Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Miami Bridge Youth and Family Services
Homestead, Florida
Miami Bridge South Residential Program

November 28-29, 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	Limited
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, 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: 96.4%
Percent of indicators rated Limited: 3.6%
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

Team Members

Marcia Tavares, Lead Reviewer, Consultant- Forefront LLC

Gabriel Medina, QI Monitor, Department of Juvenile Justice

Christine Morgan, Senior Youth Care Supervisor, Orange County Youth Shelter

Travis Scott, Residential Counselor, CDS Family and Behavioral Health Services

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
- 0 # 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
- 13 # Personnel /Volunteer Records
- **7** # Training Records
- **5** # 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.

New Reception Lobby
A new secure reception area was built on the shelter in Homestead to allow mutual privacy and confidentiality between guests, potential clients/parents/guardians, and the current youth in the shelter. The reception area is close to completion and will require secure access into the shelter facility.

Summer Program
The city of Homestead CRA provided $13K in funds for the agency to offer a summer program for the youth.

Other

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 Homestead, located at 326 NW 3rd Ave, Homestead, Florida, is under the leadership of a Board of Directors, Chief Executive Director, Deputy CEO/ Chief Financial Officer, Chief 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 as well as a Shelter Supervisor.

All fiscal, administrative, and personnel functions for both Miami Bridge program locations are handled by the MB Central administrative office. 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 Homestead facility is licensed by the Department of Children and Families for 20 beds, with the current license in effect until February 28, 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 thirteen (13) applicable personnel files were reviewed for five (5) new staff, five (5) staff eligible for 5-year re-screening, and three (3) Interns. All five new hire files maintained evidence of eligible screening results obtained prior to hire. The 5-year re-screenings were completed timely for 3 of the 5 eligible staff. The 5-year re-screenings were due 5/29/18 and 10/30/18 for two staff but were not submitted until 11/5/2018 and the results were still pending during the QI visit.

The program has three Interns providing service during the review period. The provider submitted background screening requests for all three interns. The intern files did not include an official start date but documentation was provided to support no contact with youth or access to confidential information was allowed prior to background screening clearance. The provider provided email documentation supporting approval to initiate training with one of the 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.

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 four new employees were verified, confirming the employees' work eligibility.

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.

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 5-year re-screenings were not completed timely for 2 of the 5 eligible staff. The 5-year re-screenings were due by 5/29/18 and 10/30/18 for two staff but were not submitted until 11/5/2018 and the results were still pending during the QI visit.

1.02 Provision of an Abuse Free Environment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

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

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

The program maintains both a Monthly Abuse Registry Log and a Client Grievance Monthly Log. A total of 5 Abuse Registry calls accepted by the Hotline during the review period were reviewed. None of the abuse calls were institutional. Youth receive an orientation guide and grievance procedures during admission. The program documents

the calls on Abuse Registry Log Sheets that are maintained in a binder. Per the agency's policy and procedures, the program will document an abuse report in the client's case file; however, 3 of the 5 hotline calls were not noted in the progress notes of the youths' case files.

Surveys were completed with two youth on-site during the QI visit. The two youth were knowledgeable about the abuse hotline and both knew the location of the number. None of the youths surveyed stated they had attempted to call the hotline while in the shelter. The two youth surveyed indicated staff is respectful when talking with youth they feel safe in the shelter.

During the tour of the facility, the grievance box and forms were observed to be mounted on a wall adjacent to the intake office. Two grievance reports related to youth on youth behavior were reviewed for the current review period. Both grievances were resolved promptly and signed by the youth. One of the two youth surveyed knew about the grievance process and rated it as good.

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 policy states that when a reportable incident occurs, staff must notify the Department's Central Communication Center within two (2) hours once the staff has knowledge of the incident. The policy also states that staff must write up the incident after the occurrence and before leaving the shift. Follow up procedures are included in the policy regarding any instructions required by CCC in order to close the case and to be sure that the incident has been attended to as needed.

