



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge-Central

on 10/28/2015

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	No rating

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Keith Carr, Reviewer, Forefront LLC/FNYFS

Marie Boswell, DJJ Prevention Specialist, Department of Juvenile Justice

Gabriel Medina, DJJ Monitor, Department of Juvenile Justice



Mark Olshansky, Residential Coordinator, Florida Keys Children's Shelter

Persons Interviewed

- | | | |
|--|--------------------------|-------------------------|
| <input checked="" type="checkbox"/> Program Director | 0 Case Managers | 0 Maintenance Personnel |
| <input type="checkbox"/> DJJ Monitor | 5 Clinical Staff | 2 Program Supervisors |
| <input type="checkbox"/> DHA or designee | 1 Food Service Personnel | 0 Other |
| <input type="checkbox"/> DMHA or designee | 0 Health Care Staff | |

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> CCC Reports | <input type="checkbox"/> Key Control Log | <input checked="" type="checkbox"/> Youth Handbook |
| <input type="checkbox"/> Confinement Reports | <input checked="" type="checkbox"/> Logbooks | 6 Health Records |
| <input checked="" type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 6 MH/SA Records |
| <input type="checkbox"/> Contract Monitoring Reports | <input type="checkbox"/> PAR Reports | 17 Personnel Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 9 Training Records/CORE |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 0 Youth Records (Closed) |
| <input type="checkbox"/> Escape Notification/Logs | <input type="checkbox"/> Sick Call Logs | 7 Youth Records (Open) |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Supplemental Contracts | 1 Other |
| <input checked="" type="checkbox"/> Fire Drill Log | <input checked="" type="checkbox"/> Table of Organization | |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input type="checkbox"/> Telephone Logs | |

Surveys

- 7 Youth 4 Direct Care Staff 0 Other

Observations During Review

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

Comments

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

Rating Narrative

This reviewer noted that all staff carried themselves in a professional manner and had been respectful of youth as well as actively monitored the youth for safety. Interactions between staff and youth seemed conducive to youth having a positive experience while being at the Miami Bridge. Youth seemed comfortable and relaxed with staff. The facility is clean and seems to be a safe environment for youth.

Although not listed above this writer observed a telephone screening of a youth being referred by a dependency agency.

Strengths and Innovative Approaches

Rating Narrative

Miami Bridge Central Shelter (MB Central) is a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by Miami Bridge Youth and Family Services, Inc. The program has a central office and shelter located in North Miami, Florida and a south shelter located in Homestead (in southern Miami-Dade County). The program serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also a Staff Secure Shelter and is also a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, and domestic minor sex trafficking. 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 recently received re-accreditation through August 31, 2017. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. Miami Bridge employs professionally licensed staff for both mental health and medical services. Its licensed Mental Health professionals provide oversight over its counseling services in both the residential and non-residential CINS/FINS programs at both program locations in Miami and Homestead. 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 onsite monitoring visit, MB has appointed a new CEO, Dorcas Wilcox, and also promoted the former CFO, Steve Hope to a Deputy CEO position.

This year, MB celebrates its 30th Anniversary since it was officially created as a 501(3)c organization in 1985. The celebration was hosted at the Central location and included entertainment, talent showcase by the shelter youth, arts and craft, music, sports, and food and refreshments.

MB is grateful for support from community donors who continue to assist the program through donations and funding. The following is a list of donations provided to the agency during last year:

- Girl's Scout Silver Project – raised donations to renovate the dining room with new furnishings and implemented the "Hand Tree" art display in the living room, where youth can leave their hand print and legacy at the shelter.
- Braman Vehicles- donated \$21,000 to create a tech station that includes six new built-in computer stations, giving youth access to technology and internet resources.
- Miami Bridge was selected to receive a \$2,000 grant from Walmart and is honored to be a Community Grant recipient.
- Marenas Beach Resort donated an abundance of school supplies to the program. The team also engaged the youth and staff in a game of volleyball for an additional hour of fun.
- The youth of Miami Bridge attend Carnival Arts at Barry University every Sunday. Music teacher, Dr. Celeste Frazier, collaborates with Ton Ton, a professional drummer from Haiti who is trained in the musical rhythms of the Conga.
- Florida Community Bank presented the Miami Bridge with a check in the sum of \$2,500 to support its summer program.
- NIKE Employees visit the shelter every second Wednesday of each month to interact and have fun with the youth. For each volunteer that participates, NIKE provides the Bridge with \$10 towards youth activities.
- Recently, Miami Bridge youth attended the Miami Dolphins vs Tampa Bay Buccaneers game at the Dolphin Stadium. For most of our youth, it was their first time attending a professional sporting event.
- Professional photographer hosted a photo shoot entitled "Love the Skin You're In" with the females in the Central shelter. The purpose of the photo shoot was to help the ladies view themselves in a different light and boost their self-esteem.

Standard 1: Management Accountability

Overview

Narrative

MB Central, located at 2810 NW South River Drive, Miami, Florida, is under the leadership of a Board of Directors, Chief Executive Director, Deputy CEO/ Chief Financial Officer, Chief Operations Officer, Chief Administrative/Compliance Officer, and Clinical Director (2), and Director of Admissions. Dorcas Wilcox, Executive Director oversees the Miami Bridge program and the services provided through its two (2) service locations in Central Miami and Homestead, Florida. The residential component at each site is managed by Shelter Directors as well as Shift Leaders on each of the three shifts. The clinical component for each location is under the supervision of a Director of Clinical Services.

