Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge-Homestead

on 04/05/2017

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory:71.43%
Percent of indicators rated Limited:28.57%
Percent of indicators rated Failed:0.00%

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care

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

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

Standard 4: Mental Health/Health Services

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

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

Percent of indicators rated Satisfactory:92.59%
Percent of indicators rated Limited:7.41%
Percent of indicators rated Failed:0.00%

Rating Definitions

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

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

Review Team

Members

Marcia Tavares, Lead Reviewer - Consultant, Forefront LLC

Ashley Erickson, Non-Residential Supervisor, Children's Home Society (WaveCrest)

Paula Friedrich, South Regional MQI Monitor, Florida Department of Juvenile Justice

Bill Mann, Co-CEO, Florida Keys Children's Shelter

Nitara Wiggan, QM Manager, Children's Home Society (WaveCrest)

Persons Interviewed

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

0 Case Managers
3 Program Supervisors
1 Health Care Staff
1 Maintenance Personnel
1 Food Service Personnel
1 Clinical Staff
2 Other

Documents Reviewed

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

5 # Health Records
3 # MH/SA Records
15 # Personnel Records
8 # Training Records
3 # Youth Records (Closed)
6 # Youth Records (Open)
2 # Other

Surveys

3 Youth
3 Direct Care Staff

Observations During Review

- [ ] Intake
- [x] Program Activities
- [x] Recreation
- [ ] Searches
- [x] Security Video Tapes
- [x] Social Skill Modeling by Staff
- [x] Medication Administration
- [x] Posting of Abuse Hotline
- [ ] Tool Inventory and Storage
- [x] Toxic Item Inventory and Storage
- [ ] Discharge
- [ ] Treatment Team Meetings
- [x] Youth Movement and Counts
- [x] Staff Interactions with Youth
- [x] Staff Supervision of Youth
- [x] Facility and Grounds
- [x] First Aid Kit(s)
- [ ] Group
- [x] Meals

Comments

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

The program provided a tour during this review and showed a lot of the updates to the property including renovated bathrooms for both the girls and boys room, a new basketball court, and a computer lab that maintains the new monitors in each station behind a protective glass. The facility has it's own school on the premise which the youth attend.

The staff are very nice and accommodating. All staff were knowledgeable about the program and their

specific job responsibilities. The staff treated the youth with respect and engaged in activities with them versus just watching them. The facility was well kept, clean, and had a welcoming feeling.

Strengths and Innovative Approaches

Rating Narrative

Miami Bridge Homestead (MB Homestead), located in the city of Homestead in southern Miami-Dade County, 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 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.

MB Homestead's administrative office is located in North Miami, Florida, along with its north CINS/FINS shelter. The Homestead 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 emergency shelter offers a variety of services to meet the need of its target population. These services include: 24 hours a day, seven days a week shelter services; formal on-site education program with certified Miami-Dade County Public School teachers; structured daily living programs employing positive behavior modification techniques; mental health counseling; life skills groups to promote responsibility and independence; substance abuse prevention services; family reunification services and case management; positive youth development through recreation, arts, crafts and music; and health care coordination services to insure access to medical treatment.

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

Effective July 20, 2016, the agency implemented an Electronic Medical Record (EMR) system utilizing Lauris, an online automated system, to optimize the organization's service delivery and information management processes. This system gives the agency the ability to automate workflow and manage all aspects of services. The goal is to become a paperless agency by July 1, 2017.

Grant funding from Galleria Farms allow the agency to offer music therapy to youth using IPods as well as professional music lessons by Evolution Karaoke and Motivational Edge.

The Homestead shelter and school building now boast a new metal roof paid for by the County of Homestead (COH) CDBG.

Installation of fully addressable fire system – COH CDBG.

Installation of 2 new bathrooms in First Stop for Families building – Miami Dade CDBG.

Renovation of youth bathroom at the onsite Homestead School.

Addition of 12 like-new computer desks stations to the onsite school.

A computer lab consisting of 4 computers, desks, and chairs was donated and installed by Braman Foundation and One World Properties. Youth has access to technology to assist with homework, research, and other internet related activities.

Twenty-eight new metal beds, mattresses and new bedding was donated by Braman Foundation to replace the former wooden beds.

The agency purchased a Zapper for each campus, which allows staff to 'zap' and destroy bedbugs by placing all of the child's belongings in a heated box and 'baking' them. Youth are provided scrubs so even the clothes they wear into the shelter can be placed into the zapper as well.

The agency upgraded its camera system to include increased storage capacity and improved video quality with HD infrared technology; upgrade was partially funded by CINS/FINS Maintenance and Update account.

A full alarm system was added, funded by Miami-Dade County CDBG.

- **Miami Bridge elected a new Board President in 2016.**

Standard 1: Management Accountability

Overview

Narrative

MB Central, located at 2810 NW South River Drive, Miami, Florida, is under the leadership of a Board of Directors, Chief Executive Director, Deputy CEO/Chief Financial Officer, Chief Operations/Technology Officer, Chief Administrative/Compliance Officer, Director of Shelter Services, two Clinical Directors, Director of Human Resources, and a Director of Admissions. The Chief Executive Director oversees the Miami Bridge agency and the services provided in Central Miami and Homestead, Florida. The residential component is managed by the Director of Shelter Services who supervises the Shelter Supervisor for the Central shelter and the Homestead shelter. The clinical component for each location is under the supervision of two Clinical Directors, one for each site.

At the time of the quality improvement review, the program reported one vacancy for an on call Youth Activity Worker. The MB Homestead facility is licensed by the Department of Children and Families for 20 beds, with the current license in effect until February 28, 2018.

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

The provider requires all staff and volunteers to complete a DJJ Background Screening (DJJ BSU) in accordance with FS 985.407 that includes good moral character documentation, criminal history background screening and electronic submission of Department of Homeland Security E-verify for new employees confirming work eligibility. Prior to completing a Live Scan, Human Resources will check the clearinghouse database to see if the applicant has a current background screening on file. If the prospective employee's record is not found, the agency will proceed with the submission of a Live Scan. Upon receipt of an eligible screening result, the agency will formally make an offer of employment. In addition, the provider conducts a drug screening and conducts a local law enforcement check, a driving history check with the Division of Motor Vehicles, and pre-employment TB test prior to the hiring of all staff. All employees are re-screened every 5 years from the initial date of hire.

A total of fourteen (14) applicable personnel files were reviewed for eight (8) new staff, six (6) interns, and one (1) staff eligible for 5-year re-screening. The eight new staff were hired after the last onsite QI visit in November 2015 and all eight received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. Similarly, the one staff that was eligible for 5-year re-screening had the re-screening conducted prior to the staff's five-year anniversary date.

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

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

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

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

1.02 Provision of an Abuse Free Environment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

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

The agency's policy requires staff training on Child Abuse reporting to the Florida Abuse Hotline and requires all employees to immediately report allegations of child abuse or suspected child abuse to the Abuse Hotline. Staff are trained in these procedures during the first year of employment. In addition, there are comprehensive procedures regarding the reporting of abuse as well as information about signs of abuse/neglect. The program requires that calls made to the Abuse Hotline be documented in the program logbook for residential clients.

The program has a current grievance procedure that is utilized by youth to file a complaint. The procedure is reviewed with youth during intake. A copy of the grievance procedures is included in the resident handbook and the program has a grievance box for depositing grievances.

During the tour of the facility the Reviewer observed posters with House Rules and Guidelines, Youth Rights and Responsibilities, Emergency Numbers and Evacuation Procedures in the hallway as well in the dorm rooms. A Grievance Box is mounted on a wall adjacent to the Intake office and blank forms are available next to the box.