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

viewed by staff and residents. The Shelter Supervisor is responsible for making sure the procedures are complied with.

Four (4) CCC reports made during the review period were reviewed; two of the incidents were as a result of contraband found, one was for youth behavior, and one was for a youth who absconded. All reports reviewed contained the appropriate detailed information, including witness statements and all authorities/parties contacted such as supervisors, Law Enforcement, Parent Guardian and CCC. All signatures were in place including staff, youth and witnesses as well as supervisory personnel. The program notified the Departments CCC within the two hour time frame as required for all four incidents. In addition, the program maintains email documentation of communication with CCC regarding follow-up information, special instructions, and tasks. All four incidents were documented on an incident reporting form and were also documented in the program logbook. A copy of the logbook entry is attached to the incident report and maintained chronologically in a binder.

A review of all internal incidents that occurred in the facility during the review period was conducted. Reviewer identified a reportable altercation incident that was not reported to the CCC. The incident occurred on June 1, 2018 and resulted in the arrest of two youth, one CINS/FINS and one dependent youth. An incident report was written up by the provider and was noted in the logbook but CCC was not contacted prior to the reviewer informing the provider.

Exception:

The provider failed to notify CCC of a reportable incident that resulted in the arrest of a CINS/FINS youth. Upon notification by the reviewer during the QI visit of the unreported CCC incident that occurred on June 1, 2018, CCC was called by the shelter manager the report was accepted. The acceptance is based on the youth being charged with battery and the CCC# is: 2018-05-554.

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.

All new employees are required to obtain 80 hours of training within the first year of employment based on their date of hire. Additionally, once completing the first year, staff is required to complete 40 hours of training annually. Staff meets this requirement by providing documentation of training hours. Community, on line, conference, workshops can be used to meet the training requirements. The training requirement

states staff will need to complete 80 hours of training according to their date of hire in their first full year of employment and 40 hours will be required yearly. The procedures identifies a list of training that are to be completed within 120 days of employment as well as a list of training to be completed within the first year. The procedures also list specific training to be completed in the DJJ-Skill Pro System. There is also specific training that will be provided during in service.

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 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 7 files were reviewed for this indicator for 3 first year staff, 3 in-service staff, and one applicable first year non-licensed clinical shelter staff. Two of the 3 first year staff had surpassed the first 120 days of hire and one was a recent hire (DOH 10/8/2018). For these 2 staff, all of the mandatory trainings required during the first 120 days were completed with the exception of one topic (Suicide Prevention) that was completed 5 days late for one of the two employees. The third recently hired staff had already completed 9 of the 12 trainings required in the first 120 days and has two months to complete the remaining 3 training topics. All three staff are on target or exceeded (one staff) the 80 hours of training required annually.

Three in-service training files were reviewed for staff with DOH 3/1015, 2/11/13, and 1/6/15. Two of 3 staff has completed all of the required training annually and the third staff (DOH 2/11/13) has only one required training remaining to complete during the current training year. All three staff are on target for completing the 40 hours of training required annually.

The provider had one applicable first year non-licensed clinical shelter staff (DOH 10/8/2018) during the QI review. To date the staff has completed three of the five supervised assessments of suicide risk. Documentation of Non-Licensed Mental Health Clinical Staff Person’s Training in Assessment of Suicide Risk was provided including the date, signature, and license number of the licensed mental health professional. It was not dated to date since the staff has two more supervised assessments to complete.

The program has an organized training file for each staff member that includes an individual training plan that lists required training topics, timeframes, training hours, and employment start dates. As staff completes training, a copy of the training certificate is

placed in their file. The training hours completed are up to date and the total number of hours is documented. The program encourages staff to meet the required hours of training through their new hire orientation which covers many of the initial topics required as well as on the job training. The files reviewed were up-to-date and demonstrate ongoing monitoring to ensure staff completes training on time.

The provider has a comprehensive annual training plan and process in place that is valid for FY 2017-2018. As of the QI visit, the plan was not updated to include some of the new Skill-Pro training topics and/or frequency required as well as including Confidentiality training as a required topic in the first 120 days of hire.

