Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge Youth and Family Services – Miami, Florida
Miami Bridge Central Residential Program

November 13-14, 2018

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	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 & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares, Lead Reviewer, Consultant- Forefront LLC

Tevis Bush, QI Monitor, Department of Juvenile Justice

Abraham Greene, Case Manager, Urban League of Palm Beach

Tracy Iverson, Business Systems Dept. Specialist, Hillsborough County Children Services

Joan Jordan, Clinical Director, Children's Home Society West Palm Beach

Quality Improvement Review

AGENCY – DATE OF REVIEW
Lead Reviewer: NAME

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2018).

Persons Interviewed

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

Documents Reviewed

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

Surveys

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

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Miami Bridge Youth and Family Services, Inc. contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in two locations, Miami Bridge Central Shelter (MB Central) located in North Miami and a south shelter located in Homestead, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, Family/Youth Respite Aftercare Services (FYRAC), and probation respite. MB is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth.

Miami Bridge is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through August 31, 2021. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Miami Bridge employs professionally licensed staff for both mental health and medical services. Its licensed Mental Health professionals provide oversight of its counseling services at both locations. In addition, there is a Registered Nurse who works at both facilities to oversee the referral for health care services and medication management of youth in care.

During the onsite visit, the CEO reported programmatic updates and accomplishments the agency has achieved since the last onsite QI Review in November 2017 as follows:

The agency's paperless Electronic Medical Record (EMR) system utilizing Lauris, an online automated system, is fully implemented in the CINS/FINS program for new intakes. This system was launched in July 2016 to optimize the organization's service delivery and information management processes as well as afford the ability to automate workflow and manage all aspects of services. Efforts are being made to integrate all closed files since the launch into the system.

Staff Changes – Counseling Services

- The former Clinical Director who oversaw the shelter in Miami and Homestead resigned in August and was replaced by Wendy Mitchell, LCSW. Ms. Mitchell is

responsible for clinical oversight of the residential counselors and program in both locations.

- One shelter counselor and one non-residential case manager resigned in early August 2018; both positions were filled. As of the date of the QI visit, the program had one vacant fulltime non-residential case manager position vacated within the last month.

New Program

- Miami Bridge received a recent grant that funds the Nurturing Parenting Program One counselor was recently hired to implement the program in Homestead.
- LGBTQ Program: one counselor is implementing the Nurturing Parent Program in Central as well as facilitating LGBTQ groups. She will continue to work with the LGBTQ population until we can find a replacement acquire additional funds.

Youth and families had their first overnight trip during the summer to Busch Garden, Tampa by way of Children's Trust Grant. The funding covered all the expenses for transportation, food, accommodations, and park admission.

The agency continues to reach out to the community by hosting multiple events throughout the year. Events include the annual Thanksgiving luncheon which is well attended by the community, staff, and Board members. Guests are entertained by youth performances.

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 Programing Officer, Chief Facilities and Construction Officer, Chief Administrative/Compliance Officer, Director of Admissions, Director of Shelter Services, Director of Non-Residential (FSFF) Services, Human Resources Specialist, an IT and Special Events Coordinator, and 2 Shelter Supervisors, one of which is also the Registered Nurse. The Chief Executive Director oversees the Miami Bridge agency and the services provided in Central Miami and Homestead, Florida. The residential component is managed by a licensed professional, Director of Shelter Services, who oversees the clinical component for both shelters.

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

The MB Central facility is licensed by the Department of Children and Families for 28 beds, with the current license in effect until May 31, 2019.

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 of Employees/Volunteers

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge has a policy and procedures, 1.01, in place that address the background screening of all employees, volunteers, and interns prior to any offer of employment or

volunteer service. The policy was approved on 7/01/18 by the CEO and Chief Program Officer.

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

A total of twenty-one (21) applicable personnel files were reviewed for twelve (12) new staff, one (1) re-hire, two (2) staff eligible for 5-year re-screening, and six (6) Interns. Eleven of the twelve new hire files maintained evidence of eligible screening results obtained prior to hire. The provider utilized the original background screening for the staff that was re-hired since the separation period did not exceed 180 days.

Two staff were eligible for their 5-year re-screenings during the review period; the 5-year re-screenings were not conducted on time prior to the staffs' five-year anniversary dates.

The program has six Interns providing service during the review period. The provider submitted background screening requests for all six interns; however, it was difficult to establish official start dates as they were not prominently documented in the interns' files. Upon further review of the interns' attendance log, it was verified that three of the six were not engaged in services prior to officially starting. The provider provided email documentation supporting approval to initiate training with the remaining three interns in the interim, prior to receipt of the background screening, solely for the purpose of orientation, without allowing access to clients, client files, or any HIPAA protected materials until receipt of the background screening.

The most recent submission of the Annual Affidavits of Compliance with Level 2 Screening Standards was sent via email to DJJ BSU on 1/9/18 prior to the January 31st deadline.

Prior to hire, the agency also requires employees to pass a drug screening and conducts local law enforcement check, a driving record history check, and verifies

previous employment history, and contacts up to three references. Electronic submissions of Department of Homeland Security E-verify for the twelve new employees were verified, confirming the employees' work eligibility.

The reviewer was informed that the provider selected the Berke pre-Assessment tool which is set for onboarding effective 11/19/18. A contract with Berke was recently executed on 11/6/18. As of the onsite visit, no policies and procedures were yet drafted or established for the use of the pre-assessment tool.

Exceptions:

The background screening was not completed prior to hire for one of the twelve new hires.

The program had 2 eligible 5-year re-screenings during the review period. The re-screenings were due by August 12th and August 24th 2018, respectively but were not submitted until November 5, 2018, after the required anniversary deadlines.

1.02 Provision of an Abuse Free Environment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a policy and procedure # 1.02-Provision of an Abuse Free Environment and 1.02.01 Grievance Process. The policies were last revised and signed by the Executive Director on 7/01/18.

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

Policy #1.0201 addresses Child Abuse reporting to the Florida Abuse Hotline. There are comprehensive procedures regarding the reporting of abuse as well as information about signs of abuse/neglect, licensure requirements, and code of conduct which includes dress code expectations. The program requires that calls made to the Abuse

Hotline be documented in the program logbook for residential clients. The hotline number is included in the resident handbook.

The program has a current grievance procedure, #1.02.01, that is utilized by youth to file a complaint. The procedure is reviewed with youth during intake. A copy of the grievance procedures is included in the resident handbook and the program has two grievance boxes for depositing grievances. The program's procedures state that youths are instructed to put their grievance in the box.

A random sampling of 6 personnel files verified acknowledgement of receipt of the Miami Bridge's Employee Handbook which includes information about the required code of conduct. Out of the random sampling of 6 employee files, 1 did not have a signature of acknowledgement by employee of stated policy.

Visible signs were found posted in the main recreation room areas that include the abuse registry hotline number on large posters. The posters also include other emergency numbers as well as a listing of program rules. A total of 9 Abuse Registry calls were made to the Abuse Hotline since the last onsite visit and were accepted. The program documents the calls on Abuse Registry Log Sheets that are maintained in a binder.

Eight (8) of the nine (9) abuse reports made to the hotline did not have any information documented in the "Follow-up" section of the form to be completed by Counselor, as required by agency's procedure and was cited during the last QI review. Also, only 1 of the 9 abuse reports made to the hotline was documented in the E-Logbook as required by agency's procedure.

During the tour of the facility, the locked grievance boxes were found to be mounted on a wall adjacent to the common area and in the lobby; grievance forms were observed next to the grievance boxes. Direct Care staff do not handle these grievance forms at any time and managers stated that the boxes are checked daily. Nine grievance reports for the current review period were reviewed; all of these grievances were resolved successfully. It appears that the agency is following and implementing this practice as stated in their policy.

Exceptions:

No Exceptions noted in the indicator.

1.03 Incident Reporting

☒Satisfactory ☐ Limited ☐Failed ☐Not Applicable

Rating Narrative

The agency has a written policy and procedure in place that was revised and last updated on 7/1/18 by the Chief Executive Officer and the Chief Administrative and Compliance Officer.