The program maintains both a Monthly Abuse Registry Log and a Client Grievance Monthly Log. During the last year there was eight (8) abuse calls reported, and five were accepted. None of the abuse calls were institutional. Youth receive an orientation guide and grievance procedures during admission. In the past six months there were two (2) grievances with prompt resolutions and management review. One of the grievances was related to staff not allowing youth to sleep longer and another was related to the alarm volume.

Surveys were completed with four youth on-site during the QI visit. All four youth were knowledgeable about the abuse hotline and 3 of 4 youth knew the location of the number. None of the youths surveyed stated they had attempted to call the hotline or was prevented from making the call. The four youth also indicated that they feel safe in the shelter and adults are respectful when talking with youth. All four youth surveyed were familiar with the grievance process.

The three staff surveyed stated working conditions have been good (1) or fair (2) at the shelter. None of the three staff have ever observed a co-worker using profanity when speaking to youth.

Per the HR Director, no disciplinary actions were required for any program staff for disruptive behavior or

inappropriate physical/verbal aggression toward youth.

Exceptions:

As required by the indicator, the provider's policy and procedure 1.02.01 does not clearly state that direct care workers will not handle complaint/grievance documents.

Four of the abuse calls made and accepted by the Abuse Hotline were not documented in the program logbook as required by the agency.

One of the four youth surveyed did not know the location of the abuse hotline telephone number although the number was observed to be posted in the dormitory, shelter hallway, and intake office. One of the youth also mentioned hearing adults use curse words when speaking with other youth.

1.03 Incident Reporting

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 1.03, that addresses the required elements of the CQI indicator. Program policy was last revised on 9/30/2016 and was signed by Chief Executive Officer and Chief Administrative & Compliance Officer.

The policy provides explanation of reporting time-frames to contact CCC to meet CQI indicator requirements. An explanation is provided indicating who is to be notified within the organization for the various incident reports and provides additional detail and an example instructing staff that may have to report an incident to law enforcement including examples of de-escalation techniques that may be useful for incidents involving violence. The policy also discusses who should be notified, the responsibilities of the clinical staff with certain incidents, where the incidents are to be documented, and includes the policy for reviewing/monitoring incidents as well as the time-frames.

Incidents are documented in the program logs as well as on incident reporting forms. All internal incident report forms are reviewed and signed by program supervisor/director.

The program has a great procedure for maintaining incident reports which includes photocopying the log pages that document the time-frames the incident occurred and allows for easy review of the incidents, identifying discrepancies, or providing supportive documentation.

Four incidents were reported to the CCC between 10/1/16 – 4/4/17. Three out of four incidents were deemed non-reportable by the CCC. One report was initially non-reportable and later accepted by the CCC hotline. The one incident that was accepted involved a youth receiving cold medication during an outing. The incident was called in within the required time-frame and a message was left for the CCC; it is documented that they returned the call the following morning.

There are no exceptions to this indicator at the time of the visit.

1.04 Training Requirements

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 1.04, that addresses the required elements of the CQI indicator. Program policy is signed by Chief Executive Officer and Chief Administrative and Compliance Officer and appears to be current and up-to-date with a last revision date of 9/30/2016. The policy states the required training needed for full time, part time, and on call staff and indicates that all direct care staff are

required to have 80 hours of training within the 1st year and 40 hours of training per year annually.

There is a separate training plan referenced in the policy that was recently updated in January 2017 that includes some of the required trainings that are available on the Florida Network on line system. The training plan states that all new hires undergo a comprehensive orientation training for at minimum 40 hours of the 80 annually required hours. The training plan specifically addresses 'staff ownership of training' and addresses that Miami Bridge has emphasized the importance of meeting their training requirements and is making this part of all staff annual performance evaluation. Supervisors are expected to identify training goals to monitor in annual evaluations.

The QI Coordinator and Shelter Directors are responsible for ensuring that new staff orientations are completed and documented in the staff or volunteer training file. New staff are required to sign the orientation form upon completion. The following Florida Network trainings are designated in bold and are to be completed during orientation for all program/clinical staff: CINS FINS Core training, suicide prevention, sign and symptoms of MHSA, PREA, serving LGBTQ, domestic violence, human trafficking/domestic minor sex trafficking, and positive youth development. The program staff are required to complete this orientation within 2-4 weeks depending on department and workforce needs.

Following the 1st year of employment, direct care residential staff training should include refresher training on the use of available fires safety equipment, crisis intervention, training necessary to maintain CPR and first aid certification and suicide prevention. There is a separate training file maintained for each staff or volunteer.

A total of 9 staff training files were reviewed which included 1 clinical staff file, 4 new hire staff, and 4 staff that have worked with the agency over 1 year. All new hire training files reflected that new hire staff completed 80 hours or more as per the CINS/FINS and program policy. This included 1 staff member that completed over 143 hours per their individual training log. Several of the trainings required to be completed were not completed within the first 120 days as per the program policy for all of the new hire files reviewed.

All residential new hire staff completed Orientation training as well as Title IV-E procedures, Information Security Awareness, and Child Abuse training as part of the orientation. All new hire staff files reviewed showed evidence that Medication Distribution training was completed.

The Ethics training requires 3 components: Civil rights, EEO and Sexual Harassment. The current practice is that HR covers this in review of the employee handbook under the section of equal employment opportunity and anti-discrimination. However, the handbook does not specifically address 'civil rights' which is a Florida Network required training.

The program indicates certain in-service trainings are required and, although the files did not consistently show evidence, these specific trainings were completed. There is evidence that all staff were provided in-service trainings. Three out of four staff files reviewed are on target or completed over the 40 hour training requirement as per the program policy; however, one of the staff was not on target and had completed 23 hours with one month remaining to acquire 40 hours. The majority of mandatory topics were completed by the 4 staff who had time to complete outstanding training. Note that the annual refresher training for Fire Safety equipment was not yet completed by 3 out of 4 staff.

One clinical staff reviewed showed evidence that she is currently completing the assessment for suicide risk training, which will need to be completed by June 2017.

Exceptions:

A few of the mandatory training topics were not completed during the first 120 days as required by some of the new staff namely: Managing Aggressive Behavior (MAB) (1 staff), Suicide Prevention (3 staff), CINS/FINS Core (3 staff), Mental Health Substance Abuse (3 staff), Behavior Management (2 staff), CPR/First Aid (1 staff), and Understanding Youth Development (4 staff). One of the staff did not have current Suicide Prevention or MAB training on file according to the 120 day requirement. Four new hire staff completed the Behavior Management training; however, 2 staff did not complete this within the 120-day requirement. The agency does not have a specific training that addresses Understanding

Youth/Adolescent Development which applies to the 4 new hire files reviewed. One staff has passed her 1 year without completing the Cultural Humility training.

One of the in-service staff was not on target for completing the required hours of training and had completed 23 hours with one month remaining to complete reach 40 hours.

The Ethics training requires 3 components: Civil rights, EEO and Sexual Harassment but the provider's HR manual does not specifically address 'civil rights' which is a Florida Network required training.

1.05 Analyzing and Reporting Information

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

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

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

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

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

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

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

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

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

as the active use of MSDS sheets and pro-active policy that ensures the health and safety of all parties.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The client and employee satisfaction surveys are completed bi-annually and discussed at the quarterly CQI meeting. The results are compiled and shown in relation to the last results. The most recent satisfaction survey was completed for the current FY 2016-January 2017.