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 vans used to transport youth.

The procedure outlined in the policy clearly provides guidance for the safety of youth and staff. When youth are transported from the program, they must be signed out and returned by an authorized person. Staff transportation of youth must be specific to gender when one youth is to be transported. As such, female staff must transport female client and male staff transport male client only on a 1:1 basis. Where it is unavoidable and male staff are expected to transport a female youth to an appointment, it must be in ratio and with other staff and/or youth accompanying so there is a third party. The policy states that best practice is to have a 3rd party present while transporting youth. Third party is an approved volunteer, intern, agency staff, or other youth. Single transport of youth is permitted only beyond the control of the agency and in this case, prior permission must be granted by the Chief Officer, Shelter Coordinator, or Clinical Director and that information must be documented in the logbook. A list of approved agency drivers with valid driver's license is maintained along with insurance for the approved agency vehicles to be used. Staff ratios are to be maintained during transportation of youth.

Prior to a transport, the transporting staff utilizes Rastrack to document travel and destination 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. Mileage 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.

The program maintains a list of 19 staff who are approved drivers. Approved drivers are covered through the agency's insurance. Current insurance policies were also provided for the two agency vans.

The acquisition of vehicles and their maintenance is under the responsibility of the Operations Department and Chief Operations and I/T office. Planned inspections and maintenance are scheduled to keep the vehicles safe and clean. Vehicle inspections are conducted on each shift daily and preventive maintenance is regularly scheduled.

Exception:

The transportation log includes total miles traveled, last 4 numbers of the program cell phone used during the transport, and indication of pre/post inspection done. It was observed that these fields were not frequently completed on the form by staff.

A total of 4 incidents were identified where single youth transport occurred. Per the agency's policy, staff transportation of youth must be specific to gender when one youth is to be transported. However, this was not observed in 2 of the 4 cases reviewed (8/28/18 and 9/18/18) where opposite gender staff transported youth. These two transports were also not documented in the logbook as required. None of the 4 single

transports had documentation to support that prior permission was granted by the Chief Officer, Shelter Coordinator, or Clinical Director although the Shelter Coordinator stated that permission is always given to staff prior to single youth being transported.

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 Homestead location, a total of two 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

Miami Bridge has a policy in place to address Screening and Intake Assessment. It was last reviewed 07/01/2018 and signed by the CEO and Chief Program Officer. The policy does meet the requirement for this indicator.

Miami Bridge's procedures require that an initial screening to determine client issues and eligibility be completed within 7 days of receiving a referral. In most cases, immediately upon receipt of a referral, whether by phone or in person, designated staff will complete a basic Pre-Screening and then a NETMIS Screening form on each client requesting services.

The intake assessment process begins with the completion of the screening form at the time of initial contact, whether by phone or in person. Basic client identifying information is provided. Risk assessment for all youth is completed to determine imminent danger or risk of future harm.

Youth and parents/guardians also receive availability of services, rights and responsibilities, parent/guardian Brochure, possible actions occurring through CINS/FINS services, and grievance procedures.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All reviewed files met the minimum requirements for this indicator. All of the reviewed files provided the youth and parent/guardians with availability of services, rights and responsibilities of youth and guardian, parent/guardian Brochure, possible actions occurring through CINS/FINS services, and grievance procedures. Five of the six files reviewed met the eligibility screening 7 day calendar timeframe. However, the counselor interviewed was able to articulate to the reviewer sufficient documentation explaining the gap in service delivery for the one file that did not meet the 7 day requirement.

Exceptions:

No exceptions are documented for this indicator.

2.02 Needs Assessment

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge has a policy in place to address Needs Assessment. It was last reviewed 07/01/2018 and signed by the CEO and Chief Program Officer. The policy does meet the requirement for this indicator.