At the time of the quality improvement review, the program reported five vacancies for a Book Keeper, Janitor, Case Manager, Counselor, and Youth Activity Worker. The MB Central facility is licensed by the Department of Children and Families for 28 beds, with the current license in effect until May 31, 2016.

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

An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates. The provider agency conducts orientation training to all shelter personnel through a combination of training sources that include the Florida Network, local area and in-house trainers. Each employee has a separate training file that contains a training attendance form and corroborating documentation for training received.

1.01 Background Screening

Satisfactory

Limited

Failed

Rating Narrative

Miami Bridge has a policy and procedures in place that address the background screening of all employees, volunteers, and interns prior to any offer of employment or volunteer service. The policy was last revised on 7/31/15 and requires all staff and volunteers to complete a DJJ Background Screening in accordance with FS 985.407 that includes good moral character documentation, criminal history background screening and electronic submission of Department of Homeland Security E-verify for new employees confirming work eligibility. In addition, the provider conducts a drug screening and conducts a local law enforcement check, a driving history check with the Division of Motor Vehicles, and pre-employment TB test prior to the hiring of all staff. The agency submitted the Annual Affidavit of Compliance with Level 2 Screening Standards via email to DJJ BSU on 1/2/15 prior to the January 31st deadline.

A total of seventeen (17) applicable personnel files were reviewed for thirteen (13) new staff, three (3) staff eligible for 5-year re-screening, and one (1) Intern. The thirteen new staff were hired after the last onsite QI visit. All of the thirteen new staff received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire.

Three (3) staff who were eligible for their 5-year re-screenings had the re-screening conducted within the required timeframe prior to the staff's five-year anniversary dates.

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

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

1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy and procedure for the provision of an abuse free environment that was last revised July 31, 2015. The policy states that program staff must adhere to a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. The policy requires staff to be trained to follow this code of conduct and to report all allegations of child abuse to the Florida Abuse Hotline. There are comprehensive procedures in the policy regarding the reporting of abuse as well as information about signs of abuse/neglect, licensure requirements, and code of conduct which includes dress code expectations.

In practice, the Employee Handbook has a section for Code of Business Conduct which includes (but is not limited to) dress code, compliance responsibility, cell phone, and fraternization. The handbook includes an acknowledgement of receipt for the employee to sign and the signed copy goes in the employee's file. Proof of the signed receipt was found in employee files reviewed.

During the tour of the facility, there are signs posted in the main recreation room, intake office and both dorm room areas that include the abuse registry hotline number on large posters. The posters also include other emergency numbers as well as listing all the rules of the facility.

A total of 3 Abuse Registry calls were made during the past 6 months and two were accepted. The program documents the calls on an Abuse Registry Log. In all 3 records, the caller and reporter's information was documented. A review of the 3 youth case files showed follow-up information (with the investigator) was provided in the progress notes for one of the files as well as information regarding the investigator's visit and status of the case.

Surveys were completed with seven youth on-site during the QI visit. None of the youths surveyed stated they had attempted to call the hotline while in the shelter.

Grievance procedures are reviewed with youth during intake. A copy of the grievance procedures is included in the resident handbook. The grievance box and forms were observed during the tour to be mounted on the wall adjacent to the common area, at the entry to the girl's dorm. Youth are instructed to put their grievance in the box or give it to the Program Coordinator. Three of

the seven youth surveyed were familiar with the grievance process.

Per the HR Director, the agency took disciplinary actions and terminated one staff during the review period due to verbal threats made toward youth during a clinical group. An incident report was written and an internal investigation led to the staff's dismissal.

Four staff were surveyed and asked to describe how youth are allowed to call the abuse hotline. The four staff described the procedures slightly differently but included appropriate responses to: allow youth to make hotline calls at any time; assist youth by dialing the phone number; and call for the youth and make the report. None of the staff have ever observed a co-worker telling a youth they could not call the abuse hotline.

Exceptions

A total of 3 Abuse Registry calls were made during the review period. Follow-up information about the case, such as if opened, closed, current status, or Investigator was not documented on one (1) of the Abuse Registry Logs (in the section provided on the form to be completed by the youth's assigned counselor). A review of the 3 youth case files showed that follow-up information with the investigator was missing in the progress notes of two of the three files and no information was provided regarding the investigator's visit to the facility and/or status of the case. Also, the program log book did not document the visit for one of the three cases.

According to the youth surveys completed with seven youths on-site, three youth stated they did not know about the abuse hotline and five could not say where the number was located.

Four of the seven youth surveyed indicated they did not know about the grievance process.

1.03 Incident Reporting

Satisfactory

Limited

Failed

Rating Narrative

The program has policy and procedures #1.03, Incident Reporting (Risk Management), that was last approved on 7/31/15. The policy and procedures clearly address the reporting and notification of reportable incidents to the Central Communication Center (CCC) within 2 hours of the incident or within 2 hours of becoming aware of the incident. The CCC Hotline number is visibly posted in the youth lounge and in each dorm room.

CCC Incident Reports are documented on the agency's Incident Report Form by the staff reporting the incident. A Quality Control Checklist is completed for each incident by the Shelter Director to ensure accuracy and completion of the incident report, including appropriate notifications and listing of corresponding case numbers. Employees are required to complete the incident report before leaving his/her shift.