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

There are no exceptions to this indicator at the time of the visit.

1.06 Client Transportation

☐ Satisfactory ☒ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 1.06, that addresses the required elements of the CQI indicator. Program policy was signed by the Chief Executive Officer and Chief Administrative & Compliance Officer and appears to be current and up-to-date as of the last revision on 9/30/2016.

The program's procedures captures the requirements needed to meet the CQI indicator as related to: approved agency drivers with valid Florida driver's licenses covered under company insurance policy; use of third party to avoid single youth transport when necessary; appropriate documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location; following all aspects of policy and procedure as it relates to vehicle management systems and DOT standard operating process; and maintaining an approved drivers list that is posted.

The procedures specifically state that transportation of youth is for agency vehicles only and states that youth are not to be transported in staff personal vehicles. The only exception is if permission is granted by the CEO or Deputy CEO and documented verbal and written consent must first be given by the parent or guardian in all circumstances. The Chief Operations of IT and the Chief Financial Officer are jointly responsible to ensure that all vehicles maintain current and proper registration and all vehicles are properly insured.

The program has a separate policy 'transportation and vehicle management' that addresses the maintenance and safety of vehicles in additional detail. The policy addresses that all persons operating vehicles are responsible to ensure that all passengers fasten their seat belt before departure. If a youth refuses to use a seat belt, they are to be escorted from the vehicle and returned to the shelter and if this occurs while out, an appropriate behavior consequence will be considered for that youth. There is additional information that outlines the appropriate behavior and the responsibility of how vehicles are to be used by staff and youth, which includes not texting or talking on the agency or personal phone while driving.

Youth being transported from the facility are to be signed out in log book by staff and an authorized person

and returned to the facility by an approved adult person. Appropriate identification must be provided and logged into the shelter log book.

Staff supervision of youth must be specific to gender when only one youth is transported. Female staff must transport staff on a 1:1 basis. At all times it is the expectation to be in ratio and have a 3rd party present in the vehicle when accompanying youth.

The program policy indicates they do not transport youth to school unless deemed necessary as a continuum of the service to the youth and should be authorized by the CEO and or clinical director. The program policy also indicates they do not typically transport to court unless part of DJJ/JAC or CINS/FINS requirement and need to be agreed by Shift leader, admissions director, shelter director and/or clinical director. If transport is agreed, the shift leader/YAW does not escort the youth into court and only hands over the youth to the appropriate person.

The transportation and vehicle management policy states that every vehicle use must be documented in the agency log book and must state destination, staff using vehicle and list all clients and other passengers. At the close of each shift, the shift leader is responsible for ensuring that the vehicle is inspected, has adequate supply of gas, mileage recording is correct, and staff's printed name, signature and any findings is documented in the shift summary form.

The program maintains a mileage log book and transportation logs to specify date, time, name of driver and signature, destination, trip purpose, mileage, number of passengers, and last four digits of cell phone. Cell phones to be used during vehicle operations are maintained in the intake office with the van keys for staff to easily access.

A sample review of the shelter log indicates that there is evidence of documentation in the shelter log book that the use of van keys and cell phone are signed out and returned by staff in compliance with program policy. One staff member in particular appears to be consistent in their documentation on an ongoing basis; however, this is not consistent with all staff in practice according to program policy.

There is evidence that staff are documenting both staff transporting youth on the mileage logs when more than 1 staff is transporting youth. However, this does not appear to be a consistent practice and it is difficult at times to identify single youth transports when 2 passengers listed on the log refer to one staff plus youth or two staff only.

The program does not currently use any interns or volunteers that is approved for transporting clients.

Exception:

Although it is addressed in the policy and procedures, there was no consistent practice of supervisory consent and documented approval whenever a third party was not present and/or available resulting in single transports of youth. There was evidence in the shelter log that staff transported 1 youth alone without consideration of the clients' history, evaluation and recent behavior or the supervisor giving consent prior to transport and documenting it accordingly.

1.07 Outreach Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 1.07, that addresses the required elements of the CQI indicator. Program policy was signed by the Chief Executive Officer and Chief Administrative & Compliance Officer and was last revised on 9/30/2016.

The program's written policy and procedures require effective community outreach services as essential to developing a comprehensive continuum of services, increase public awareness, enhance referrals, and improve access to services for community members. The program is required to have a written plan addressing site specific targeted outreach activities, conduct outreach activities to provide presentations

and disseminate printed materials, designate a lead staff member to coordinate and provide outreach services, and attend DJJ board and council meetings and maintain meeting minutes/agendas as verification of attendance at the meetings.

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.

Miami Bridge has a designated Outreach Coordinator who is responsible for community outreach services. Outreach activity is maintained in a binder on a monthly basis. The program also maintains a binder that contains executed written agreements with twenty-nine community partners ranging from Miami Dade Juvenile Services Department to Kristi House that include services provided and a comprehensive referral process. The agreements specified the dates through which each agreement is in effect. The program also maintains a spreadsheet to track the initiation date, end date, term, and the contact person for each written agreement.

The program provided Circuit 11 Community Advisory Board sign-in sheets for the past six months with the exception of December 2016 because no meeting was held. The sign in sheets document the attendance of a Miami Bridge staff representative at each meeting. Council meeting attendance is kept in a binder with monthly agendas and meeting minutes.

There are no exceptions to this indicator at the time of the visit.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Miami Bridge Youth and Family Services is contracted to provide both shelter and non-residential services for youth and their families in Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week 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 Aid 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 For Families (FSFF) via the Director of Admissions. FSFF Counselors work with youth both in the First Stop office as well as in the community. 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.

2.01 Screening and Intake

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure 2.01 that addresses all of the key elements of the CQI indicator. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

Procedures are in place to ensure that the parents/guardians and youth will receive the following in writing during the intake:

Available service options

Rights and responsibilities of the youth and parent/guardian

Grievance procedures

Behavior Management and Intervention systems

Possible actions occurring through CINS/FINS services.

A total of 3 residential and 3 non-residential files were reviewed for two closed files and four open files. All

of the files were found to meet the requirement that parents/guardians received: available service options; rights and responsibilities; grievance procedures; information about the program's behavior management and intervention systems; and possible actions occurring through CINS/FINS services, including the parent/guardian brochure signed and dated during intake by the youth, parent/guardian, and the 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. The Eligibility Screenings were completed within 7 calendar days of referrals in all case files reviewed.

There were no exceptions within the 3 residential or 3 non-residential cases reviewed.

2.02 Needs Assessment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.02, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

The provider's policy states:

Each youth shall have a needs assessment initiated within 72 hours of admission by a bachelor's or master's level staff and signed by a supervisor.

Each youth served will receive a full assessment if the most recent is over 6 months old.

The needs assessment will be completed within 2-3 visits/sessions. For non-residential services the needs assessment must be initiated during the first face-to-face.

A suicide risk assessment will be included in the needs assessment.

The needs assessment contains elements required by the Florida Network Policy and Procedure Manual for CINS/FINS which are: 1) initiated or attempted within 72 hours of admission, if the youth is in shelter care, or updated if most recent needs assessment is over six months old, and 2) completed within two or three face-to-face contacts following the initial intake if the youth is receiving non-residential services or updated if most recent needs assessment is over six months old.

A total of 3 residential and 3 non-residential files were reviewed for two closed files and four open files. All 6 needs assessments were initiated within 72 hours of admission. All 6 needs assessment were completed within 2 to 3 face-to-face contacts and none were over 6 months old. All 3 residential needs assessments were completed by a case manager aid whose degree is a high school diploma. The supervisor did sign all of the assessments and she is a LCSW. All 3 non-residential needs assessments were completed by a bachelor level case manager. Three of the 6 youth were identified with an elevated risk of suicide during the assessment. A suicide risk assessment was completed for both residential youth, and the non-residential youth was baker acted from home and returned home.