Miami Bridge's procedures require that each youth shall have a Needs Assessment completed or initiated within 72 hours of admissions. For non-residential services, the Needs Assessment must be initiated during the first face-to-face visit/session and completed within 3 visits/sessions. Each youth served will receive a full Needs Assessment or an addendum if the most recent assessment if over six (6) months old. The agency provides access to more intensive assessments and/or evaluations, if indicated by the youth's needs.

Needs Assessments are completed only by Bachelor's and Master's level staff and signed by a supervisor. Needs Assessments will also include a suicide risk assessment to determine existing mental health issues that may require immediate and/or additional services not provided by the agency.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All reviewed files met the minimum requirements for this indicator. Needs Assessments in all of the six files reviewed were initiated within 72 hours of admissions and completed within 2 to 3 face-to-face contacts after the initial intake in the 3 non-residential files reviewed. All of the reviewed files were conducted by a Bachelor's or Master's level staff member. Two of the six files reviewed (1 closed residential and 1 closed non-residential) identified a youth with an elevated risk of suicide during the Needs Assessment process. The youth were referred for an Assessment of Suicide Risk that was conducted by a licensed mental health professional or staff under the supervision of licensed mental health professional.

Exceptions:

No exceptions are documented for this indicator.

2.03 Case/Service Plan

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge has a policy in place to address Case Service Plan Development. It was last reviewed 07/01/2018 and signed by the CEO and Chief Program Officer. The policy does meet the requirement for this indicator.

Miami Bridge's procedure requires that the service plan defines the goals, objectives and services for each individual client. A service plan with the youth and family must be completed within seven (7) working days following Intake and completion of the needs assessment where the youth and family agree to participate by signing the plan. The procedure states that specific needs and goals of youth and family are identified, realistic time frames (target dates) are established, date of initiation of service plan, responsibilities of youth, family and agency are established, and frequency and location are established.

The service plan for all clients are signed and dated by the counselor and supervisor. All service plans must be reviewed at 15, 30, 45, 60, 90, and 180 days, whenever appropriate and depending on the program type.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). Four of the six files met the minimal requirements for this indicator. In those four files, the case service plan was developed within 7 working days of Needs Assessment, Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment, service type, frequency, and location established, person(s) responsible established, target date(s) for completion established, actual completion dates established, signatures of youth, parent/guardians and supervisor provided, initiation date established, and progress revised every 30 days for the first three months and every 6 months after (if available). In one of the four files (1 closed residential file), youth, guardian and supervisor signatures were not provided. The reviewer was able to establish that the youth was removed from the agency on the same day of the initiation of the service plan.

In one of the files reviewed (1 residential closed file) a service plan was not conducted. The reviewer was able to establish that the assigned counselor was out on bereavement leave which explained the absence of the service plan. It should be noted that the youth was assigned a counselor intern and service delivery was not interrupted or hindered in the interim. In another file reviewed (1 non-residential file) the service plan was not constructed. The reviewer was able to establish through sufficient documentation that many attempts from the counselor were made successfully and unsuccessfully to both youth and guardian. Documentation also illustrated the lack of participation from the family resulting is dismissal of service delivery.

In this indicator, it was observed that the completion dates on the service plan (in open residential files) were predated before actually completing the goals/objectives. The reviewer was able to establish and understand, from the clinical shelter, the logic of predating the completion dates, using those dates as an indication of anticipated closure dates and timeframe for which all goals should be completed. However, the practice of documentation of actual completed dates for achieving goals was not observed.

Exception:

No exceptions are documented for this indicator.

2.04 Case Management and Service Delivery

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge Youth has a policy in place on Case Management and Service Delivery. It was last reviewed 07/01/2018 and signed by the CEO and Chief Program Officer. The policy does meet the requirement for this indicator.

At Miami Bridge each youth and family is assigned a counselor who will follow the youth's case and ensure delivery of services through direct provision of referrals. Case management coordinates service plan implementation, monitor youth/family progress, provides support for family's progress, monitor out of home placement (if necessary), referrals to case staffing committee, accompany youth and family to court hearings (if necessary), case termination, and 30 to 60 day follow ups.