The provider's policy and procedures require, when applicable, incidents to be reported within 2 hours of the occurrence or knowledge thereof to the CCC. The procedure states that the Clinical Directors and Shelter Supervisor will be responsible for compliance with this policy.

The agency has a system for tracking these events to support program management and risk management effort. The provider's procedures also state that the program will maintain separate confidential files of all incident reports, electronically as well as hard copies. Incident reports are maintained chronologically in a binder. The provider also has copies of the DJJ CCC incident reports that were accepted by CCC during the review period.

In the past 6 months there were a total of 12 incidents reported including**:** 4 abscond; 5 medical; and 3 program disruption or behavioral related incidents. All incidents were reported within the two hour frame and well documented with follow-up communication from staff and supervisor. However, 2 of the 12 reported incidents that were entered in the log book were missing time of the incident on the Face Sheet. All incidents were reported on incidents report forms and reviewed and signed by a program supervisor.

Exceptions:

No exceptions are noted for this indicator.

1.04 Training Requirements

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a written policy and procedure, #1.04, revised on 7/1/18 and signed by CEO and Chief Administrator on 7/1/18.

Agency training requirements will be 80 hours for full time and part time employees in their first year and a minimum of 40 hours for each subsequent year. Written documentation of all training activities will be kept in separate, individual employee training file. All supervisors will review this documentation annually to ensure staff compliance with minimum training requirements and agency policy. The providers Annual Training Plan states Orientation are required to be completed within 90 days from hire.

The program maintains individual employee training files that are kept separate from the personnel files for the purpose of making them accessible for updating and monitoring. The files are organized by training year and include a cover page with a training log documenting all of the trainings completed. Training logs, sign-in sheets, and certificates are stored in the files and these files are maintained by the Quality Improvement Coordinator. The provider has a comprehensive list of training topics that is offered throughout the year. The files and records are well kept and organized.

In- service training may be held at some monthly staff meetings for enriching staff's knowledge base and work skills. These training events will be documented on the meeting agenda, in the meeting minutes and with separate training sign in sheets made available. Staff is given the opportunity to attend workshops, seminars, conferences, and participate in approved online trainings.

A total of 6 employee files were reviewed for this indicator for 3 new staff and 3 in-service staff. The provider did not have any applicable first year non-licensed clinical shelter staff during the QI review.

The 3 new staff members were beyond the first 120 days of hire. All three first year staff are on target for completing the 80 hours of training required. One of the 3 staff completed all of the mandatory training topics required during the first 120 days of hire. The other two new employees did not complete all of the mandatory required training's to be completed in the 1st 120 days of employment. One of two employees was missing two trainings (CINS/FINS Core training and Signs and Symptoms of Mental Health and Substance Abuse). The other employee was missing 4 mandatory training's: CINS/FINS Core, Signs and Symptoms of Mental Health and Substance Abuse, Child Abuse, and Universal Precautions. Staff members still have time during their current training year to complete all required trainings prior to the end of the training year.

All three in-service staff exceeded the 40-hour training requirement; only one of the three in-service staff did not complete all the mandatory annual trainings required and was missing “Sexual Harassment” training.

Exceptions:

There were no exceptions noted for this indicator.

1.05 Analyzing and Reporting Information

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has policy and procedures # 1.05 that last revised/reviewed on 7/1/18. 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.

In addition to Policy 1.05, the agency also has a PQI plan that describes the structure and protocols involved in the monitoring, evaluation, and improvement of its processes and outcomes. The agency has a CQI Steering Committee that meets regularly. Sub-committee membership includes staff of various levels from both the Central and Homestead location. To support PQI processes, the organization will analyze data in relation to the following:

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

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

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

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

Flammables Control: The agency operates in an area that risk must be contained to a minimum for clients, staff and the physical plant. The agency has an active no smoking policy that is adhered to via its staff policy and client information brochure. All chemicals

and potential flammables are strictly controlled via an inventory of acceptable items and ensuring that all flammables are accounted for daily. An active review is conducted each year to make that we are in compliance of storage, retention and information such as the active use of MSDS sheets and pro-active policy that ensures the health and safety of all parties.

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

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

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

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

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

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

Employee Satisfaction Survey: Annually, the HR Director distributes an Employee Satisfaction Survey to all staff to identify areas of satisfaction and areas in need of improvement. Components of the survey include: mission and purpose, quality of services, compensation, and respect for employees, staff satisfaction, and communication, opportunities for growth, workplace resources, personal expression and diversity. This data is collected and shared with all staff. Program Directors address areas of needed improvement with individual programs and develop an action plan. This

process is included for discussion at management team meetings, CQI meetings and staff meetings and reported at BOD meetings. 4 Client User Satisfaction Survey: these are conducted when each client leaves the shelter or when they stop using the FSFF community based services. A thorough survey about the overall service rating is entered into the NETMIS system.

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

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

The last two quarterly CQI Committee meeting agendas and minutes were reviewed for meetings held in July and October 2018. A sign in sheet, agenda, and minutes is maintained for each meeting. Agenda items include: incident reports, risk prevention, training update, clinical subcommittee update, health care and medication management, client satisfaction surveys (if applicable), review of Netmis report analysis, and case record review report.

The provider conducts quarterly case peer record reviews. Case record reviews for Q3 and Q4, FY 2017-2018 and Q1 FY 2018-2019 (completed 10/19/18 and in the process of being tallied) were reviewed onsite. 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 meets monthly (except when quarterly meetings are held) to review incidents, accidents, and grievances. The meeting agenda includes a review of: incidents, grievances, medication, health and safety, flammable control, technology, surveys results when they are completed during the period. Each meeting is accompanied by a sign-in sheet and minutes. A written report is created by the committee that includes data in tables and graph form. Trends and issues are discussed at the quarterly meetings. A review of meetings held for the past 6 months was conducted and were found to be held 6/28/18, 7/19/18 (CQI meeting), 8/23/18, 9/27/18, and 10/11/18 (CQI meeting).

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

The client and employee satisfaction surveys are completed bi-annually and discussed at the quarterly CQI meeting. Client satisfaction data is retrieved from the Netmis and the employee satisfaction surveys are distributed and compiled by the program. The most recent satisfaction surveys completed for the current FY were discussed at the 7/19/18 and 10/11/18 CQI meetings.

Staff and management meetings held during the QI period provided minutes for each meeting that incorporates findings reviewed at the quarterly CQI meetings. The QI Coordinator and/or Chief Compliance Officer participate in the staff meetings to share information related to CQI and program monitoring.

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

Exception

No exceptions were noted for this indicator.

1.06 Client Transportation

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has written policy and procedure 1.06 pertaining to client transportation which was approved and signed by the Chief Executive Officer (CEO) and Chief Facilities and Construction Officer on July 1, 2018. The program provides adequate transportation to meet the needs of the youth. Any staff or persons driving the vehicle are fully authorized to do so and have a valid Florida Driver's License and receive vehicle training. The program has two van used to transport youth.

When youth are being transported by staff, staff must be specific to the gender of the youth, staff to youth ratio must not exceed a one to six staff to youth ratio, and staff are not allowed to transport youth on a one to one basis unless a supervisor is made aware. Youth are not allowed to be transported in staff's personal vehicle.

The program maintains a list of authorized drivers that is updated on a monthly basis. All approved drivers are covered under company's insurance policy. A review of pre-service training records verified staff receives vehicle training during orientation. Prior to a transport, the transporting staff utilizes Rastrack to document travel and location of transportation. Rastrack is an electronic application used by the program to document pre-trip vehicle inspections, the number of youth transported, and name of the driver. Millage is automatically calculated through the application once the driver departs and

returns to the program. Inspection of both vehicles used to transport youth verified each was locked while not in use and contained an up-to date fire extinguisher, flashlight, first aid kit, a vehicle emergency kit, and operable seatbelts for passengers. During the review period, the program updated their client transportation policy to indicate single staff transports must be approved by the CEO, CPO, or the Clinical Director and the information is to be documented in the program's logbook.