Exception:

The Needs Assessments for the 3 residential files were completed by a Case Manager Aid who has a high school diploma and not a Bachelor's degree as required. When this Reviewer spoke with the supervisor about the Case Manager Aid completing the Needs Assessment she said that she conducts the assessment with the aid and signs off on her work. This is not documented in the file. The agency's policy, 2.02, states that a bachelor's or master's level staff will complete the assessment.

2.03 Case/Service Plan

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.03, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

The plan is developed based on information gathered during initial screening, intake and assessment. The plan includes: 1) identified needs and goals; 2) type, frequency and location of services; 3)person(s) responsible; 4) target dates; 5) actual completion dates; 6) signature of youth, parent/guardian, counselor, and supervisor; and 7) date plan was initiated. In addition, the case/service plan is reviewed by the counselor and parent/guardian (if available) every 30 days for the first three months, and every six months thereafter, for progress in achieving goals and for making any necessary revisions to the case/service plans. When youth and/or parent/guardian are not available to sign the case/service plan, this is documented on the case/service plan and progress notes.

A total of 3 residential and 3 non-residential files were reviewed, two closed files and four open files. All 6 files included service plans that were developed within 7 working days and were individualized and prioritized in all of the eight files reviewed. Two of the 6 files were closed and one did not have the actual completion date in the initial or updated service plan; per the supervisor it was due to the youth not completing the goals so the case was transferred to non-residential services. Three of the 6 cases were opened over 30 days and all 3 had updated case plans with timely case plan reviews.

No exceptions were found in the 3 residential or 3 non-residential cases.

2.04 Case Management and Service Delivery

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.04, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

Per Policy 2.04, each youth is assigned a counselor/case-manager who will follow the youth's case and ensure delivery of services through direct provision or referral. The process of Case Management includes:1) establishing referral needs and coordinating referrals to service based upon the ongoing assessment of the youth's/family's problems and needs; 2) coordinating service plan implementation; 3) monitoring youth's/family's progress in services; 4) providing support for families; 5) monitoring out of home placement, if necessary; 6) referrals to the case staff committee; 7) recommending and pursuing judicial intervention in selected cases; 8) accompanying youth and parent/guardian to court hearings and related appointments, if applicable; 9) referral to additional services, if needed; 10) continued case monitoring and review of court orders; and 11) case termination with follow-up.

A total of 3 residential and 3 non-residential files were reviewed, two closed files and four open files. The youth is assigned a counselor when they are admitted into the program. Under section one, there is a print out from the Lauris Online system that shows the assigned case manager's name. One of the files also had it documented on the intake eligibility screening at the bottom of page 4. The supervisor also indicated they print a day sheet every morning for the staff, which tells them which shelter youth is assigned to which counselor. The Counselor/Case Manager established referrals needs and coordinated referrals to services based upon the ongoing assessments of the youth's/family's problems and needs. The Counselor/Case Manager coordinated service plan implementation. Youth's/Family's progress was monitored. It was evident Youth/Family were referred to additional services when appropriate. Case monitoring was provided and case termination was provided with follow-up.

There were no exceptions for the 6 files reviewed.

2.05 Counseling Services

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.05, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

Agency policy 2.05, Counseling Services and Family Involvement, provides for and reflects the requirement of Indicator 2.05. Per Policy 2.05, youth and families receive counseling services, in accordance with youths case/service plan, to address needs identified during the assessment process. Shelter programs provide individual and family counseling, as well as group counseling sessions held a minimum of five days per week. Non-Residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out of home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families in the delinquency and dependency systems. Services are provided at youth's home, community location, or the local provider counseling office. When counseling services are offered, the case reflect coordination between presenting problems such as needs assessment, case/service plan reviews, case management, and follow-up. The program maintains individual case files with chronological case notes on youth's progress and adhere to all laws regarding confidentiality.

A total of 3 residential and 3 non-residential files were reviewed, two closed files and four open files. In most of the files, the service plans included individual and family sessions for the youth and family. Group counseling was provided at least 5 days a week for the three residential cases. In all 6 cases, presenting problems were addressed in the needs assessment and service plans. Case notes were well maintained for all counseling services provided and youth's progress was documented. In addition, an ongoing internal process is in place where the clinical supervisor reviews cases with staff and peer record reviews are conducted.

Exception:

For the 3 residential cases reviewed, per each youth's case plan, the youth were to receive weekly individual and family therapy. One open file showed both weekly services in the progress notes. However, the progress notes for the other open file showed weekly individual therapy was occurring but not the family session. The closed file showed weekly family sessions were occurring but only one note as to individual therapy occurring.

2.06 Adjudication/Petitiion Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.06, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

Per Policy 2.06, a case staffing meeting is scheduled to review the case of any youth or family that the program determines is in need of services or treatment such as if youth/family is not in agreement with services or treatment or the youth/family will not participate in the service selected or the program receives a written request from the parent/guardian or any member of the committee. A Case Staffing committee is convened within 7 working days from receipt of the written request from parent/guardian. As a result of the case staffing committee meeting, the youth and family are provided a new or revised case plan for services.

Within 7 working days of the meeting a written report is provided to the parent/guardian outlining the committee recommendations and the reason behind the recommendations. In addition, the program works with the circuit court for judicial intervention for the youth or family, as recommended by the case staffing committee. The program's Case Manager or designee completes a review summary prior to hearing, informing the court of the youth's behavior and compliance with court orders and providing recommendations for further dispositions.

Three eligible cases during the review period were reviewed. The program has a case staffing committee

and according to notes of meetings held, they have regular communication with the committee. The staff requested the staffing in all three cases and case staffing were held within a 7 day time frame for each. In addition, the family and committee were notified 5 days prior to the staffing. The Case Staffing included all needed representation such as a local school representative, DJJ Representative, and CINS/FINS representative. No additional tasks were recommended by the committee for two of the cases reviewed.

Exception:

One of the files reviewed did not have an updated case plan as a result of the case staffing. An additional task was requested at the staffing and although the case manager did complete the task and documented the information, the case plan was not updated.

2.07 Youth Records

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure, 2.07, that addresses all of the key elements of the CQI indicator. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

Per agency's Policy 2.07, the program maintains confidential records for each youth that contains pertinent information involving the youth and his/her treatment at the program. All records are marked "Confidential" and kept in a secure room or locked in a file cabinet that is marked confidential, which is accessible to program staff. All records that are transported are locked in an opaque container that is marked confidential. Youth records are maintained in a neat and orderly manner so that staff can quickly and easily access information. All youth records should be accessible only by program staff. Records should be organized for optimal information retrieval.

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

No exceptions were found in the 3 residential files or the 3 non-residential cases.

Standard 3: Shelter Care

Overview

Rating Narrative

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

Staff members in the Residential Program include: Shelter Director, Director of Admissions, one Residential Counselor, a Case Manager Aid, three Shift Leaders, eight Youth Activity Workers, a RN, a LPN Health Care specialist, a Food Specialist/Cook, a Recreation Specialist, an Outreach Specialist, and a Facilities Coordinator that is shared between the two shelters. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The Youth Activity Workers are also responsible for processing new admissions, providing orientation of youth to the shelter, and supervision of youth.