For non-residential services, a youth is informed during initial contact that their parent/guardian must be notified and consent given to participate/receive services. The agency staff will make diligent efforts to contact/notify parent/guardian within 24hours. If non-residential agency staff are unable to contact/notify parent/guardian within 24hours of initial contact with self-referred youth, youth is informed service delivery cannot be rendered. All information will be documented in the progress note section.

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). Five of the six files reviewed met the minimum requirements for this indicator. All five reviewed files, were assigned a counselor, referral needs were established based on on-going services, service plan was initiated, youth/family services were monitored, support for families were provided, referrals for case staffing were conducted (if needed), additional services were provided and case termination notes were completed. In one of the files reviewed (1 closed residential file) a counselor was assigned and referral needs were established but youth was discharged before any other additional services were rendered. In another file reviewed (1 closed non-residential file) a counselor was assigned and referral needs were established but service delivery was not provided due to the lack of participation from youth/family. There was sufficient documentation explaining the gap in service delivery.

None of the six files reviewed warranted counselors accompanying youth/guardian to court hearings. The reviewer interviewed the Director of Admissions who verified completion of 30 and 60 days follow ups for applicable files.

Exception:

No exceptions are documented for this indicator.

2.05 Counseling Services

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge has a policy in place for Counseling Services and Family Involvement. It was last reviewed 07/01/2018 and signed by the CEO and Chief Program Officer. The policy does meet the requirement for this indicator.

Miami Bridge provides youth and families with counseling services, in accordance with the youth's Case/Service Plan, to address needs identified during the assessment process. They provide services to youth, their families, and legal guardians; make efforts to engage families including guardians and significant others in planning services; ensure family conferences, family outreach and access to family counseling are provided to address issues; ensure case files coordinate presenting problems, needs assessments, case/service plan, case management and follow-up; maintain individual case files on all youths; maintain chronological case notes; and provide residential group counseling sessions a minimum of five days per week.

Group counseling is provided 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."

There were a total of 6 files reviewed for this indicator: 3 residential (2 closed and 1 open) and 3 non-residential files (2 closed and 1 open). All of the six files reviewed had completed needs assessments based on the presenting problems. Four applicable files met the minimum requirements for this indicator: development of initial case/service plans, completion of case/service plan reviews, case notes were maintained for all counseling services provided, provided on-going internal process that ensures clinical reviews, and youth and family received counseling in accordance with the service plans.

In regards to group counseling, two of the three residential files reviewed met the minimum requirements for this indicator. Group counseling was provided at least 5 days/week, at least 30minutes, facilitator established, relevant topic established, and youth engagement permitted. In one residential file reviewed, youth was discharged before any participation or group session documented.

A psychoeducational group related to communication was observed during the QI visit. The main topic indicated that the biggest communication problem is that we do not listen to understand but we listen to reply. The group consisted of one shelter counselor

facilitator, one Youth Activity Worker and ten participating youth. The group was divided in three sections. One section included a discussion of the importance of clear communication and relevance of the topic, one section related to the characteristics of effective communication, and one section related to the habits to avoid conversation. All the youth can express their opinions, receive feed-back, listen to instructions, model the correct communication skills, and actively participate in the group process.

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 Adjudication and Petition Process last revised 7/1/18 and signed off by the CEO and Chief Program Officer. The policy meets the requirements.

The program's procedure states the purpose of Case Staffing Committee for cases that cannot be resolved by the assigned counselor due to either the youth/family is not in agreement with services or treatment; the youth /family will not participate in the services; or the program receives a written request. Staff will provide notice of the meeting to all parties within seven working days to include family, youth, guardian, school representative and all providers. Case Staffing Committee meetings are scheduled monthly; if additional meetings are needed or requested they are then scheduled accordingly. Clients who are present at the meeting are notified of the outcome in writing at the conclusion of the meeting. If the client is not present, the assigned counselor/case manager will send a written report of the recommendations of the case staffing committee to the client within seven days of the meeting. A copy of the report is placed in the file. The file will also contain documentation that the parent/guardian received the report. Service plans will be modified based on the findings of the committee, which will be signed by all parties. All CINS/FINS petition recommendations will be filed by the counselor with the DJJ CINS/FINS attorney. The Case Staffing Committee is comprised of a representative from the youth's school district, a DJJ representative, a CINS/FINS contracted provider, representative from the State Attorney Office, mental health, social services, and health services and any persons recommended by the youth, family or CINS/FINS program.