Exception

All youth transports are required to have a third party approved passenger to avoid situations which may put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. If a single driver and single youth is being transported, a supervisor must be made aware of the transport. A random review of the program's electronic logbook contained documentation staff conducted a single transport on November 13th and 14th of 2018, but there was no evidence the on-duty supervisor was made aware and approved the single youth transport

1.07 Outreach Services

☒Satisfactory ☐ Limited ☐Failed ☐Not Rated

Rating Narrative

The agency has a written policy and procedure, # 107-Outreach Services and Interagency Agreements that addresses all the key elements of this indicator. The policy was reviewed and approved on 7/1/18 and was signed by the CEO and Chief Administrative and Compliance Officer.

The provider builds strong community partnerships and collaborations to ensure youth and families receive medical, educational, therapeutic, and other supports that are identified in the service plan. Targeted outreach services increase public awareness of services available, enhance the referral process, and improve access to services for community members. To increase community awareness of services, the agency establishes written agreements and informal linkages with other community-based service providers as needed to enhance the outcomes for youth and families served. Staff conducts outreach activities that include, but are not limited to, dissemination of printed materials and performing presentations to audiences from low-performing schools, other prevention agencies and neighborhoods where juvenile crime is high.

Designated staff participates in local DJJ board and council meetings to ensure CINS/FINS services are represented in a coordinated approach. Miami Bridge also maintains written agreements with other community partners that include services

provided and a comprehensive referral process. The assigned representatives to these groups will advocate for the effective use of CINS/FINS services and update agency leadership on meeting activities. There is a lead staff member designated to attend local and circuit level meetings convened by the Department of Juvenile Justice as well as staff designated to coordinate and provide outreach services to community audiences, individuals, and groups. Outreach activities are documented in the Netmis database.

Outreach events were reviewed for the past 6 months. The program maintains written agreements with community partners that include services provided and the referral process. There has been an increase of interagency partnerships from 41 MOU's last year, to 43 for 2018. The list of MOUs includes the initial date and end date of partnership as well as contact information.

The agency keeps an Outreach Binder with an updated Outreach Plan and printouts by month from Netmis of all the Events that designated staff performed. During the review period, the agency participated in numerous community events to advocate for the effective use of CINS/FINS services and ensure that community partners are aware of Miami Bridge scheduled events. The outreach activities for the review period included: 13 school events, 82 community based activities, and 21 LGBTQ focused educational events. In addition, there were 2 fundraisers this review year: a fishing tournament and a 2nd Annual Luncheon. The agency also held a barbeque, which was an agency/neighborhood good-will event.

The provider participates in local DJJ board and council meetings. A binder is maintained with the meeting agendas and minutes when designated staff member attends. If the meeting was cancelled, the agency keeps necessary documentation as well. The agency provided evidence of attendance to two of the four 11th Judicial Circuit Advisory Board Meetings held during the past 6 months; two of the meetings were cancelled and agency staff did not participate in two of the meetings held.

Exceptions:

None are documented for this indicator.

Standard 2: Intervention and Case Management

Overview

Rating Narrative

Miami Bridge Youth and Family Services is contracted to provide both shelter and nonresidential services for youth and their families in Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week for youth who meet the criteria for CINS/FINS, Staff Secure, DV and Probation Respite, DMST, and FYRAC. The program has an Admission's Director who is responsible for Intake and Admissions. Additionally, trained staff members are available to determine the needs of the family and youth. Residential services include individual and family counseling, and group services. Case management and substance abuse prevention education are also offered. Aftercare planning includes referring youth to community resources, on-going counseling, and educational assistance.

The clinical component of the program is under the supervision of a licensed Clinical Director. For the Central location, a total of four Non-residential Counselors and two Residential Counselors are responsible for providing counseling and case management services and linking youth and families to various community services.

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

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

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

The agency has implemented electronic files through the Lauris system. As of the onsite visit, it was fully implemented in the CINS/FINS program.

2.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a written policy 2.01 that addresses the screening and intake process. Policy 2.01 was implemented on 10/01/02 and was last reviewed, signed, and dated by the Chief Executive Officer and the Chief Program Officer on 7/1/18.

The program has written procedures for completing an initial screening to determine client issues and eligibility, within 7 days of receiving referrals. The initial screening is completed immediately during the initial contact with the guardian and youth as the primary information sources. A NetMis screening form gets completed for each completed screenings.

The intake assessment must be completed within 24-hours for all clients being admitted to the shelter. The non-residential intake assessments can take longer, but there are progress notes, with clear documentation showing the attempts made to initiate services.

There were 6 client files reviewed for indicator 2.01 consisting of. 3 residential (2 open and one closed) and 3 non-residential (1open and 2 closed). Of those 6 reviewed files, all met the 7-day eligibility requirement. The intake assessment was completed within 24-hours for each residential intake. For the non-residential files, 2 of the 3 files contained progress notes documenting efforts to set their intake appointments.

Exceptions:

No exceptions are documented for this indicator.

2.02 Needs Assessment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a written policy 2.02 that addresses the Needs Assessment, implemented on 10/01/02 and last revised on 07/01/18 by the Chief Executive Officer and Chief Program Officer.

The program's procedure is to initiate a formal and comprehensive written Needs Assessment within 7 days of the case being assigned to the non-residential counselor or within 72 hours of shelter admission for residential clients. As per the policy, the Needs Assessment should be initiated during the first face-to-face contact and completed within 2-3 meetings for nonresidential clients.

Either Bachelor- or Master-level staff members complete the Needs Assessment. Each assessment is reviewed and signed by a supervisor. The Needs Assessment will include a suicide risk assessment to determine if there are mental health issues requiring immediate and/or additional mental health services not provided by Miami Bridge. In those cases, the staff completing the form will consult with the licensed clinical director and make referrals and recommendations to address the youth's mental health needs.

If the suicide component of the assessment is required because of the result of the suicide risk screening, it must be reviewed, signed and dated by the licensed clinical supervisor or by a licensed clinical staff member.

There were 6 client files reviewed for 3 residential (2 open and one closed) and 3 non-residential (1 open and 2 closed) youth.

Of the 3 residential files reviewed, 2 completed the Needs Assessment within 72-hours of intake. One of the residential clients was admitted on 09/19/18 but his needs assessment was not implemented until 09/26/18, which is beyond the 72-hour requirement for residential clients. In addition, the same youth's non-residential file was opened on 10/23/18 and the residential needs assessment and service plan were implemented; however, there was no addendum or progress note to reflect incorporating those documents. Non-residential progress notes do show that the youth is getting the services addressed on both the needs assessment and the service plan.

Of the 3 non-residential files reviewed, the Needs Assessments were initiated and completed during the first face-to-face contact in two of the files reviewed and completed within 2 days of the intake in the 3rd file. All 6 Needs Assessments were conducted by a Bachelor's or Master's level staff member and signed by the Supervisor. None of the files reviewed were identified with an elevated risk of suicide.

Exceptions:

No exceptions are documented for this indicator.

2.03 Case/Service Plan

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a written policy 2.03 that addresses the service plan, implemented on 10/01/02 and last revised on 07/01/18. The policy was reviewed, signed and dated by the Chief Executive Officer and the Chief Program Officer.

The program's procedure is to initiate a service plan within seven working days of intake and completion of the Needs Assessment. The plan will be developed with the youth and family to ensure active participation in the process and support of identified goals. The service plan is an active and working document that can be modified as needed or requested by client or counselor. Service plan reviews must be at 15, 30, 45, 60, 90, 180, and 360 days, whenever appropriate and depending on the program type, shelter or community based service, and must be signed by the youth, guardian(s) and counselor.

Completed service plans will contain: identified needs; how those needs are to be addressed; time-frames for goals/completions; individuals responsible; target and completion dates; how these goals will be assisted; and signature of the youth, guardian(s) and assigned counselor.

There were 6 client files reviewed for 3 residential (2 open and one closed) and 3 non-residential (1 open and 2 closed) youth. Of the 6 reviewed files, all had service plans implemented within 7 working days and after the completion of the Needs Assessment. All required signatures were present on 4 of the 6 service plans. Two residential files did not have parent signatures: for one of the two files, a subsequent progress note indicates that a phone discussion with the parent was held within one week of the youth's intake. One of the 4 applicable files reviewed (non-residential youth) did not have a 30, 45, or 60-day service plan review.