Health and medication related activities are the responsibility of the RN and Licensed Practical Nurse who maintain inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administer first aid when needed, and coordinates all offsite appointments to medical providers. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication office, and kitchen. All medications are stored in a locked cabinet in the staff office.

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

3.01 Shelter Envonment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Policy 3.01, Shelter Environment, that covers all required elements of the policy. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

The agency’s procedures states Miami Bridge’s facilities will be clean, landscaped and well maintained. The Chief Operations and Technology Officer (COTO) will be responsible for implementing appropriate maintenance procedures and schedules in the respective facilities to ensure a safe, clean and attractive environment for agency clients and employees. The shelter environment will promote the healthy social, intellectual and physical development of youth in care. Staff is encouraged to take responsibility for their

work environment and maintain a “home-like” atmosphere. General maintenance, equipment, and furnishing replacement costs will be factored into annual budgets.

The Homestead shelter is a residential program for both youth who meet the criteria for CINS/FINS as well as youth who are referred by the Department of Children and Families. During the tour of the facility, the building appeared to be clean and well maintained despite its age. The provider shares a Maintenance staff between its two locations and it appears that the maintenance staff does an excellent job in maintaining the building and grounds.

The facility has a large lounge used for resident meetings and a space for youth to relax during downtime. The facility also has a separate area for dining and a large commercial kitchen equipped with a large freezer and two refrigerators. The Youth Care Intake office sits next to the lounge and has clear windows to ensure continuous view of the youth. The counselors’ and staff offices are located on the periphery of the lounge and along one hallway that leads to the girl’s dorm.

Additional rooms in the facility include a family meeting room, a laundry room, and a Nurse’s/Med room/station. There are separate dormitories for the male and female residents. Each dorm area is furnished with bunk beds, comforters and pillows, and individual youth lockers. Each bathroom includes: 3 showers, 3 dressing rooms, and 3 sinks, all recently remodeled. The grounds were well manicured and landscaped.

The provider recently added a new 32-digital camera security system with web-based monitoring. All the cameras were operational during the visit. During the tour, eight fire extinguishers were strategically located throughout the building and they were all updated with same expiration dates of June 2017. The agency's annual Fire Permit was conducted by the Miami Dade Fire Rescue on 3/29/17 for all three buildings on the site. No violations were found. The Range Hood in the kitchen was inspected on 7/30/16. The Sanitation certificate from the Florida Department of Health was up-to-date and expires on 09/30/2017. The Department of Children and Families issued the agency’s Child Caring License for 20 beds on 3/1/17 with an effective date through 2/28/2018.

At the time of the review, the program had 12 youth-- 7 females and 5 males-- in the shelter. During the tour, the youth were participating in school. The facility has its own building used for school which is separate from the main living area. The atmosphere was conducive for learning and instructions were provided by certified Miami Dade instructors.

The facility also has a Youth Care Staff who coordinates structured activities for the youth. Food menus were approved by a licensed Dietician and were posted in the kitchen. Fire Drills were performed consistently, with at least five a month being conducted over the last six months that were reviewed. The provider maintains excellent records of the fire drills which include a critique by the Residential Manager and various simulations. All of the drills reviewed since October 2016 were completed in less than 2 minutes. Emergency drills were conducted in accordance with policies; there was a minimum of 3 mock emergency drill each month.

All Chemicals were locked up and had MSDS sheets. Grievance forms and a secure box was accessible to youth and all grievances were resolved in a timely manner. Facility map and egress plans were posted throughout the facility. The agency has two vans; both were well-maintained and had all necessary safety equipment. The agency also has an approved emergency procedures manual. The agency states that they do weekly maintenance/safety checks and it was reported that this is done visually by the maintenance person but there was no documentation; however, very detailed quarterly checks are done by a supervisor.

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

3.02 Program Orientation

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Orientation Policy and Procedures (3.02) that covers details of the youth stay at the shelter

such as program philosophy, goals, services, and expectations. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

Employees will be trained in developing rapport with youth and provide effective orientations for new clients using Positive Action techniques. Miami Bridge will conduct a formal orientation for all youth during the intake process. Exceptions can be made for attention to immediate medical needs, hygiene issues, hunger or other personal needs may be made but the orientation must be completed within the first 24 hours of placement.

The orientation process will be based on clearly defined and consistent procedures as defined by the intake checklist in each new client case file. Staff will specifically and deliberately review each of the key intake issues listed above with youth during the orientation process and clarify any questions that may arise.

The orientation ensures that each youth is given a list of contraband items, and that each youth is informed of: disciplinary actions; program's dress code; access to medical and mental health services; procedures for visitation, mail and telephone; grievance procedure; disaster preparedness instructions; physical layout of the facility; sleeping room assignment and introductions; and suicide prevention precautions including alerting staff of their feelings or awareness of others having suicidal thoughts.

A review of three client files revealed that the Orientation process began on the date of intake and each client signed their orientation checklist sheet. Each youth was given a list of contraband items, an explanation of: disciplinary actions, the grievance procedure, emergency disaster procedure, rules on contraband, and a tour and layout of the facility were given. They were oriented on room assignments, and suicide prevention precautions including alerting staff of their feelings or awareness of others having suicidal thoughts. Additionally, they received a review of daily activities; they were given and shown postings of the abuse hotline and a tour of the facility. All youth also receive youth handbooks explaining all the above.

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

3.03 Youth Room Assignment

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Policy and Procedures related to room and bed assignment (3.03) that includes an initial classification of the youth for purposes of room or living area assignment with consideration given to potential safety and security concerns. This includes but is not limited to: review of available information about the youth's history, status; initial collateral contacts; initial interactions with and observations of the youth; separation of younger youth from older youth; separation of violent youth from non-violent youth; identification of youth susceptible to victimization; presence of medical, mental or physical disabilities; suicide risk; and sexual aggression and predatory behavior. In addition, the agency has a policy and procedure specifically addressing criminal street gangs. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

The agency's procedure states:

Staff involved in the admission, interviewing and room assignment process will ensure the safety of all youth placed in residential facilities. Both the Admissions and Shelter Directors will be responsible for training staff in and following these procedures.

Upon admission, agency staff will interview youth. An initial assessment will occur to determine the most appropriate bed assignment 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 agency rules and expectations.

Staff conducting the initial interview and assessment will consider 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 will be assigned a bed pending further assessment. If at any time information or circumstance change, the youth will/can be assigned a different bed or different sleeping arrangements.

The agency requires that all youth files at residential facilities include a place for a photograph to identify youth. The Admissions and/or Shelter Director will train and supervise staff in these procedures to ensure compliance. The photograph should be taken to capture adequate facial detail for identification purposes.

Having a photo identification process is also essential for law enforcement personnel and missing person's reports should the youth abscond from the facility. The admission data form will be contained in the youth's individual case file for permanent record of the youth's placement and review by agency staff as necessary.

Staff may also take photographs of any identifying marks and/or evidence of abuse or neglect with the youth's consent. These photographs are confidential material and will not be shared with other youth at the facility.

The dormitories are broken down into two separate modules: Module A is for the younger, more vulnerable client while Module B is for the better adjusted youth. There is an island containing lockers, separating the two sides in the dorm and the staff supervising the unit is stationed on the Module A side for maximum supervision whenever youth are in their sleeping quarters. During the orientation process, the youth are informed of their bed assignments. Several factors are considered before placing a youth in a room.

A review of three youth files showed the youth's history, age, gender, disabilities, physical size, gang affiliation, suicide risk, and other risk factors are all considered when assigning a youth to a room. Room assignment is documented on page 2 of the CINS/FINS intake form.