Incident reports are kept in binders in a chronological order and CCC accepted Incident Reports are maintained separately from non-accepted reports. In addition to the Incident Report and Quality Control Cover Sheet, a copy of the log book entry is also attached with supporting documentation of the reporting time and log book entry for the incident.

A total of 16 incidents were accepted by CCC during the review period. Of these 9 were absconds, 4 – contrabands, 1 – medication incident, 1 – youth behavior, and 1 – offsite medical treatment. All sixteen incidents reviewed were reported within the two-hour timeframe required. All 16 incidents were reported as "closed" by CCC, with none requiring follow-up communication, tasks, or special instructions required by the CCC. An email from the CCC office also confirmed the closed status of incident reports for the provider as of October 19, 2015.

Exception

One incident regarding suspected contraband, discovered by staff on 10/25/15, was reported to the CCC during the 2-hour timeframe; however, during the QI visit it was observed that it was not reported to the police until the following day on 10/25/15. A review of two prior contraband incidents revealed law enforcement was called.

1.04 Training Requirements

Satisfactory

Limited

Failed

Rating Narrative

The agency has a training policy #1.04 that requires agency staff members to address training requirements for all new hires and on-going full-time, part-time and on-call agency staff members. The agency's policy and procedures was last updated on 7/31/15.

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

A total of nine (9) training files were reviewed to assess the agency's compliance with the training standard. Of these files, four (4) were for new staff after the last review, four (4) were in-service staff, and one (1) was for a non-licensed clinical staff.

All four new hires had completed Orientation training, including CPR/First Aid, and were on target for completing the 80 hours required annually. The Orientation training is scheduled for four days and includes the training topics and facilitators. The staff is required to sign an Orientation Training Acknowledgement form upon completion. Eight of the thirteen mandatory trainings were completed by the four staff as of the date of the QI review. Three of the four staff still had at least nine months to complete the mandatory trainings.

The four in-service training files reviewed demonstrate evidence of on-going training. All four staff had current valid CPR/First Aid certification in their files. As of the date of the review, three of

the four in-service staff had not yet completed the mandatory Fire Safety, Crisis Intervention, and Suicide Prevention training but still had time to complete them.

The training file for one clinical shelter staff revealed completion of the mandatory Assessment of Suicide Risk training which documented five supervised Suicide Assessments and written confirmation by the licensed mental health professional but was missing the license number which was provided and added during the visit.

Exceptions

One new staff (DOH 11/3/14) had not yet completed CI, Suicide Prevention, CINS/FINS Core, Signs and Symptoms of Mental Health and Substance Abuse. Three of these topics are available on the FNYFS website. A similar trend was observed for the other 3 new staff but they had at least nine months to receive the training.

Domestic Minor Sex Trafficking training is a recommended training topic; however, it is not included on the provider's training plan as a recommended in-service training.

The orientation training certification signed by the staff and supervisor is missing the date in 3 of the 4 new hire files.

One of the 4 in-service staff whose training year recently expired on 10/22/15 had not completed Fire Safety training, CI, and Suicide training required. Fire Safety was not completed in the prior year for the same staff as well.

1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

Rating Narrative

The program has a policy for analyzing and reporting information (Policy 1.05) that describes the process for the collection and review of several sources of information to identify patterns and trends. The procedures indicate that all data and reports are presented at Quarterly CQI Committee Meetings and the minutes are typed and filed in a binder by year. Discussions at the meetings include: Incidents, Grievances, Health and Safety, Abuse and CITS reports; contract Performance Outcomes; and Case Record Reviews.

The CQI Committee meeting held on October 1, 2015 was reviewed. Case record reviews for Q3 FY 2014-2015 was discussed as well as expectations and update on Q4 case record reviews which had not yet been completed, revealing the case record reviews were behind schedule. Case record reviews include cases from both Miami Bridge locations.

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

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

Outcome data is reviewed quarterly. The reports are separated by Emergency Shelter and First Stop for Families (FSFF). The outcome measures translate directly to contract measures from the 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 meeting held October 1, 2015. The meeting agenda included a review of prior FY 2014-2015 up to the Q4 but not inclusive of the current FY Q1 data.

The client and employee satisfaction surveys are completed bi-annually and discussed at the quarterly CQI meeting. The results are compiled and shown in relation to the last results. The most recent satisfaction survey was completed in March 2015.

Netmis data reports are presented at the CQI quarterly meetings. Meeting minutes from the last CQI quarterly meetings specifically reflect discussion on Netmis data. The monthly data reports were present for June, July, and September 2015.

The program's nurse runs daily medication management reports of practice via Knowledge Portal or Pyxis Med-Station Reports since the system went active in August of 2015 and the first quarterly review is due on November 2015. The nurse maintained documentation of the medical management practice in a file.

Exception

The program's monthly review of NetMIS data reports was inconsistent.

1.06 Client Transportation

Satisfactory

Limited

Failed

Rating Narrative

The provider has a policy and procedures for Client Transportation that requires approved drivers (considering their work performance and history) and the inclusion of a third person as a best practice whenever possible. The policy was last revised on 7/1/2015 and includes:

- Approval by administrative personnel
- Prohibition of transport without at least one other passenger/third party present
- Insurance coverage for approved agency drivers
- Written policy in the event a 3rd party is not available or present
- Consideration of client's history, evaluation, and recent behavior prior to waiving third party passenger.