The program held case staffing meetings once a month unless they were rescheduled. There were two non-residential files reviewed for case staffing meetings that were held. The Parent/family and Case Staffing Committee were notified more than five days before the scheduled hearing and the Case Staffing Team had more than five working

days' notice. Both cases were under the court supervision and case plans were revised due to recommendations made by the Circuit Court Judge.

Exception:

No exceptions are documented for this indicator.

2.07 Youth Records

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

Miami Bridge has a policy in place on Youth Records. It was last reviewed 07/01/2018 and signed by the CEO and Chief Program Officer. The policy does meet the requirement for this indicator.

Miami Bridge partially maintains a manual case record system that is still in effect for a transition period. The policy ensures that manual records will be marked "CONFIDENTIAL" are kept in a locked file cabinet or locked room with controlled access, which is marked "CONFIDENTIAL". All manual records that are transported are locked in an opaque container that marked CONFIDENTIAL". All youth case records for each youth is to be organized in a consistent, neat and orderly manner. Each file should include: screening form and NETMIS forms, CINS/FINS Intake Assessment Form, service plan, psychosocial assessment, case management information and miscellaneous. All files are reviewed monthly by a supervisor.

All six files reviewed (3 residential and 3 non-residential) met the minimum requirements for this indicator. All records were marked "Confidential". All records are kept in a secure room or locked in a file cabinet that was marked "confidential". All records are maintained in a neat and orderly manner. It should be noted that five and six files were on the Lauris Online system. Usernames and Passwords are required to access youth's records.

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. Rainbow wraps were also added to a few trees on the grounds. 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. Two groups in were conducted prior to the review in November, one on LGBT and the other on Cultural Diversity.

The program did not serve youth who met the criteria for the indicator. 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.

It should be noted that the room assignment section of the CINS/FINS Intake form does not identify which sleeping quarters i.e. male or female dormitory the youth is assigned, just the youth's gender, module and bed number.

Exception:

No exceptions are documented for this indicator.

Standard 3: Shelter Care and Special Populations

Overview

Rating Narrative

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

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

Health and medication related activities are the responsibility of the RN and Licensed Practical Nurse who maintain inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administer first aid when needed, and coordinates all offsite appointments to medical providers. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication office, and kitchen. All medications are stored in the Pyxis Med-Station 4000.

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

3.01 Screening and Intake

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has a written policy and procedures, 3.01, regarding shelter environment that addresses all if the elements of this indicator. The policy was last revised on 7/1/18 and was signed by the CEO and the Chief Program Officer. The program's policy meets all requirements of this indicator.

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. 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.

Documentation reviewed revealed the program implemented a general housekeeping and maintenance plan that provides specific guidelines for the cleaning and maintenance of all the facility. Youth Activity Workers are responsible for the daily inspections and cleaning of the shelter. A shelter environmental tour of all the inside and outside of the program completed with the help of the QI Coordinator found the program clean, neat and well maintained. The provider has a maintenance staff onsite to complete routine and needed repairs and maintenance.

All chemicals were listed, approved for use and maintained in the kitchen under three locks. All the furniture observed was in good repair. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. The annual Health and Safety Inspection was satisfactorily conducted on 8/13/18 and no violations were documented.

Documentation reviewed found the program staff conducted monthly facility maintenance walkthroughs. Dumpster and garbage cans are covered. All bathrooms were clean and functional. No graffiti was observed. The program was free from insect infestation.