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

3.04 Log Books

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Policy Procedures related to the keeping of a bound log book (3.04). The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

The agency's procedure states:

Miami Bridge requires each residential facility to maintain a daily logbook to document general program operational information including. The permanent log will be kept in a hardbound, sequentially numbered page format. The top of each page should be dated to maintain an accurate chronological record of events. This logbook can be used to document shift changes, specific resident care or behavioral information, planned intakes/discharges, and other critical program operational issues. Employees are required to sign their initials at the end of each entry. No blank spaces should be left on any page. Staff must draw a line to the end of the line on which they are writing and then sign each entry. Critical information must be highlighted. Errors must be corrected by drawing a single line through the entry; void should be written by the error, and initial above the error. Scratching out or crossing out entries is prohibited. The use of correcting liquids or products (White Out) is also prohibited.

Log book entries that could impact the security and safety of the youth and/or program are highlighted in the log book. All entries are brief and legibly written in ink and include the date and time of the incident, event or activity; names of youth and staff involved; a brief statement providing pertinent information; and the name and signature of the person making the entry. All recording errors are struck through with a single line and the staff person must sign the correction and the use of whiteout is prohibited. The

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

The oncoming supervisor reviews the logbook of the previous two shifts to become aware of any unusual occurrences, problems, etc. and makes an entry signed and dated into the logbook indicating the dates reviewed to document the review. Direct care staff in the unit reviews the logbook for the previous two shifts and make an entry in the logbook and sign/date that they have reviewed it.

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

A review of the log book showed where recording errors were struck through with a single line. The entries were legible and captured the overall shelter operation. The quality improvement manager reviews the facility logbook weekly and makes a note in the logbook indicating the date reviewed and if any correction, recommendations and follow-up are required and signs/dates the entry. The staff do document shift change and staff turnover but do not each specifically document that they have reviewed the log book for at least the previous two shifts as required by the standard and stated in the agency's policies and procedure.

Exception:

Staff document coming on duty but only occasionally also document that they reviewed the log book (previous 2 shifts at a minimum).

3.05 Behavior Management Strategies

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has Policy and Procedures (3.05) covering all elements of behavior management system and a detailed written description. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

The agency's procedure states:

Miami Bridge utilizes a behavior management system (BMS) that is based on a system of rewards, privileges, and consequences that encourage positive behavior discourage negative behavior and sets clear behavioral expectations. The Shelter Director and/or Clinical Director will be responsible for training, monitoring and supervising staff in the implementation of the behavior management system.

The BMS is administered by the Youth Activity Workers under the supervision of the Shift Leaders and Shelter Directors. As a result of directly observing youth's behavior during their shift, Youth Activity Workers will document and report on the youth’s behavior through the behavior management system defined by the agency.

The BMS is in place to help staff determine if the individual youth is meeting behavioral expectations and treatment goals. The BMS is designed to be both flexible and consistent in working with different populations of youth who have different issues and needs. The BMS will consist of some documented formal mechanism to evaluate and document behavioral performance by youth placed at the Miami Bridge.

The BMS consists of a point and level system that rewards positive behavior by increasing privileges and

incentives (positive reinforcement) and provides consequences for negative behavior (negative reinforcement). Agency rules, guidelines of the BMS privileges and consequences are clearly defined at intake and posted in the facility for review by youth to generate cooperation.

The agency has a policy and procedures covering all elements of the behavior management system and a detailed written description. The Behavioral Management System (BMS) being used by Miami Bridge-Homestead is a positive reinforcement model that accentuates and promotes acceptable behaviors by the youth. The system is a point system that runs Friday-Thursday. On Friday a "feel-good Friday" is conducted where points are totaled and awards are received/chosen. Points are earned for positive behaviors and tasks completed while negative behaviors can result in a loss of points. The shelter maintains a cabinet filled with items for the clients to purchase with their earned points. It's equipped with clothing items, special food items, and an assortment of items that the youth can use. Gift cards are available and youth can be taken shopping. In addition, special outings are used as an added reward/incentive within the behavior management system. Grievance reports are readily available to youth and a process is in place for supervisors to review all grievances with youth within 48 hours and with staff if applicable so that a resolution can be reached. Six of eight staff reviewed had training in the BMS. The supervisor was trained in BMS as well as managing aggressive behaviors (participated in train the trainer which teaches to critic others use of BMS).

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

3.06 Staffing and Youth Supervision

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a policy for staffing and youth supervision (3.06 & 3.06.01) as well as youth and facility searches to ensure adequate staffing is provided that optimizes the safety and security of all youth and staff. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

The agency's procedure states:

Miami Bridge implements a staff coverage schedule that provides adequate supervision of clients and ensures the safety and security of all youth and staff. This schedule includes a system to consider staff training requirements, regular days off, holidays, vacation and sick leave, diversity issues, budgetary issues, and other service delivery issues.

Program holiday and vacation coverage schedules are planned on a quarterly basis. Policies related to staff leave are contained in the agency's Employee Handbook. A list with the names and phone numbers of all employees will be maintained in an accessible location to staff to ensure adequate shift coverage that allows scheduled activities and routines to be maintained.

Miami Bridge program staff included in the staff-to-youth ratio includes Youth Activity Workers, supervision staff and treatment staff (counselors). If program does not meet male and female guideline, the program must present proof of effort during the time frames where guideline is not met. These efforts must be documented in the agency log book. Overnight shifts should always be covered with a minimum of two staff while effort is made to find staff of both genders to cover the shift.

The Shelter Director or designee will oversee staff scheduling responsibilities and monitor and review this process. Schedules should follow a consistent format that contains the names of individual employees and is easy to comprehend. Schedules will be posted in the facility in an area accessible to all staff, the Intake Office and mail room. Scheduling should take into account the needs of the youth, program schedules and routines, and individual employees' strengths, skills and abilities.

Staff schedule issues are usually resolved by the Shift Leader. The Shift Leader may contact the Shelter Director if necessary to handle staffing and scheduling issues that remain unresolved. When a Youth Activity Worker is unable to fill their shift, it is primarily the Shift Leader's responsibility to seek coverage

of that shift. The Shelter Director has overall responsibility to assist in seeking or will directly provide additional shift coverage when necessary.

Each shelter has at least one Youth Activity Worker on duty for every six clients in the shelter during times when clients are scheduled to be awake. Each shelter has one Youth Activity Worker on duty for every 12 clients during times when clients are scheduled to be asleep. During the time clients are asleep, one Youth Activity Worker, of the same gender, will be assigned and stationed at each of the dormitories to provide adequate supervision and conduct bed checks. All client dormitories will remain locked during the day. Client(s) will not be allowed access to the dormitory without adequate supervision.

Miami Bridge will consistently comply with the requirement of having one male and one female staff member on duty at all times. The shift coverage schedule will be completed by the Shelter Director on a weekly basis and posted in the facility. The schedule must indicate the actual staffing patterns and verify that one female and one male staff member are on duty at all times. The scheduling of male and female staff is a licensing requirement and beneficial to client care. Shelter video camera monitoring systems assist staff in monitoring the location and movement of youth and staff and alleviate many of the client supervision and safety issues.

Miami Bridge requires all residential programs to manage the number, movement and specific location of each youth at all times. While the Youth Activity Workers have this function as their main priority, all program staff is considered to be essential parts of maintaining a safe and therapeutic milieu and are trained and tasked to actively assist in monitoring the location and movement of youth in the facility.

Miami Bridge utilizes several forms of formal and informal head counts to ensure adequate client supervision. Clients are within vision of Youth Activity Workers or other appropriate program staff supervision at all times with the exception of personal hygiene activities (showering) and sleeping hours during which clients are monitored every 15 minutes. All formal client counts are to be documented in the agency professional log book.