A review of the transportation log revealed the vehicle log does not include the time the vehicle was used. Review of the vehicle log and log book does not clearly document the process for a 3rd party's absence in vehicle while transporting clients nor is there evidence that, if there isn't a 3rd party, that the program supervisor is aware prior to transportation and consent is documented.

Exception

Lack of time on the vehicle transportation log and illegible documentation in the log book makes it difficult to validate Supervisor's consent for transport without a 3rd party present.

1.07 Outreach Services

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures for Outreach Services and Interagency Agreements, 1.07, last revised 7/31/15.

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

A review of its current agreement show that the agency has approximately 43 active MOU's, inter-agency agreements and/or contracts for services to the youth and families.

Minutes of Circuit 11 Circuit Advisory Board (CAB) meetings document the agency's presence at five (5) of six (6) most recent meetings.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

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

The clinical component of the program is under the supervision of a licensed Clinical Director. A total of three Non-residential Counselors, one Residential Counselor, and a Case Manager are responsible for providing counseling and case management services and linking youth and families to various community services.

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

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

The First Stop non-residential program is responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court. However, the provider has not initiated case staffing for any youth during the review period and/or since the last onsite QI review.

2.01 Screening and Intake

Satisfactory

Limited

Failed

Rating Narrative

Agency Policy 2.01, Screening and Intake, provides for and reflects Indicator 2.01 while including all necessary elements.

The following requirement standards were met for the three residential case files reviewed:

1. Eligibility screening within 7 calendar days of referral.
2. Available service options
3. Rights and responsibilities of youth and parents/guardians
4. Parent /Guardian Brochure
5. Possible actions occurring through involvement with CINS/FINS services.
6. Grievance procedures.

Of the 3 residential files reviewed, all 3 files met the standard as evidenced by dated signatures reflecting the above stated criteria.

The 3 non-residential files reviewed met all of the standards listed above; however, there isn't a signed document in the files that show that a Parent/Guardian Brochure was provided. Per Counselor, at the time of intake, a CINS/FINS services brochure is given to the parent/guardian in English, Creole or Spanish and the intake counselor reviews the brochure with the parent/guardian.

Exception

Evidence of receipt of information in writing regarding possible actions occurring through involvement with CINS/FINS services was not found in the three non-residential files.

2.02 Needs Assessment

Satisfactory

Limited

Failed

Rating Narrative

Agency Policy 2.02, Needs Assessment, provides for and reflects all the requirements of Indicator 2.02.

The following requirements were reviewed for each youth:

1. Needs assessment initiated within 72 hours of admission.
2. Needs assessment done within 2-3 face to face contacts.
3. Needs assessment conducted by Bachelors or Masters level staff.
4. Needs assessment includes a supervisor's review signature.
5. Youth identified with an elevated risk of suicide as a result of the needs assessment.
6. If yes for 5, the youth was referred for an assessment of suicide risk conducted by or under the direct supervision of a licensed mental health professional.

All three residential case files met all of the requirements and the needs assessments were conducted within 72 hours of admission. None of the three youth were identified as needing an elevated suicide assessment; therefore, a referral was not made for an additional suicide risk assessment.

The 3 non-residential files reviewed indicate that all of the above-stated requirements had been met and the needs assessment were completed within 2 to 3 face to face contacts. None of the 3 non-residential files reviewed reflected a need for further suicide assessment for any of the 3 youth.

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

2.03 Case/Service Plan

Satisfactory Limited Failed

Rating Narrative

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

1. Case/Service Plan
2. Development within 7 working days of psychosocial assessment
3. The Case Service plan includes: Individual and prioritized needs and goals identified by the psychosocial assessment, service type, frequency, location, persons responsible, target dates for completion, actual completion dates, signature of youth, signature of parent/guardian, signature of counselor, signature of supervisor, the date the plan was initiated and the progress reviewed every 30 days for the first 3 months and every 6 months after.

Two of the three residential files reviewed showed compliance with the indicator. In one of the files, in lieu of parent/guardian signature a notation was made that the parent/guardian agreed to the service plan by phone. In the second file, the parent/guardian signature was not present, however, in a case note dated 10/23/2015 it is noted that the youth's guardian will come in around 12 noon on 10/30/2015 to review the service plan. As the service plan was done within the past two weeks, the 30 day review is currently N/A. The third residential case file reviewed did not have a service plan as the youth is a recent intake and his needs assessment was completed on 10/26/2015 and was currently within the 7 working days to develop the service plan.

All of the non-residential case service plans reviewed had been developed in a timely manner and reflected the needs presented at the time of intake and any subsequent counseling sessions.

Exception

One of the service plans reviewed was missing the review date signatures. Per note dated on 7/13/2015, the youth was in the CINS/FINS court process; the service plan was developed on 1/8/2015. There is a 30 day review dated 2/9/2015. There are no further signatures for service plan reviews although counseling notes reflect that services are still being provided.