Exception:

No exceptions are documented for this indicator.

2.04 Case Management and Service Delivery

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a written policy 2.04 that addresses case management and service delivery, implemented on 10/01/02. The policy was reviewed, signed and dated by the Chief Executive Officer and Chief Program Officer on 07/01/18.

The program's procedure is to: establish referral needs and coordinate referrals based on Needs Assessment; coordinate implementation of service plan; monitor progress; providing family support; monitoring out of home place, if necessary; provides case staffing referrals; recommending judicial intervention in certain cases; accompanying client to court and related appointments; providing additional referrals; ongoing case monitoring and/or court order reviews; and case closure and follow ups.

Each client is assigned a counselor in order to ensure services are provided directly by program or through referral, as necessary. Services include, but not limited to: intensive crisis counseling; parent counseling; individual, family & group counseling; community mental health services; prevention & diversion services or services provided by volunteers or other community agencies; runaway, homeless/emergency shelter services; reunification; special education, tutorial or remedial services; recreational services; and discharge and aftercare planning.

There were 6 client files reviewed for 3 residential (2 open and one closed) and 3 non-residential (1 open and 2 closed) youth. Each of the 6 files showed evidence that a counselor was actively involved with delivering services to clients and families. There was a direct relationship between the specific needs of each client/family and the development of their individual service plans. Substance abuse referrals were in place for 4 of the 6 clients (3 residential and 2 non-residential). Progress notes indicate in all 6 of the files that individual and family counseling was being offered. Follow-ups were completed on 2 of the 3 closed files. The third closed file has not been closed long enough to require a follow up.

Exception:

No exceptions are documented for this indicator.

2.05 Counseling Services

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a written policy 2.05 that addresses counseling services and was implemented on 10/01/02. The policy was reviewed, signed and dated by the Chief Executive Officer and Chief Program Officer on 07/01/18.

The program's procedure is to develop service plans with involvement from the youth and family, that these plans are viewed at prescribed intervals to determine progress in achieving service goals. An assigned counselor is the primary service delivery person for each case. The counselors' responsibilities are to ensure a service plan is developed with active involvement and input from youth, family, and others who are involved in service delivery. This can be either through direct services, providing external referrals or coordinating other related services as identified in the service plan.

Service plans are developed and reviewed by the counselor, youth and family, and signed off by the supervisor. Changes are documented on the updated service plan by all parties and the counselor and supervisor must initial the document.

Group counseling will be provided a minimum of 5 days per week by staff trained by the clinical director. Topics will be determined by assessing current client needs and issues. Group counseling services will be scheduled at consistent times on a daily basis and documented in client case file and/or group counseling logs. This should be different from other types of gatherings that may occur in the residential setting. These include house meetings, conflict resolution meetings, and recreational activities. Per program policy, "as it has become apparent, there are occasions in every residential milieu when an impromptu group or house meeting may be needed to address a specific current issue. These groups may be held in addition to or in place of the planned daily group, if appropriate."

All six files reviewed had evidence in the case notes of counseling services provided and documented youths' progress. The six files also demonstrated an ongoing process for clinical reviews of case records and staff performance. It was evident that the youth/family received counseling services in accordance with the case/service plan.

Group meetings are being conducted 5 days per week. Each group form has a place for topic, date, time and client signatures. Signatures of each of the 3 residential clients were found on various sign-in sheets.

It was also noted that some sign-in sheets do not have the topic specified. Some were also missing their start date or time. Also, there is no place on the forms to indicate what time each group meeting ended; therefore, it is unclear if each group meeting goes a full 30 minutes.

Exception:

No exceptions are documented for this indicator.

2.06 Adjudication / Petition Process

☒Satisfactory ☐ Limited ☐Failed ☐Not Applicable

Rating Narrative

The program has a written policy 2.06 for adjudication/petition process that was implemented on 10/01/02. The policy was reviewed, signed and dated by the Chief Executive Officer and Chief Program Officer on 07/01/18.

The program's procedure is to offer case staffing in situations when the counselor cannot assist the youth and family in resolving truancy and/or ungovernable issues. A parent may submit a written request for a case staffing with the case staffing committee. That meeting is to be held within 7 working days of the receipt of the written request. Notification goes out to the youth's family within 5 working days of the scheduled meeting. Notification of the time and location of the meeting must be provided by phone and in writing within 5 days of the scheduled meeting.

The Case Staffing Committee is made up of DJJ representative, CINS/FINS provider, school representative, and Court Liaison. The committee may also include state district attorney, health, mental health representatives, or any person requested by the guardian(s), youth, or CINS/FINS staff.

A signed, written report of the findings of the committee will be provided to the family at the conclusion of the meeting, or it can be mailed to them within 7 days after the Case Staffing.

There was only one applicable case staffing conducted by the provider since the last QI review. The parent of the youth was offered a case staffing because of her son's ungovernable behaviors and it was initiated by Miami Bridge staff. The family was notified of the case staffing date of 07/11/18 by phone, with a written follow-up mailed to them on the same day. The hardcopy case staffing form shows the signatures of the youth, parent, DJJ representative, school representative, mental health professional, and Miami Bridge Counselor.

As a result of the case staffing, the youth was deemed to be ungovernable and a CINS client. His initial service plan includes observing his curfews, following household rules, and attending school regularly. The case staffing extended his service plan to include

substance abuse treatment, recreational activity, and weekly counseling services through Miami Bridge. His parent received a referral to attend parenting classes.

Miami Bridge Central has a list of case staffing committee members, along with possible additions or alternates. The program has a scheduled monthly case staffing meeting date, which is when case staffings are conducted or committee discusses potential cases. Emergency case staffings are held if and when needed.

Exception:

No exceptions are documented for this indicator.

2.07 Youth Records

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a written policy 2.07 for maintaining confidential records that was implemented on 10/01/02. The policy was reviewed, signed and dated by the Chief Executive Officer and Chief Program Officer on 07/01/18.

The program has written procedures for maintaining confidential records in a locked file cabinet. Their non-residential program has implemented a paperless tracking system with Lauris On-Line; however, there are still some older binder files maintained on-site in the secured, non- residential FSFF office building. Two of those binders were reviewed and both were marked “Confidential.” The shelter case files are also maintained securely at the FSFF office building on the campus. The file cabinet is locked and marked “Confidential,” as are the 3 binder files.

All seven youth record reviewed were marked confidential and were maintained in a neat, orderly manner. A tour of the facility was given, which included the storage of youth records. When youth records are transported, they are done so in securely locked, nylon cases, which are also marked “Confidential.

Exception:

No exceptions are documented for this indicator.

2.08 Sexual Orientation, Gender Identity, Gender Expression

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has a written policy 2.08 to ensure a safe and therapeutic environment for youth regardless of sexual orientation, gender identity, and gender expression. The policy was implemented on 07/01/2018 and was signed and dated by the Chief Executive Officer and the Chief Program Officer.

Per the agency's procedures, all youth are provided a safe environment and therapeutic case planning regardless of the youth's actual or perceived sexual orientation, gender identity, or gender expression. Youth are addressed according to their preferred name and gender pronouns by staff as well as in written documentation such as in the logbook, all outward-facing documents, and the census board. All staff, service providers, and volunteers will receive information relating to the Florida Network policy #5.08 and the terms defined therein.

During a tour of the facility, "safe zone" rainbow flags were posted in the facility indicating that all youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The stickers were visible throughout the shelter, in common areas and youth dormitories. The program displays three different types of brochures providing education and information about LGBTQ; one from the Alliance for LGBTQ, and 2 in Spanish from Latino Salud and the National Runaway Switchboard. Alliance occasionally conducts groups for the provider.

