult with licensed professional was documented in client case note. All suicide risk assessments reviewed reflected that suicide risk assessments were completed within the 24-hour time frame required.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.03 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of three open residential client files were reviewed. Program staff including the RN and direct care staff were interviewed. All the files reviewed included completion of a Healthcare Screening on same day as admission. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is placed behind a locked door that is inaccessible to youth. The agency has more than 2 superusers for the Med-Station. The program does not accept youth currently prescribed injectable medications, except epi pens. The agency has documentation that non-licensed staff have received training in the use of Epi-pens provided by the program's RN which was observed to be posted in the medication room. A refrigerator was observed to be secured with a lock in the medication storage room; however, the program does not currently have any meds needing refrigeration. The temperature requirements for the refrigerator are being met. At the time of the review the program did not have any narcotic medications. Program practice indicates that narcotics and controlled medications are stored in the med station.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Shift to shift count documentation was reviewed. All areas of shift to shift counts are verified by a witness and is documented for medications. The program has a binder which was observed to include shift to shift count as well as documentation of current client medication, dosage, and time. For controlled substances the perpetual running balance is indicated on the shift to shift count. Designated staff have access to secured medications with limited access to controlled substances. Syringes and sharps were observed to be secured in a locked storage cabinet. Syringes and sharps inventory documentation shows that these are counted weekly. There is also documentation of a weekly review completed by the RN. Over-the-counter medications that are accessed regularly are inventoried weekly on a perpetual log that is reviewed and signed by the RN. A medication distribution log is utilized and placed in a medication log binder. The program RN or Healthcare Specialist conducts daily reviews of medication management practice via reports from med station. The outcome of these reports is then discussed during weekly Multi-Disciplinary Treatment team meetings. The agency verifies medications using methods listed in the FN Operations Manual. The medications are verified according to policy requirements by the RN when on site or unlicensed trained staff. Staff assists in the delivery of medication by verifying the five rights (right dose, right route, right med, right patient, and right time) and both youth and staff initial the med log which was reviewed. Documentation of medication distribution off-site was reviewed on corresponding form in instances when medications are removed from the facility. The program's practices and process is consistent with the FNYFS Medication and Distribution Policy. If there are discrepancies to be cleared the RN is informed and cleared after each shift.	

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.04 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO. This was revised during the on-site review on 11/7/19 to indicate RN or designee will sign medical screening within 72 hours. The program has a policy that meets requirements.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of four residential client files including, two closed and two open files were reviewed. All client files reviewed did have a medical or mental health condition or food allergy. All files reviewed demonstrated that the youth were appropriately placed on the program's alert system as this was reflected on the Youth Alert System form. The youth receives an initial medical screening at intake by either the RN if on site, the Health Specialist, or other non-licensed program staff. The agency's practice reflects that the RN or designee reviews and sign off on the medical screening. Policy was revised during onsite review to include screening can be signed by a designee. The agency's alert system includes precautions concerning the prescribed medications, medical/mental health conditions are documented in several locations throughout the client's medical file and electronic medical record. An alert board located in the intake officer also documents the client's name and alert in a confidential manner. A nutritional alert clipboard is in the kitchen which includes a list client's who have an allergy or other kind of nutritional alert. Interview with the program's RN demonstrated that staff are provided sufficient information/instructions to recognize/respond to the need for emergency medical/mental health problems which was observed to	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable		
						be documented in the electronic medical record, client medical file, and staff communication log.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** Policy and procedure 4.05 addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and CPO.	No exceptions
RATING	☒	☐	☐	☐	☐	There was one Crisis youth transported offsite due to a medical emergency in the time frame reviewed. The program documents off site emergency medical incidents on the Client Transported Offsite Due to Emergency Medical Attention log. The documentation reviewed includes date/time of incident, summary of incident, parental notification, summary of notification to parent, date/time client transported back and by whom, medical follow up recommended via discharge instructions, and parental notification of follow up as well as a critique by supervisor. The incident report was reviewed and a call was placed into the CCC within the reporting time frame and included appropriate follow up to CCC in required time frames. All staff are trained on emergency medical procedures through CPR/FIRST AID/AED through the RN who also provides additional training to staff which is documented in client training files. Knife for life and wire cutter were observed in the shelter intake office as well as are located in the school building, First Stop Counseling building, and in both vans. First Aid kits/supplies were observed in the shelter intake office and kitchen as well as are located in the school building and counseling building	No exceptions