2.04 Case Management and Service Delivery

Satisfactory Limited Failed

Rating Narrative

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

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

Three residential case files were reviewed. All 3 files had well documented notes from individual counseling sessions that indicated that the counselor was addressing service plan and other needs of the youth. Case management notes reflected inclusion of parent/guardian input into the attainment of goals as well as supportive counseling. None of the 3 files reviewed indicated that referrals had been needed or made for the youth or family. Out-of-home placements are clearly monitored. None of the files reflected a need for accompaniment to court or other off-site appointments up to this time. Additionally, case termination was not yet appropriate for the reviewed files.

In all 3 non-residential files, case management notes are clear and easy to understand. Case management notes reflect that all of the criteria are being met and that youth are actively receiving case management services that are reflective of the youth's presenting and subsequently identified needs. All of the youth appears to be receiving supportive case management to address their academic and substance abuse issues as well as ongoing supportive counseling and attempts to engage the youth's parent/guardians.

2.05 Counseling Services

Satisfactory

Limited

Failed

Rating Narrative

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

The three residential files reviewed indicate that all of the criteria for the standard are being met and counseling services relevant to the youth are being provided. All of the case notes reviewed were precise, easy to understand and addressed the needs of the youth and family as relevant to the youth's placement in the shelter.

Group notes are kept in a separate binder with a sign-in sheet for all of the youth who participated in group. Per Clinical Counselor, quarterly reviews of case records are conducted in which random staff is assigned random files to review, thus ensuring that all files are subject to review. Case record reviews are kept in a separate binder. Every week the clinical team and the school teacher meet to staff each of the youth in the shelter.

In all 3 non-residential files it is reflected that services are being provided in accordance with the case service plans. All 3 youth are receiving individual counseling. One youth seems to be actively involved in family counseling as well as individual counseling geared to support the grandmother in her role of guardian. Two other youth are both receiving counseling based on their service plan needs. Multiple phone conversations and attempts to provide family counseling to the parents are well documented.

2.06 Adjudication/Petition Process

Satisfactory

Limited

Failed

Rating Narrative

The agency has a policy and procedures in place that describes the Case Staffing process. Meeting notes and agendas are maintained for the CINS/FINS staffing in a CINS/FINS Petition binder with monthly tabs in which communication - via email- with the various committee members is kept.

On 3/23/2015, a letter was sent to a youth's mother to inform her that the staffing would be held on 4/17/2015. The staffing was attended by youth's mother and sister, CINS representative, Miami Dade School representative and FSFF Counselor. A follow up letter was sent to youth's mother on 4/27/2015. A DJJ representative was not present for the staff; however a CINS/FINS provider participated as the DJJ Representative.

Regular communication with case staffing committee is reflected in the case management notes for each youth and the binder is kept to reflect the schedules of committee meetings.

Exception

Parental notification of the Case Staffing was in excess of the 5 working days required.

2.07 Youth Records

Satisfactory

Limited

Failed

Rating Narrative

Agency Policy 2.07, Youth Records, provides for and reflects Indicator 2.07 while including all necessary elements.

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

All of the youth records reviewed were consistently organized and were marked "confidential", and kept in a secure manner. In addition, all 6 files reviewed were maintained in a neat and orderly manner so that staff can quickly and easily access information.

Exception

The opaque bag used to transport youth records was not locked and not marked confidential.

Standard 3: Shelter Care

Overview

Rating Narrative

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

Staff members in the Residential Program include: a Shelter Director, one Counselor, one Case Manager, 4 Shift Leaders, 7 Youth Activity Workers, a PT Registered Nurse, a Health Care specialist, and a Food Specialist/Cook. The provider also employs a Maintenance person who is responsible for facility repairs and maintenance for both the Central and South Miami program facilities.

The Direct Care workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the Registered Nurse and Health Care Specialist who maintains inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administers first aid when needed, and coordinates all off-site appointments to medical providers.

Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility (to include the staff station, medication office, and kitchen). All medications are stored in the Pyxis Medication System located in the Nurse's office.

3.01 Shelter Environment

Satisfactory Limited Failed

Rating Narrative

The agency has a policy that outlines procedures to maintain a safe and clean shelter environment. An inspection of the shelter interior areas and exterior perimeter was conducted during this on-site program review. The shelter is located in a populated urban area of Miami. The facility is located in a low traffic area near the Miami River and Miami International Airport. The program is situated on a large lot that includes the Emergency Shelter and general administration building in the same building. The property also includes the non-residential building (FSFF) and on-site school equipped with Miami-Dade County instructors. The agency has record of a Child Caring Agency certificate of license issued by the Florida Department of Children and Families issued on June 1, 2015, effective through May 31, 2016. In addition, the agency is accredited by the Council on Accreditation (COA) through August 31, 2017.

A tour of the program found that the shelter had a clean, landscaped, and well maintained environment for youth, staff and visitors. Documentation reviewed indicated that the program has a general housekeeping and maintenance plan in place to ensure the regular maintenance of all the program's physical plant and equipment. The tour of the program also confirmed that the program is equipped with adequate bathroom facilities, furnishings are in good repair and in each dormitory youth has an individual bed, clean cover mattress, pillow, linens and blanket, as well as a lockable place to keep personal belongings.

The agency has record of the annual agency fire permit that is valid through 9/30/16. A facility Biomedical Waste inspection was conducted and a violation is documented to provide an annual refresher course training for staff involved with the management and handling of on-site generated bio-hazardous waste. The agency's last Food Service Inspection conducted 9/9/2015 did not cite any violations. A satisfactory Group Care Inspection on 3/30/15 cited a hole in the AC Closet of the classroom, repair needed to the vent system of the common bathroom, and non-working soap dispenser in the handicap female stall.