The program served two youth who met the criteria for the indicator. Both youth identified as female transgender. Documentation reviewed demonstrated the youth were addressed according to their preferred name and gender pronouns and preferred name and gender pronouns were used in the e-logbook records as well as case notes, and other client information. Youth preference was considered and documented for room assignment and the two youth were assigned to the female bedrooms as requested/preferred and was observed on the Client Daily Point Sheet Log and in the e-logbook during bed checks; however, the room assignment documented on the CINS/FINS Intake form does not identify which gender dormitory the youth are assigned, just the Module and bed#. Both youth were documented as male and not the preferred female gender on the CINS/FINS Intake form. None of the youth indicated were identified as needing specialized support. The program provided hygiene products and other items needed by the youth to support their gender identity or gender expression.

The 3 new staff training received LGBTQ training. Interns participate in groups when onsite and are also required to complete core competencies related to gender biases and cultural differences as a part of their learning contract with the provider.

Exception:

No exceptions are documented for this indicator.

Standard 3: Shelter Care and Special Populations

Overview

Rating Narrative

Miami Bridge Central is licensed by the Department of Children and Families (DCF) for twenty-eight (28) beds and it primarily serves youth from Miami Dade County. The shelter building includes a large day room, girls' and boys' sleeping rooms, dining room, kitchen, laundry, staff offices and a conference room. During the Quality Improvement review, the shelter was found to be in good condition, the furnishings in good repair, and the rooms and common areas were clean. The dormitory is divided into two separate areas, one for the boys and one for the girls. There are 2 large bathrooms, one on each dorm wing. The bathrooms consist of three sinks, six showers and three toilets. The bathroom floors are tiled and the plumbing appeared functional. The sleeping rooms house fourteen (14) youth each. The sleeping room is equipped with bunk beds and each youth has an individual bed, bed coverings and pillows. The windows are frosted to provide privacy for youth. In addition, the youth have access to a computer lab with 6 computers, recreational games, a volley ball court and basketball.

Staff members in the Residential Program include: a Shelter Supervisor, 2 Counselors, 4 Shift Leaders, 7 Youth Activity Workers, a PT Registered Nurse, a Health Care specialist, a Recreation Specialist, and a Food Specialist/Cook. The provider also employs a Maintenance person who is responsible for facility repairs and maintenance for both the Central and South Miami program facilities. The Direct Care workers are responsible for completing all applicable admission paperwork, conducting youth orientation to the shelter, and providing necessary supervision. Health and medication related activities are the responsibility of the Registered Nurse and Health Care Specialist who maintain inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administers first aid when needed, and coordinates all offsite appointments to medical providers. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication office, and kitchen. All medications are stored in the Pyxis 4000 Med Station in the Nurse's office.

3.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a policy and procedure in place, 3.01 Shelter Environment that addresses the indicator. The policy was signed and dated on 7/1/2018 by the CEO and Chief Program Officer.

The agency maintains a clean, safe environment for clients and staff that are essential to successfully managing and operating a residential facility. Residential facilities should be equipped with adequate bathroom facilities to accommodate clients and staff to promote good personal hygiene practices. To enhance client safety, program sanitation, and ensure the highest level of quality, the Miami Bridge will ensure all furnishings are in good repair; health and fire safety inspections are current; ensure the facility is free from insect infestation; the facility grounds are clear of debris, landscaped, and well maintained; bathroom and shower areas are clean and functional; there is no graffiti on walls, doors or windows; require all sleeping areas have adequate lighting; and provide bed and bed covering for individual youth.

During the tour of the facility and grounds, it was observed that all Miami Bridge facilities were clean, landscaped and well maintained. The Chief Facilities and Construction Officer (DFCO) is responsible for implementing appropriate maintenance procedures and schedules in the respective facilities to ensure a safe, clean attractive environment for agency clients and employees. Miami Bridge has implemented a general housekeeping and maintenance plan that provides clear guidelines for the cleaning and maintenance of all agency facilities. In addition, the provider has a maintenance staff onsite and is shared between the two program locations to complete routine and needed repairs and maintenance.

Documentation for the last six months of fire drills and mock drills were reviewed. The fire drill logs were all documented. The mock drill logs were missing drills for the third shift.

All health and fire safety inspections are current with the Department of Health and the Annual Fire Safety inspection.

All health and fire safety inspections are current as of 10/02/18 when the Department of Health completed the last food inspection and the group care inspection on 12/29/17. All fridges/freezers are equipped with thermometers and are maintained at required temperatures. All food is properly stored, marked, labeled and pantry area is clean. The City of Miami issued a Fire Safety Permit effective 10/1/18-9/30/19 as a result of its Annual Fire Safety inspection completed on 10/26/18. Agency has a current DCF Child Care License for 28 beds, which is displayed in the facility, effective through 5/31/19.

All furnishings appear to be in good repair. The program is free of insect infestation and no findings of droppings were observed while touring the facility. The facility's washer and dryer are operational and general lint collectors were clean upon review.

All youth dorms are in compliance with agency policy. Beds are labeled and youth are assigned to module A or B, depending on alerts/associated risks. Linen is cleaned weekly and youth are able to wash linen upon request. All youth dorm bathrooms and public restrooms observed were well maintained and functional. There is adequate

lighting throughout the facility. Each youth is assigned a locked storage cabinet that is safe and secure to keep personal belongings.

Youth are engaged in meaningful, structured activities seven days a week during wake hours. Some of the activities include large muscle activity (LMA) and exercise, playing pool, or various activities coordinated by the Recreation Specialist. Idle time is minimal. The daily schedule reflects at least one hour of physical activity/recreation.

Daily programming includes opportunities for youth to complete homework and access books in the facility library that have been approved by the agency. Daily programming scheduled and is publically posted in each dormitory.

Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities are offered as an alternative to youth who do not choose to participate in faith-based activities.

All staff is assigned keys individually. All doors are secure, in and out access is limited to staff members, and the front door entry is controlled by the Office Assistant or accessible only with electronic key access.

The facility has detailed egress plans throughout facility, client rules, grievance forms, abuse hotline info, DJJ incident Reporting number and other vital information posted in common areas (lounge/staff desk).

During the review, the agency vehicles were observed and were secured, clean, and had working seat belts. The vans had first aid kits, fire extinguishers, current registration & insurance and a multi-task tool (able to use as a seat belt cutter, glass breaker, flash light).

Exception:

No exceptions are documented for this indicator.

3.02 Program Orientation

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge Shelter has a policy and procedure 3.02 in place for program orientation that was signed and dated 7/1/2018 by the CEO and Chief Program Officer.

New youth orientation is an important early step in the service delivery process. Orientation is an opportunity for staff to begin building positive relationships with youth and set clear expectations for their behavior and cooperation. The orientation process will provide youth with the information they need to ensure a successful stay at Miami Bridge and inform them how to access services offered.

Within at least 24 hours and preferably immediately upon completion of each youth's intake, staff will begin the orientation process by discussing the program's philosophy, goals, services and expectations. At intake or admission, the following are reviewed with each youth: philosophy, goals, services, and expectations; a review of the agency's policy on contraband and unauthorized items; a review of rules governing youth conduct and the disciplinary actions or consequences which may result when youth violate rules of the behavior management system; a review of the program's dress code; a review of procedures to access medical care; a review of the visitation schedule, mail procedures and telephone procedures; a review of the youth's rights and the grievance procedure; a review of the disaster preparedness plan and emergency evacuation plan; the physical layout of the facility and a tour of the program; room assignment; introductions to program staff and youth; a review of the daily schedule; and a review of how to contact the Florida Abuse Hotline and DJJ Incident Hotline etc.

Employees are trained in how to develop rapport with youth and provide effective orientation for new youth 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 but the orientation must be completed within the first 24 hours of placement.

A review of three client files, two open and one closed, was conducted for three youth. Each of the files had documentation indicating that the procedures and practices are being followed as indicated in the policy and procedure manual. The orientation process was initiated within 24hrs each on the date of intake and each client and staff signed the orientation checklist sheet. Each youth was given a list of contraband items and a layout of the facility as well as an explanation of: disciplinary actions, the grievance procedure, emergency disaster procedure, and rules on contraband. They were oriented on room assignments and suicide prevention precautions, including alerting staff of their feelings or awareness of others having suicidal thoughts. Additionally, they received a review of daily activities and were given and shown postings of the abuse hotline and a tour of the facility. The client handbook provides valuable information which includes policies regarding behavior management and consequences for non-compliance, key staff, rights and responsibilities, privacy of information, grievance procedures, consumer rights and responsibilities, behavioral procedures at school, and abuse registry and DJJ CCC phone numbers. The youth and parent sign an acknowledgement of receipt of the

handbook. Evacuation routes and floor plans, abuse hotline numbers, program schedules etc. are located in the common area where youth reside.