The program maintains minimum staffing ratios as required by the Florida Administrative Code and contract. The agency has a weekly staff schedule that is developed by the Program Manager and is posted in the staff office in the shelter. The schedule includes youth care staff work hours/days over three shifts. The three shifts run from 6:30 AM to 3:00 PM, 2:30 PM to 11 PM and 10:30 PM to 7 AM. This provides for a 30 minute overlap between shifts to facilitate the transfer of information between staff working on different shifts. The shelter is licensed for 20 beds and the staff schedules reviewed for the review period reflect a minimum staffing ratio of 1 staff to 6 youth during the afternoon shift and 1 staff to 12 youth during sleep period.

The program always have at least two staff working during the evening shift and always have a male and female on shift. The program has an on-call roster that includes the names and telephone numbers of staff who may be accessed when additional coverage. A review of the program logbook shows that staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or when youth are in their sleeping rooms. Staff schedule is posted for staff and an on-call roster is maintained.

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

3.07 Special Populations

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a written policy and procedure that addresses the required elements of the CQI indicator. Program policy was signed by the Chief Executive Officer and Chief Administrative & Compliance Officer and appears to be current and up-to-date as of the last revision on 9/30/2016.

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. Program staff are assigned shift to shift for (Special Populations) youth on the client roster board located in the staff office. The procedures outline in detail the staff assigned to the youth will be located in the staff roster, client roster, and/or in the staff roster as well as noted in the communication log book. The policy indicates that assigned staff will monitor all movement of the staff secure youth and will document activities as per program policy. The policy includes that youth will receive orientation upon admission and that youth will be placed at either location that has available space and resources to meet the needs of the youth at either the Homestead or central campus.

There were 2 files reviewed in accordance with special populations for domestic violence. All files reviewed showed evidence that the youth received orientation upon admission and there was clear evidence of parental involvement. The files reviewed had evidence of a pending domestic violence charge and the placement did not exceed 21 days. Services provided were consistent with CINS/FINS program requirements. The case plan reviewed documented goals focusing on truancy intervention, communication skills, and other necessary interventions to reduce behaviors outlined in the Needs Assessment. There was also evidence the youth had a pending DV charge. The youth was transitioned to a CINS/FINS bed after twelve days. The case plan reviewed documented goals focusing on anger management, coping skills, and other necessary interventions to reduce violence in the home.

The agency did not serve any youth who met the criteria for Staff Secure, Probation Respite of Domestic Minor Sex Trafficking during the review period or since the last onsite QI Review.

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

3.08 Video Surveillance System

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The agency has a video surveillance policy (3.08) which covers all required elements of the policy. The policy manual was last revised on 9/30/16 and was signed by the Chief Executive Officer.

At a minimum, Miami Bridge has implemented procedures to meet the following requirements:

Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit.

Ensure that while video footage access is available via web and on cell phones, it is not used for covert operations and/or misused by authorized personnel.

Never place cameras in bathrooms or sleeping quarters.

Have cameras visible to persons in the area (no covert cameras) and a written notice is conspicuously posted on the premises for the purpose of security.

Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits (DJJ/FN) and when an investigation is pursued after an allegation of an incident, including the Department of Children and Families. This will also be used internally or by Law Enforcement.

Have a method to retain video and images in a hard drive or designated secured network storage. Access is restricted to personnel determined by the Chief Executive Officer. Chief Operations and Technology Officer will be the overall designated Program Administrator.

Ensure recorded video is stored for a minimum of 30 days unless video is associated with a specific incident that is requested for review. In that case, video shall be stored for the length of time needed to complete investigation. Video clips which could become evidence in civil or criminal proceedings are kept indefinitely unless otherwise directed by the Department of Juvenile Justice and/or the Florida Network.

Have video surveillance system only accessible to designated personnel, such as: Chief and Deputy Chief Executive Officers, Chief Operations and Technology Officer, Chief Compliance Officer, QI Coordinator (access both locations), Clinical Directors, and Shelter Directors/Coordinators (site specific access).

Have designated staff trained to handle the equipment and monitor or review footage in a professional, ethical, and legal manner.

Ensure that overnight bed check logs are reviewed weekly by the Shelter Director and the QI Coordinator against footage from the video surveillance system and entered into agency log book, per DJJ QI expectation.

The agency has 32 cameras positioned throughout the facility including exits and entries. There is a posted sign stating there is video surveillance. All cameras are visible and none are placed in youth's sleeping areas or in bathrooms. Video was reviewed back 30 days and images were clear and facial recognition was easily identifiable. The system is plugged into a battery backup in case of power failure. There is a list of people with access to the system to review, and weekly monitoring by supervisors was documented in the log book. There is the ability to download the video footage in the case that third-party review is necessary. Two random nights were reviewed (3/6/2017 and 4/4/2017) which both showed staff conducting 15-minute room checks.

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

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Director and 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 provider has a RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility. Medications are stored in the Pyxis Medication Unit; topical and injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

4.01 Healthcare Admission Screening

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number 4.01 to address healthcare admission screening. The policy was last revised on 9/30/16.

At initial intake the residential nurse, if present, or non-healthcare staff is to complete the health screening using information obtained through the screening process by, telephone or face-to-face, utilizing the CINS/FINS intake assessment form, to assess any immediate medical needs, any current condition or contagious illness or communicable disease, or chronic medical condition. Contact with parents not present at the time of admission is documented in the professional log book and each youth's medical case file. The preliminary health screening is to include current and past medications for physical or mental health, allergies, existing acute or chronic medical conditions, recent illnesses or injuries, the existence of current pain or other physical distress, observations for evidence of illness, injury or physical distress and the presence of scars, tattoos or other skin markings. The Clinical director, shelter director and director of admissions are to be immediately notified of any existing medical, dental or mental health condition.

Of the files reviewed, each youth admitted to the shelter received a health screening completed by the shelter nurse or direct care staff. The program's health screening form addressed chronic medical conditions inclusive of diabetes, pregnancy, epilepsy, seizure disorders, cardiac disorders, asthma, tuberculosis, hemophilia, hepatitis, and recent head injuries as well as high blood pressure; chronic pain, cough or headaches; eating disorders; gynecological, vision, hearing, kidney, skin, fainting/dizziness,

sexually transmitted diseases, digestive problems and other disabilities.

Three youth files were reviewed and each contained a completed preliminary healthcare screening identifying each youth's healthcare concerns. Documentation evidenced youth on current medication, with allergies, asthma and observed with tattoos and piercings. One reviewed medical record for a youth in the program during the review period with asthma; however, no instances of follow-up medical care was required prior to the youth's discharge from the shelter. An informal interview with the registered nurse confirmed he was able to state the program's procedure for referring youth for follow-up medical care for chronic conditions, although such an event is extremely rare due to the typically short length of stay for youth in the program.

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

4.02 Suicide Prevention

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number 4.02 to address suicide assessment and precautions. The policy was last revised on 9/30/16.

The program's policy requires a comprehensive mental health and substance abuse screening at the time of admission. If indicated on the suicide risk screening, a youth will be assessed within 24 hours by a specified licensed mental health staff or non-licensed mental health staff working under the supervision of the licensed professional. Any screenings completed between 5pm Friday and 9am Monday with an indication must have an assessment of suicide risk completed on the morning of the next business day.