Observation and the review of the daily youth schedule indicated that the program consistently involved youth in structured/meaningful activities, including voluntary religious practices and the interactions between youth and staff observed were appropriate and cordial.

Documentation reviewed revealed that the program has a comprehensive disaster plan, and all the safety, security and health inspections, fire drills and mock emergency drills were regularly completed, as required.

The program has two vans that were locked at the time of the inspections and both are equipped with major safety equipment including first aid kits, fire extinguishers, flash lights, glass breakers, and seat belt cutters.

Observation found that all the chemicals in the program are stored securely and the Material Safety Data Sheets (MSDS) were maintained for each chemical. The program's vans are not equipped with air bag deflators.

3.02 Program Orientation

Satisfactory Limited Failed

Rating Narrative

The agency has a policy that addresses the requirements of this indicator. A review of three active youth residential files found that the program provided a comprehensive orientation to each youth at the time of the admission to the program. The program's orientation provided each youth with information related to the program expectations, the services provided by the program, emergency procedures, the youth's rights, privileges and responsibilities, the roles of the staff and the behavior management system needed to be successful at the program. In addition, as part of the program's orientation each youth receives a tour of the program, a copy of the Client and Guardian Handbook and Orientation Guide for Shelter Services, and introduction to all of the program's staff.

Each youth file reviewed contained an orientation checklist signed by youth and staff. An interview with the program director and documentation reviewed found that the program match one staff member with each new youth (Each One Reach One) that help youth in an ongoing orientation to the program's process.

3.03 Youth Room Assignment

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy that includes all the components that meet the general requirements of the indicator. The program's policy indicated that youth sleeping assignments are critical to the youth's safety and supervision.

A review of three youth active files confirmed that the program had a classification process in place to ensure the most appropriate sleeping room assignment for youth. All files include evidence of youth's general history, age, gender, history of violence, disabilities, conditions, illnesses, physical size, suicide risk, sexual aggressiveness, and alerts if applicable. All files are organized and review-friendly for easy identification of specific sections and documents. The program's process included and had in consideration all the potential safety and security concerns, and other mandatory elements required. Each youth's file reviewed contained a CINS/FINS Intake Form signed and dated by a program's supervisor and staff that contained a Client Room Assignment section.

All trained agency direct care staff that conduct intakes evaluate the youth on the aforementioned traits and circumstances (age, gender, height, weight, build, history of assault or aggressive behavior, history of mental health/substance use issues and attitude scale of 1-10) prior to documentation of the placement. The document captures the designated module (A or B) and the actual bed number assignment (1-14).

Exception

In two of the three CINS/FINS Intake forms reviewed the documentation was incomplete and the module and bed assigned were not identified.

3.04 Log Books

Satisfactory

Limited

Failed

Rating Narrative

The agency has a comprehensive Logbook Policy (#3.04) that describes the agency's procedures for maintaining a professional, accurate and concise written documentation of major activities, events and incidents. The agency requires all staff to read the professional log at the beginning of shift and document reading the two preceding shifts.

Documentation reviewed, observation, and staff interviews confirmed that the program maintained a permanent, bound logbook with sequential pages. The logbook consistently utilized a color code system and recorded routine information, shift changes, visitors, emergency situations, and incidents. Entries that impact the security and safety of the youth and/or the program were highlighted.

The entries included date and time of the activity, a brief description of the activity/event, and the names of the youth and staff involved. The majority of the entries reviewed were legible and had no recording errors in the logbooks reviewed. The incoming supervisors and direct care staff in the unit reviewed the logbook information documented by the previous two shifts, made an entry in the logbook and signed/dated that they have reviewed it.

Exception

The Program Director (PD) or designee weekly review of the facility logbook was inconsistent.

3.05 Behavior Management Strategies

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed Policy 3.05, Behavior Management System (BMS), which describes the agency's current BMS process and practice. The current BMS includes rewards and consequences and sanctions. These rewards and sanctions are delivered according to behavior that ensures rewards outnumber consequences. The agency's BMS is designed to implement both consequences for violation of program rules and rewards are applied logically and immediately.

The program's BMS clearly defines rewards, privileges and consequences. The program has a detailed written description of the BMS that is included in the youth's handbook. The program's BMS consist of a point and four levels system that includes an orientation level that youth receive upon admission to the program.

The program maintains a Client Daily Point Log that contains each youth weekly points and a Client Point System log by teams that also include a Group Participation Form. Observation found that the program had a canteen/rewards/incentive store.

The program has a protocol for providing feedback to staff regarding their use of rewards and consequences. Training documentation reviewed revealed that the new staff hired by the program received BMS training in the program's BMS during the orientation phase.

3.06 Staffing and Youth Supervision

Satisfactory

Limited

Failed

Rating Narrative

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

Documentation reviewed and information confirmed that the program had adequate staffing to ensure the compliance with the minimum staffing ratios required. During the tour of the facility, the review of the staff schedule for the three shifts and observations completed during the time of the review validated that there is always at least one staff on duty of the same gender as the youth. Program staff included in the staff-to-youth ratio includes youth activity workers, supervision staff and treatment staff. Staff issues are usually resolved by the assigned shift leader.