Exception:

No exceptions are documented for this indicator.

3.03 Room Assignment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has policy and procedures 3.03 in place for youth room assignment that addresses this indicator. The policy was signed and dated by CEO and the Chief Compliance Officer on 7/1/2018.

The youth admission and classification process is an important part of agency operations. The task of assigning clients sleeping arrangements is viewed as critical to client safety and supervision. To ensure the safety of clients and staff, the Miami Bridge has a process in place that includes an initial classification of youth for the purpose of room assignment to determine the appropriate sleeping arrangements for each youth. This process should increase staff awareness of any safety or security risk associated with the youth's placement and the following must be documented when placing a youth in a multi-occupancy room: review of youth's history and status (delinquency and or dependency); initial collateral contacts (DJJ or DCF); initial interactions and observations of the youth's behavior; separation of older from younger youth using module system; separation of violent from non-violent youth using module system; identification of youth susceptible to victimization using module system (small, young or immature); presence of medical, mental or physical disabilities using module system; potential suicide risk; history of sexual aggression or predatory behavior; physical characteristics including age, sex, height weight and physical stature; and past involvement in gang activity, aggressive behavior, physical assault, sexual misconduct, or demonstration of emotional disturbance. Alerts are documented into the program's Medical and Mental Health Alert System and EMR medical section when youth is admitted with special needs or risks such as mental health, substance abuse, physical health, suicide risk or other security factors.

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 issues. Based on this information, the youth will be assigned a bed pending further assessment. The agency requires that all youth files at the residential facilities include a place for a photograph to identify youth. Having a photo identification process is also essential for law enforcement personnel and missing person's reports should the youth abscond from the facility. 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.

A review of three client files, two open and one closed, was conducted for three youth. Each of the files had documentation indicating that the procedures and practices are being followed as indicated in the policy and procedure manual and the youth room was assigned based on the classification. During walk through of youth rooms, the designated beds for youth that are at risk were closer to the door where staff desk is located.

Exception:

No exceptions are documented for this indicator.

3.04 Log Books

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has policy and procedure 3.04 for logbooks in place that was signed and dated on 7/1/2018 by the CEO and the Chief Compliance Officer.

Miami Bridge requires maintaining professional, accurate and concise written documentation as an essential communication tool for staff that enhances their ability to provide appropriate supervision of youth and ensure youth safety. This is especially true in a 24-hour residential facility. To ensure the highest levels of safety and quality, the agency will ensure to maintain either a paper or electronic daily logbook to document routine information, emergency situations, and incidents.

Electronic log books document routine daily activities, events and incidents in the program and are reviewed by direct care and supervisory staff at the beginning of each shift. Electronic log book entries that could impact the security and safety of the youth and/or program are highlighted. Entries include: date and time of the incident, event or activity; names of youth and staff involved; a statement providing pertinent information; and the name and signature of the person making the entry. All recording errors are struck through with a single line. The staff person initials or signs for the deleted entry. The program director or designee reviews the facility logbooks every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date entry.

The oncoming supervisor reviews the logbook of the previous two shifts (at a minimum) 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 (at a minimum) in order to be aware of any unusual occurrences, problems, etc. They make an entry in the logbook and sign that they have reviewed it and the dates reviewed.

Miami Bridge requires its residential facility to maintain an electronic daily logbook to document general program operational information. Random days in the months of July, September, and November 2018 were reviewed in the E-logbook. All critical information is highlighted. Staff documents when they come in on their shift and when they leave. Some staff are utilizing the icon features in the E-logbook.

Documentation can be found for whereabouts of the youth, intakes, exits, number of youth in the shelter and various activities that they are participating in. Any errors are struck through with a single line and initialed by the staff. Documentation is in real time. Also, if an entry was not made on time, it is noted with late entry and the reason for the late entry. Staff and supervisors also make note of when they reviewed the logbook for the previous shift(s).

Exception:

No exceptions are documented for this indicator.

3.05 Behavior Management Strategies

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge has policy and procedure 3.05 for behavior management strategies in place that was signed and dated on 7/1/18 by the CEO and Chief Compliance Officer.

Residential programs require structure, routines and consistency to function in a safe and organized manner. A formal, standardized behavior management system (BMS) is a significant component of this structure. This system should set clear boundaries and expectations for clients and provide clearly defined rewards and consequences for their behavior. To promote positive behavior and ensure the highest level of quality the Agency will: develop and implement a behavior management system designed not only to gain compliance with program rules but to change the behavior of youth and increase accountability. This strategy is critical to the program's effectiveness and to reduce recidivism; have a detailed written description of the behavior management system that is consistent with the principles including: provide a wide variety of rewards, provide appropriate consequences and sanctions, apply consequences immediately and

consistently and are matched to the level of severity of the behavior, ensure that rewards outnumber consequences, positive behavior, discourages negative behavior and sets clear behavioral expectations.

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 supervisor and/or clinical director is responsible for training, monitoring and supervising staff in the implementation of the BMS. BMS is administered by the Youth Activity Workers (YAWs) under the supervision of the shift leaders and shelter supervisor. YAWs will document and report youth behaviors. 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 need. The BMS has a formal mechanism to evaluate and document behavioral performance by youth. 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.

This reviewer spoke with staff about how the BMS is implemented. Staff explained how they use the system. Points are documented on a point log sheet and tallied at the end of the week. The most the youth can earn is thirty points, sometimes a little more if the youth receive extra points. Youth are recognized on “Feel Good Friday’s”. This is where they receive awards/certificates for Most Improved, Most Respectful, Best Helper and etc. Staff are trained on the point system and very knowledgeable on how it works.

Exception:

No exceptions are documented for this indicator.

3.06 Staffing and Youth Supervision

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The facility has policies in place, 3.06-Staffing and Youth and Staff Supervision and 3.06.01-One on One (1:1) Staff/Client Supervision, to ensure adequate staffing is provided to ensure the safety and security of youth and staff. These policies were last reviewed and approved 7/1/18 and signed by the CEO and the Chief Program Officer.

To ensure the highest level of safety and quality the Miami Bridge will establish and maintain the following: 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during the sleep period Staff must clock in and out when they arrive and depart their shift and log their arrival and departure in the log book The program will ensure that there is always at least one staff on duty of the same gender of the youth; The staff schedule is provided to staff or posted in a place visible to staff. There is an on call or overtime roster. Staff performs bed checks at least every 15 minutes while clients are in their dormitories asleep, when sick, or other times in their sleeping room. All room checks are documented in the agency log book in real time. Youth on suicide watch are placed on constant supervision until clinically assessed and removed from suicide watch. Youth will be transported in accordance with written policy. The organization has a system of supervision that promotes effective use of organizational resources and positive outcomes.

Miami Bridge implements a staff coverage schedule that provides adequate supervision of clients and ensures the safety and security of all youth and staff. Program staff included in the staff-to-youth ratio includes Youth Activity workers, supervision staff and treatment counselor. If program does not meet male and female guideline, the program will 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 will always be covered with a minimum of two staff.

A review of staff schedules during the review period demonstrated the program maintains 1 staff to 6 youth during awake hours and 1 staff to 12 youth during the sleep period. The overnight shift is staffed with a minimum of two staff. A staff schedule was observed to be posted in an area accessible to all staff.

Exception:

No exceptions are documented for this indicator.

3.07 Special Populations

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a written policy and procedure 3.07 that addresses all the key elements of the QI indicator. The policy was last updated on 7/1/18 and was signed by the CEO and Chief Administrative and Compliance Officer.