There were three files applicable for CINS youth with assessments of suicide risk completed during the review period. All three youth were screened for suicide risk during the initial intake and screening process. All three youth were placed on sight-and-sound supervision until assessed by a licensed professional or a non-licensed professional under the supervision of a licensed professional. Documentation evidenced the three youth were placed on the appropriate level of supervision based upon the results of the suicide risk assessment. Staff documented both youth's behavior every 15 minutes on the precautionary observation log sheets.

Exceptions:

A review of two of three intake risk screenings revealed the signature for the supervisory review and approval was the same electronic signature as for the staff completing the suicide risk screening. Informal interview with staff revealed that the cloud-based log-in for the program's electronic Lauris system retains both the user ID and the password of the person last using a computer to access the system. Explanation provided was that supervisors are not diligent in ensuring they log in under their own user ID and password in order to complete supervisory reviews, resulting in the electronic signature of the computer's previous user entered next to the supervisors name to acknowledge the approval. The retention of user ID and password by the cloud-based system possibly jeopardizes the security of the confidential information stored in that system. However, corrected explanation provided at the daily debrief indicated the error lay with the staff completing the risk screening mistakenly entering her electronic signature on both the line for her signature and the line for the supervisors signature.

One reviewed Assessment of Suicide Risk (ASR) was completed by an MSW and approved by the LCSW with two contradictory recommendations regarding suicide precautions, for both emergency Baker Act and discontinuation of precautionary observation and placement on standard supervision. The youth was not Baker Acted, but was stepped down to standard supervision. During the review, the program entered a case note in the youth's record to clarify the notation on the ASR recommending emergency Baker Act was a typographical error in the electronic system, and the youth was appropriately removed from sight and sound precautionary observation.

4.03 Medications

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number 4.03 to address medication storage, access, administration, documentation and disposal. The policy was last revised on 9/30/2016.

The program's written procedure requires the program to:

- **Verify and document the verification of prescription medication with the pharmacy.**
- **Store all medications in the Pyxis med-station which should be inaccessible to youth.**
- **The program must have two supervisors for the med-station.**
- **Store controlled medication in the med-station.**
- **Store oral medications separately from injectable and topical medications.**
- **Utilize a secured refrigerator solely for the storage of medication with storage temperature requirements.**
- **Allow only staff designated with user permissions to have access to secured medication and allow only limited access to controlled substances.**
- **Perpetually inventory controlled substances via witnessed shift-to-shift counts.**
- **Maintain a perpetual inventory for OTC medication which must be inventoried at least weekly.**
- **Secure sharps and document of weekly inventory counts of same.**
- **Utilize the Medication Distribution Log form to document distribution of medication by all staff.**
- **Conduct a review of medication management practices at least monthly via the knowledge portal or med-station reports.**
- **Verify medication via telephone contact with the pharmacy.**
    - **Have the nurse conduct medication pass when the nurse is on duty.**

All medications, including controlled medications, are stored in the Pyxis med-station, which was inaccessible to youth. The agency verified youth medications with the parent/guardian at admission and via telephone contact with the pharmacy inclusive of the name of the pharmacist with whom the verification was conducted. All medications were stored within the Pyxis med-station and the med station is stored in the locked medical office which is inaccessible to youth. The program has two super users for the med-station consisting of the nurse and the shelter program coordinator. Oral medications are stored within the Pyxis med-station separately from both injectable and topical medications.

The program maintains a secured refrigerator which was used only for the storage of medication. The program maintained a thermometer in the refrigerator to ensure adherence with storage temperature requirements and the refrigerator has a built in padlock. When on duty, the nurse conducts medication pass. Only staff designated with user permissions has access to the Pyxis med-station and limited access to controlled substances is maintained via a required electronic staff witness log in to the station.

Controlled substances are perpetually inventoried. A perpetual inventory was maintained for OTC medication and OTC medications were inventoried weekly by the registered nurse. Sharps are secured in a locked cabinet and documentation of weekly inventories is maintained. The program does not maintain syringes at the program. The Individual Client Medication Distribution Log form was used to document distribution of medication by all staff to each youth. Monthly medication management practice is conducted by the program via the knowledge portal as required by Network policy and copies are maintained in a binder.

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

4.04 Medical/Mental Health Alert Process

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number 4.04 to address the program's medical and mental health alert process. The policy was last revised on 9/30/2016.

To ensure client safety, information concerning a youth's medical, nutritional, substance and mental health conditions, including allergies, prescribed medications, common side effects, food/medication contradictions, and previous suicide attempts are to be effectively and redundantly communicated to all staff through an alert system inclusive of documentation in the program log, electronic medical records, case progress notes, shift summary reports and on the white board located in the intake office. Additionally nutritional alerts are to be posted in the kitchen. Staff are to be trained on how to recognize and respond to emergency care and treatment as a result of identified medical or mental health problems. Suicide risk alerts are to be utilized to inform staff of needs which may require emergency care, assessment and treatment.

The program maintains a Client Alert binder in the shelter as a reference of alerts active for each youth currently in the shelter. An interview with the nurse indicated staff are informed of youth alerts through reading the logbook and the white alert board in the glass enclosed intake office. The alert board utilizes a color-coded dot system without a posted color code legend on the board, as it is visible to youth from the day room. Three applicable files were reviewed and found to include applicable medical or mental health conditions or allergies. All three youth were placed on the program's alert system, which identified the alert for nutritional restrictions, substance abuse, history of victimization, medical and mental health conditions. Staff are trained during orientation as to the color-coded alert system and provided information and instructions to recognize/respond to the need for emergency care for medical and mental health problems.

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

4.05 Episodic/Emergency Care

☒ Satisfactory ☐ Limited ☐ Failed

Rating Narrative

The program maintains policy and procedure number 4.05 to address episodic and emergency care. The policy was last revised on 9/30/16.

The program's written procedure for emergency medical care requires the program to obtain off-site emergency services for youth in need of urgent medical or dental care. All direct care staff are to be trained in CPR, first aid, knife for life, AED. Notification of the need for medical attention is to be made to the youth's parent/guardian as soon as possible. Documentation must be maintained of the details of each crisis, emergency or off-site care as well as all staff responses and responses to each situation. The program's policy outlines reporting requirements, which requires incidents for youth classified as DJJ clients and meeting the criteria of DJJ reportable critical incidents to be reported to the Central Communications Center within two hours.

All direct care staff completed training in cardio pulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). The program had only one instance of emergency/off-site care during the review period of youth requiring off-site urgent medical care; therefore, two additional incidents occurring since the last annual QA review were selected in order to meet the minimum sample size for this indicator. It is the program's practice to complete an incident report for any incident requiring off-site care although that is not specifically required by the program's written policy. Incident reports were completed and

maintained for each of the three reviewed records.

Notification of the need for medical attention was made to each youth's parent/guardian and documented in all three reviewed instances of off-site care. The program maintained a log to document all off-site care, which included the date and time of the parent/guardian notification. Two of the three reviewed records were applicable for return to the shelter after receiving off-site care, and in both instances the program received medical clearance via discharge instructions with follow-up requirements as applicable. Additionally, the program attached a photocopy of the related facility logbook page to each incident report to evidence the program's documentation of the episodic/emergency care in the logbook.

Additionally, the program purchased an automated external defibrillator (AED) for the program approximately two months prior to the review. An inspection of the AED revealed the battery installed in the AED had an expiration date of April 30, 2024. The AED electrode pads were maintained in a sealed pouch within a built in storage compartment on the AED, and the pouch is only opened when the AED is actually used. The electrode pads had an expiration date of March 31, 2019. The program's registered nurse powered on the AED during the review demonstrating it was functional.

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