The program has a Staff Contact Numbers log that includes contact numbers to reach staff when additional coverage is needed. Observation found that the program was equipped with sixteen functioning surveillance cameras. Observations completed during the review confirmed that the program's staff consistently maintained the required and appropriate interaction and attention to each youth.

3.07 Special Populations

Satisfactory

Limited

Failed

Rating Narrative

The agency has a detailed policy (3.07) for Special Populations that address the general requirements for this indicator. The written policy includes the procedures for staff secure, domestic minor sex trafficking, domestic violence respite, and probation respite.

As of this review period, there were no staff secure or domestic minor sex trafficking youth admitted in the program going back to the last QI review. However, the provider has specific procedures in place for in-depth assessment and service planning, enhanced supervision and security, parental involvement, and collaborate aftercare for these special population placements.

Similar to staff secure, the program has specific procedures for DV respite placements. During the visit, (6) DV referrals were reviewed. All six DV cases have prior approval for services prior to placement at the shelter. Pending DV charges were contained in the case files. None of the youth were in the DV respite for more than 14 days. Three (3) of the DV placement youth transitioned to CINS/FINS. Of the three DV placements, one (1) youth picked up a new offense and two (2) returned to parent/guardian.

The program has applicable probation respite policies and procedures in place and provided a list of 3 youth who were served in the last 6 months. Two of the three youth files reviewed showed referrals from DJJ Probation where the youth were on probation and adjudication was withheld. Evidence of Florida Network referral was included in the files. Case management and counseling services consistent with CINS/FINS were provided to the two youth.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Chief Clinical 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 surrender those medication to staff during admission. The agency stores all prescribed medications in the Med-Station 4000 cabinet and has several staff members as regular users and more than 2 Super Users for the Pyxis Med-Station 4000. The provider has an RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility. Topical and injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication and ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in an MDR Binder.

4.01 Healthcare Admission Screening

Satisfactory Limited Failed

Rating Narrative

The program has a written policy and procedures to ensure medical care for youth who are admitted to the program last updated July 31, 2015. The agency's policy has been fully updated. The policy now reflects adherence to the July 1, 2015 Florida Network of Youth and Family Service Policy and Procedure Manual. The agency has updated its policy to include that the Registered Nurse, the Licensed Practical Nurse, and Non-health care staff are required to perform preliminary health screenings at the time of admission to the shelter. The reviewer conducted interviews on the Health Admission Screening process with the Registered Nurse and the Licensed Practical Nurse. The Reviewer was informed that the agency utilizes health screening forms that includes CINS/FINS Intake Form; Health-Related History Form; and Medical Services Consultation Form. The provider's aforementioned preliminary health screening process includes: current medications; allergies; existing medical conditions; evidence of recent injuries or illnesses; presence of pain or signs of physical distress; observation for evidence of illness, injury, physical distress, difficulty moving; and presence of scars, tattoos, or other skin markings.

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

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

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

The program has procedures to ensure medical care for youth admitted with chronic medical conditions which includes a referral process and mechanism for follow-up. The program now utilizes a Registered Nurse (RN) to manage all medical care for youth in the program. The RN is responsible for overseeing and documenting any follow-up care provided to clients.

The agency still maintains individual medical files for each resident. The file contains the over-the-counter consent form, prescription consent form, off-site acknowledgement form for treatment, financial responsibility form, Camillus Health Concern form, all Family health forms, and Medicaid/Insurance forms. In addition, all documentation related to medical services received is maintained in the medical file.

Reviews of six (6) open client files were reviewed to assess the agency's adherence to the standards of this indicator. The agency maintains inter-agency agreements with Camillus Health for the medical care of youth needing non-emergency care. All 6 client files reviewed contain evidence that the program performs physical health screenings for each youth admitted to the shelter. Of these files reviewed, 2 of the 6 residents were in need of on-site medication during their shelter stay. The agency maintains a process in place for referring youth admitted with acute medical conditions that are acceptable for admission to the program.

4.02 Suicide Prevention

Satisfactory Limited Failed

Rating Narrative

The shelter has a Suicide Prevention policy that is current. This policy includes the agency's suicide prevention and response procedures. The agency's suicide risk assessment policy has been approved by the Florida Network of Youth and Family Services. The policy requires that each resident admitted to the shelter will be screened for suicidal risk by the utilizing the six (6) suicide risk questions on the CINS/FINS Intake form. The agency executes the policy by administering the questions to all residents. The Direct Care staff are trained to ask each resident the risk screening questions. If the resident answers "yes" to any of the 6 questions, the policy requires that resident be placed on elevated supervision (Constant Sight and Sound supervision) until a full suicide assessment can be completed by a qualified mental health professional. If the qualified mental health professional is not available, the youth will be placed on Constant Sight and Sound supervision until the counselor is available to conduct a full suicide assessment. Following this action, Direct Care Staff will immediately refer the youth to the agency's licensed mental health professional. The agency's President and CEO is a qualified Licensed Clinical Social Worker. The agency's Clinical Director oversees all Masters level counselors.