The provider has specific procedures in place for providing services for Staff Secure, Domestic Violence Respite (DV Respite), Probation Respite, and Domestic Minor Sex

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

The policy states these youth will be served at a higher level of supervision with assigned staff to monitor all movement. All youth will receive a standard CINS/FINS Intake and Needs Assessment within 72 hours of intake. Service plans will be developed within 7 days of the intake or admission. Staff Secure youth will receive a higher level of assessment, supervision, intervention, and services.

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

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

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

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

Youth served under the Intensive Case Management contract must meet the following criteria:

- Youth must be court-ordered or referred by case staffing committee
- Each youth and family must have six direct contacts per month as defined in policy #4.051.
- Each youth and family must have a minimum of six collateral contacts per month as defined in policy #4.051.
- Child Behavior Checklist (CBCL) must be completed within 14 days of intake.
- An approved self-report assessment is completed at intake and no less than every 90 days following intake, and at discharge.
- Case plan demonstrates a strength-based, trauma-informed focus.

Youth served under the FYRAC contract must meet the following criteria:

- Youth is referred by DJJ for the following reasons: a Domestic Violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating. All FYRAC referrals must have documented approval from the Florida Network office.
- All intake and case files must adhere to Florida Network policy requirements.
- Deliverables can be verified by one or a combination of the following and adhere to these services as defined in policy #4.121: Intake and initial assessment session; Life Management Sessions; Individual Sessions; and Group Sessions.

The provider did not serve any youth who met the criteria for Staff Secure, DMST, or Intensive Case Management during the review period.

Three (3) DV Respite files were reviewed for this indicator. All three (3) files had documentation of youth pending DV charges and had evidence of being screened by JAC/Detention and did not meet the criteria for secure detention. All three (3) youth in the program did not have a length of stay in DV Respite placement that exceeded the 21 days. One applicable youth was transitioned to CINS/FINS and supporting documentation was in the file. The case plan reflected goals consistent with the issues identified regarding aggression and coping skills in the one applicable file. The 1 file demonstrated similar services are provided to the DV youth consistent with all other general CINS/FINS program requirements.

One applicable probation respite file was reviewed. Documentation in the file demonstrated the referrals came from DJJ Probation; the length of stay was less than 30 days, there is evidence that all case management services and counseling needs were considered, and services are provided to the PR youth are consistent with all other general CINS/FINS program requirements.

The two applicable FYRAC cases were referred by DJJ for a domestic violence arrest on a household member. There is evidence the referrals were approved by the Florida Network office. The intake and initial assessments sessions met the requirement of a face-to-face assessment with both youth and with the development of a service plan implemented with signatures of the youth and parent in one of the two files. Staff was unable to meet with the family of one of the two youth to conduct face-to-face life management sessions.

Exception:

No exceptions are documented for this indicator.

3.08 Video Surveillance System

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Standard 3.08 Video Surveillance is addressed in Miami Bridge's policy and procedure 3.08-Video Surveillance System. The policy was last reviewed and approved in 7/1/18 and signed by the CEO and the Chief Program Officer.

Miami Bridge Youth and Family Services, Inc., is committed to excellence in its daily operations and in all its service delivery practices. As an extension of our risk prevention initiative, the video surveillance system monitors our facilities both internally and externally at both locations. As required by all CINS/FINS Shelters, Miami Bridge's video surveillance system operates 24 hours a day, 7 days a week to monitor and capture recordings of agency happenings to assure the safety of all youth, staff, and visitors to residential shelters. Miami Bridge's video surveillance system, at a minimum, shall demonstrate the following in adherence to this policy: system can capture and retain video photographic images which must be stored for a minimum of 30 days; system can record date, time, and location: maintain resolution that enables facial recognition; the locations of the cameras placed in interior and exterior (general locations of the shelter where youth and staff congregate and where visitors enter and exit); cameras are never placed in bathrooms or sleeping quarters; video surveillance system is only accessible to designated personnel; all cameras are visible to persons in the area (no covert cameras) and a written notice is conspicuously posted on the premises identifying that the facility uses cameras for the purpose of security. Camera footage will be reviewed periodically to ensure functionality and quality services and when deemed beneficial as an investigative tool.

The existence of this policy does not mandate cameras to be monitored 24 hours a day, 7 days a week but video recording is imperative. At a minimum, Miami Bridge will: 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, any use is authorized by the CEO and it is not used for covert operations and/or misused by authorized personnel; 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; not place cameras in bathrooms or sleeping quarters; and ensure that overnight bed check logs are reviewed fortnightly by the Shelter Supervisor and periodically by the QI Coordinator against footage from the video surveillance system and entered into agency log book, per DJJ QI expectation. The CEO and Technology Officer will be the overall designated program administrator. 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 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. Video surveillance system is only accessible to designated personnel, as follows: Chief and Deputy Chief Executive Officers, Chief Operations and Technology Officer, Chief Compliance Officer, and QI Coordinator. Site specific access is available to the Clinical Directors or Shelter Directors/Coordinators. Designated staff is trained to handle the equipment and monitor or review footage in a professional, ethical, and legal manner.

The Miami Bridge camera system is new and consists of 32 cameras, 16 inside the facility and 16 outside. All cameras are easily visible both internally and externally as well as signs located in the front window and rear door indicating that video surveillance is in use. The video footage is high resolution and the system can store footage for a minimum of 30 days. Supervisory staff reviews the footage from a designated laptop computer.

This reviewer met with the Miami Bridge QI Coordinator to review the video surveillance System. Video from random shifts were observed as well as viewing the video review log notebook. A review of the program video surveillance system shows that staff observes youth at least every 15 minutes while they are in their sleeping room with the exception of a few nights. During the review of bed checks for 11/9/18, it was observed that the bed checks in the male dorm were not being completed timely, every 15 minutes. Staff documented in the e-logbook that a bed check was performed at 1:16am then at 1:42 am which was consistent with the camera footage. The other times noted were 2:02am; 2:25am; 3:00am; 3:17am; 3:44am; 4:11am; and 4:58am; however, the reviewer was unable to verify whether these times were accurate since the staff was sitting in the dorm and movement was not captured on the camera. Two other dates reviewed, 7/21/18 and 9/19/18, also, showed untimely bed checks. On 7/21/18, bed checks were done at 5:17am, 5:41am, 6:07am, and 6:31am. On 9/19/18, bed checks were noted for: 12:07am, 12:38am, 12:59am, 1:24am, 2:30am, 3:00am, 3:14am, and 3:32am. All other bed checks were being performed timely on shifts.

Exception:

During the review of bed checks for 11/9/18, it was observed that the bed checks in the male dorm were not being completed timely, every 15 minutes as required. Staff documented in the e-logbook that a bed check was performed at 1:16am then at 1:42 am which was consistent with the camera footage. The other times noted were 2:02am; 2:25am; 3:00am; 3:17am; 3:44am; 4:11am; and 4:58am; however, the reviewer was unable to verify these times on the video footage since the staff was sitting in the dorm and movement was not captured on the camera. Two other dates reviewed, 7/21/18 and 9/19/18, also showed untimely bed checks. On 7/21/18, bed checks were done at 5:17am, 5:41am, 6:07am, and 6:31am. On 9/19/18, bed checks were noted for: 12:07am, 12:38am, 12:59am, 1:24am, 2:30am, 3:00am, 3:14am, and 3:32am.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

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

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

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Clinical Director and Residential Coordinator are notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board, youth alert forms, and in the youth files using a color coding system.

Youth admitted to the shelter with prescribed or over the counter medication will surrender those medication to staff during admission. The agency is storing all prescribed medications in the Med-Station 4000 cabinet and has several staff members as regular users and more than 2 Super Users of the Pyxis Med-Station 4000. The provider has a RN and Health Care Specialist whose main responsibilities are the provision of medical care and medication management in the facility. Topical and injectable medications are stored separately from oral medication. Refrigeration is available for medication requiring cool storage. The program has a list of staff who are authorized to distribute medication 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 has written policy and procedure 4.01, which was approved and signed on July 7, 2018 by the Chief Executive Officer (CEO) and the Chief Program Office, to ensure all youth in the program with chronic medical condition are provide medical care. The policy indicates general procedures and practices to gather medical and mental health information of youth in a confidential manor.

Youth are screened by the on-site registered nurse (RN) or non-licensed medical staff to identify if a youth is on any current medications, have any existing medical conditions to include chronic conditions, allergies, have any recent illness or injuries. The RN will follow-up on any medical screenings performed by non- licensed medical staff. Any additional information applicable to this process is obtained from the parent/ guardian by way of telephone to assist the program staff in determining a more effective course of action for admission or any applicable treatments required. The program utilizes the CINS/ FINS Intake Screening Form to document any health issues, medical conditions, and medications a youth may have. Any youth currently on medication at the time of admission is documented on the Medication Management Issue form. If a youth displays a serious or chronic condition or emergency which requires immediate medical services, the program utilizes a Medical Treatment Form to make arrangements for additional medical services and ensure all necessary follow-up is completed.

A review of three youth medical healthcare records supported a preliminary healthcare screening was conducted with each youth during the admission process. The program procedures include a thorough referral process for follow-up medical care for youth admitted with chronic medical conditions. An interview with the RN verified this practice.

Exception:

No exceptions are documented for this indicator.

4.02 Suicide Prevention

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has written policy and procedure 4.02 related to suicide prevention which includes a written suicide prevention plan approved and signed by the Chief Executive Officer (CEO), and the Chief Program Officer on July 7. 2018. All youth will be screened for mental health, substance abuse, and suicide risk at intake. The program utilizes the statewide Suicide Risk Response Protocol approved by the Florida Network of Youth and Family Services and has clear procedures to train staff to assess, respond, report and document any suicidal behaviors communicated or demonstrated by youth.

Any youth identified as having suicidal ideations will be placed on constant sight and sound supervision and will be assessed by a licensed mental health professional, a non-licensed mental health professional under the supervision of a licensed mental health professional, licensed social worker, or a non-licensed clinical social worker under the supervision of a licensed social worker within twenty-four hours. If the youth is believed to be an imminent danger to himself or other, the youth will be placed on one-to-one supervision and law enforcement will be contacted and/ or Baker Act. Staff supervising youth who are placed on one-to-one or constant sight and sound will observe the youth at least every thirty minutes of less and document on the Observation Log. The staff completing the observation documents the date, time, behavior, warning, and initials the Observation Log.

A review of three youth mental health records indicated each contained a suicide screening form completed within twenty-four hours of the youth's admission. Each reviewed record contained results from the screening form and were signed by the supervisor. Each of the three reviewed youth were placed on constant sight and sound supervision until assessed by a licensed or non-licensed professional under the direct supervisor of the licensed professional and were placed on the appropriate level of supervision based on the results of the suicide screening form. Review of the Observation Logs for each of the three reviewed youth indicated staff documented observations every fifteen minutes which included an observation of warning signs, and youth behavior. Each log contained the date, time and initial of the staff supervising the youth. In each instance, the youth remained on the appropriate level of supervision until seen by a licensed professional or a non-licensed professional under the supervision of the licensed professional.

Exception:

No exceptions are documented for this indicator.

4.03 Medications

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program follows written policy and procedures 4.03 which addresses the safe and secure storage, access inventory, disposal, and distribution of oral medications and pharmaceutical products to include over-the-counter (OTC). The policy was approved and signed by the Chief Executive Officer (CEO) and the Chief Program Officer on July 1, 2018.

The program's policy requires all non-healthcare staff are trained in medication distribution by a licensed registered nurse, incoming clients who are currently on prescribed medication have their medication at intake, ensure the program provides a continuum of healthcare services, ensure youth receive medications as ordered, and ensure all medications are stored in the Pyxis Me-Station 4000 medication cabinet.

The program has a process to verify medication by contacting the pharmacy to verify the youth's current prescription, view the Pyxis Medication Station, or review the physicians' desk reference. Each method used to verify medication is documented. The program only accepts medication from a licensed pharmacy with a current patient-specific label intact to the container. In all cases, the program verifies with the pharmacist, documents the medications, and initiates the Medication Distribution Log. Medications, including narcotics and controlled medications, are stored in the Pyxis Medical Station 4000 and is maintained by two super users. The program maintains a list of non-licensed staff who were trained by a registered nurse to administer medication and who have access to secured medications with limited access to controlled medications. The program does not accept any youth prescribed injectable medication except for epi-pens. A review of the Medication Distribution Log book indicated the program staff conducted medication counts daily on each of three shifts and maintains a perpetual inventory with an accurate count for controlled substances. Any medication discrepancies are cleared prior to the end of each shift. Syringes and sharps were observed to be secured in a locked metal medical box located inside the nurse office. Weekly inventory of all syringes and sharps is conducted. The program has a small secured refrigerator located in the nurse office designated for medication requiring refrigeration. There was one incident reported to the Central Communication Center (CCC) during this review period related to youth medication distribution.

Exception:

No exceptions are documented for this indicator.

4.04 Medical/Mental Health Alert Process

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has written policy and procedures 4.04 related to the medical and mental health alert process which was approved and signed by the Chief Executive Officer (CEO) and the Chief Program Officer on July 1, 2018. The policy requires all program staff involved in the care and supervision of youth to be made aware of the youth's health needs, safety issues, and be able to effectively care for all youth.

The program has developed and implemented an alert system to identify youth with medical, mental health, nutritional, and substance abuse which is a priority for all direct delivery staff. The alert system is a color coded system which is communicated to staff through the program logbook, the alert board which is located in the intake office, and documented in the youth's individual healthcare file. The licensed registered nurse (RN) conducts an initial healthcare screening to determine and document if a youth has a medical, dental or mental health issue. If a non-licensed medical staff conducts the screening, the RN will review the screening form within seventy-two hours. All direct care program staff are required to review medical and mental health information of the youth in the program.

A review of three youth healthcare records indicated each identified an alert which was documented on a color coded label and each record contained a Youth Alert System form completed, signed by the RN. The program also maintains a medical alert board located in the intake office which identifies medical, mental health, substance abuse, and nutrition alerts. The program also maintains special nutritional diet alerts for youth with dietary restrictions located on a clip board in the kitchen.

Exception:

No exceptions are documented for this indicator.

4.05 Episodic/Emergency Care

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The program has written policy and procedure 4.05 which was approved and signed by the Chief Executive Officer (CEO) and the Chief Program Officer on July 1, 2018 to ensure episodic/ emergency medical and dental care is provided to all youth in the program who require services. The policy requires staff to effectively respond to any episodic/emergency health or medical needs of youth.

The program has identified appropriate resources to provide emergency medical and dental care to all youth who require services. When a medical or dental emergency occurs, the parent/ guardian is notified by the licensed registered nurse (RN) or shift supervisor to get direct assistance and approval to have services performed. A referral is initiated by the RN or shift supervisor to have the youth receive the appropriate services.

A review of three youth healthcare records indicated each received a referral for off-site emergency care. An incident report was completed on each emergency and the parent/ guardian was notified. In each instance discharge documentation was maintained and documented in the program's daily log for follow-up care. There are seven first aid kits located throughout the program. Two are located in the vehicles used to transport youth, one in the intake office, one in the kitchen, one in the admission office, one in the reception area, and one in the school classroom. First aid kits are checked weekly by the nurse and replenished when needed. The program has one automated external defibrillator (AED) located in the nurse office. The device has automated instructions and the battery and pads expire April, 30, 2024 and March 31, 2019 respectfully. The AED is inspected monthly by the nurse to ensure it is in good working order. A review of three in-service and three pre-service training records verified each staff received first aid, cardiopulmonary resuscitation (CPR), and AED training.

Exception:

Observation of the program's suicide response kit found the program has five seatbelt cutters identified as the knife-for-life located in the intake office, admissions office, kitchen, school classroom, and reception area. There were no wire cutters located in the kits. Further observation of the identified tool indicated it may not be suitable to cut bulky material if a youth performs a suicide act. This was brought to the CEO's attention and the program has ordered ten new knife-for-life, ten long-nose wire cutters, and ten storage boxes.