A review of six (6) client files serviced in the last 6 months were randomly selected to assess the agency's adherence to the requirements of this indicator. All client files reviewed (6 closed

files) were screened and deemed positive for suicide risk. All 6 client files had evidence that they had been screened for suicide risk during the intake process. Youth that were deemed positive were placed on sight and sound supervision until assessed by a licensed clinician or a non-licensed Master's level counselor under the direct supervision of the agency's licensed professional. The files contained suicide screening results that were reviewed and signed by a supervisor and the youth remained on sight and sound supervision until their status was reviewed and confirmed by the counselor under the direct supervision of the agency's licensed professional. The supervision level status of residents was not changed from sight and sound, remained on sight and sound, and was not placed back in to general population until the agency's LCSW approved the level change. Documentation of observation logs validated the majority of precautionary observation logs conducted a minimum of thirty-minute checks.

Overall, the agency is addressing all elements of the Health Admission Screening form indicator and complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.

Exceptions were noted for this indicator.

One out of 6 files reviewed is missing the licensed clinician's signature on the Assessment of Suicide Risk.

One out of 6 Suicide Observation logs reviewed is missing observation and initials of the YAW on two (2) fifteen (15) minute checks.

One out of 6 Suicide Observation Logs reviewed is missing the Mental Health Clinical Staff Person's Signature to confirm that the log had been reviewed as required.

4.03 Medications

Satisfactory Limited Failed

Rating Narrative

The agency has written policy and procedures to ensure that residents that are admitted to the program are provided medication during their shelter stay. This policy was last updated July 31, 2015. The agency's policy has been fully updated. The policy now reflects adherence to the July 1, 2015 Florida Network of Youth and Family Service Policy and Procedure Manual. The agency has updated its policy to include the mandatory use of the Pyxis Med-Station 4000 to store all prescribed medications. The policy also incorporates that a Registered Nurse (RN) is being authorized to administer medications and approve injectable medications. The reviewer conducted interviews on the agency's Medication Distribution practices with the Registered Nurse and other staff members that are authorized to provide medications. The agency maintains a list of staff members that have been trained and are authorized to provide medications. At the time of this on-site program review, there was a total of twenty (20) staff authorized on an official list to distribute medication. The aforementioned list contains staff members that are designated to have access to secured medications and limited access to controlled substances.

An on-site tour revealed that the agency is storing all prescribed medications in the Med-Station 4000 cabinet. The agency has several staff members as regular users and more than 2 Super Users of the Pyxis Med-Station 4000. A review of the medication cabinet found that all oral and topical medications are not stored together. The agency has a refrigerator to store medication that requires cold storage. All controlled and non-controlled medication is stored behind two (2) locks. The Med-Station has pass-code lock and a biometric fingerprint scanner as a second lock. The machine is not accessible to residents and is secured behind a locked key only access door. The agency conducts medication counts on all controlled medication 3 times per day. Controlled substances are counted. The agency maintains a perpetual inventory with running balances that is maintained on the resident's medication log. The agency conducts a daily shift-to-shift inventory. Counts are conducted by direct care staff as well as daily counts by the RN. All counts of over-the-counter medications are inventoried daily by the Nurse as well as trained staff members. A perpetual inventory is maintained when given. The agency completes weekly sharp counts. All sharps are secured in a locked cabinet in the Intake Office. The agency does have a red biohazard container for sharps disposal. The facility has a Bio-medical waste agreement with Steri Cycle for biohazard waste. A review of current client cases on medication was reviewed to determine the agency's adherence to the standards of this indicator. All files are marked confidential.

All medication distribution files reviewed contained required evidence of name, picture, medication, dosage, instructions, side effects and other relative areas. All files are generally compliant in all areas with minimal errors. The Registered Nurse performs 40 hours of nursing services divided across both the Miami Bridge Central and South locations. The Registered Nurse oversees the documentation, storage, and distribution practices executed at both Miami Bridge youth shelter locations.

Exception

An exception is noted for this indicator. The agency has a documented medication incident on April 23, 2015. Residents informed the nurse that they distracted the direct care worker during medication pass in order to give medication prescribed to one client to another client. The client that took the medication was not prescribed that particular medication. The agency noted that this was a critical incident that compromised the safety of the clients due to the lack of supervision and carelessness. Personnel action on the direct care worker involved an agency corrective action; follow-up is documented in the file worker involved in this incident.

4.04 Medical/Mental Health Alert Process

Satisfactory Limited Failed

Rating Narrative

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

Six (6) youth files were reviewed to validate practice of medical/mental health alert process as outlined in the procedure. Initial medical screenings is conducted during the admission screening. If the RN is not on-site to conduct the screenings, the medical/mental health alerts are reviewed by the RN within 72 hours of admission. In all six cases, the youth were appropriately placed on the program's alert system. Staff provided sufficient information/instructions to recognize and respond to the emergency care if needed.

A review of three new hire staff training showed that Medical/Mental Health Alert Process is reviewed during their orientation training.

4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

Rating Narrative

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

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

Staff Training files document emergency medical procedures is included in the orientation training. Staff are also trained in CPR and First Aid and were up-to-date on the training.

The program has a knife-to-life and wire cutters in the Intake Office, school, and Nurse's office. First aid kit and supplies are located in seven locations: Intake office, one in each of two vans, school location, First Stop office, the kitchen, and nurse's office.

First aid kits are checked weekly by the Nurse who maintains the weekly records in a binder. First aid kit/supplies are located in: 2 vans, the school, kitchen, Intake Office, First Stop program. The First Aid kits are inventoried and the supplies restocked weekly. This is documented on the weekly check list reviewed.