The program environment was therapeutic, safe and conducive to positive learning and treatment. The shelter has adequate space for all the planned activities, and at the time

of the review the shelter was in the process of adding a new reception area/entrance for visitors to increase the safety of youth and staff.

The program has two twelve passenger vans for the transportation of youth that were inspected. Both vehicles were equipped with major safety equipment including first aid kits, fire extinguishers, glass breakers, seat belt cutters, and air bag deflators. The program has limited access and control of the vehicles' keys. The back door for one of the program vans was found unlocked during inspection.

Annual facility fire inspections were conducted by the Miami-Dade Fire Rescue Department and the permit is valid through April 2019. The program also conducted fire drills on the three shifts monthly. Documentation reviewed indicated the fire alarm was inspected and tested on January 23, 2018. Documentation reviewed found the program has a current DCF Child Care License effective through February 28, 2019.

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).

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. The program's policy meets all requirements of this indicator.

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.

The review of three youth records indicated each youth received a program orientation and a copy of the youth's program handbook during the first twenty-four hours of admission to the program. Each orientation includes an explanation of the daily activities, disciplinary actions, program's grievance procedure, emergency/disaster procedures, contraband rules, room assignment, suicide prevention, Abuse Hotline number, and alert notification. In addition, each orientation reviewed was signed and dated by youth, and parent/guardian. The program has a youth and guardian handbook and orientation guide for emergency shelter services.

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 program's policy meets all requirements of this indicator.

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.

The review of three youth records found each youth received at intake an initial classification that include the review of the youth's history, status and exposure to trauma, age, gender, history of violence, disabilities, physical size/strength, gang affiliation, suicide risk, sexually aggressive or reactive behavior, gender identification, alerts, collateral contacts. A review of the youth's initial interactions and observations of any markings is also documented.

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. The program's policy meets all requirements of this indicator.

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.

A review of the program's log books for the past six months found the program utilizes a color code log book system that documents daily activities, events, and other major occurrences. Logbook documentation included safety and security issues, incidents, youth supervision and counts, visitation and home visits, transportation, and any other significant events. All entries were brief and legible written in ink, youth and staff involved in any incident with date, all recording errors were struck through with a clear line with staff initial and date, supervisory reviews were conducted weekly, dated and signed. Supervisory and staff reviews of the previous two shifts and all entries were made in ink without erasures and white-out areas. All entries included statements related to who, what, when and where. All the applicable log bog pages included attached to the top of the entry page copies of the visitor valid photo identifications with date and time written in red on the photo.

Exception:

No exceptions are documented for this indicator.

3.05 Behavior Management Strategies

☒Satisfactory ☐ Limited ☐Failed

Rating Narrative

The agency has two written policies and procedures, 3.05, and 3.05.01 regarding behavior management strategies (BMS) and behavioral interventions that address all the elements of this indicator. Both policies were last revised on 7/1/18 and were signed by the CEO and the Chief Program Officer. Both program's policies meet all requirements of this indicator.

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.

Documentation reviewed confirmed the program has in place a BMS that is appropriate and relevant to the youth served, the type of program, and the average length of stay for youth. The program's BMS is designated to gain compliance with the program rules, influence positive behavior, and increase accountability. The program's BMS information is included in the Youth and Guardian Handbook and the youth's orientation guide. The program's BMS uses a wide variety of awards/incentives to encourage participation and completion of the program. The BMS consequences for behavior are logical and designated to promote skill-building for the youth. In general, the program's BMS promotes order, safety, security, respect, fairness, protection of the youth's rights, constructive discipline dialogue and peaceful resolution, and minimizes separation of youth from the general population.

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.

The program implements a staff coverage schedule that provides adequate supervision of youth and ensures the safety and security of all youth and staff. The program schedule includes a system to consider staff training requirements, regular days off, holidays, vacation and sick leave, diversity issues, budgetary issues and other service delivery issues. Program holiday and vacation coverage schedules are planned. The program staff included in the staff-to-youth ratio includes Youth Activity Workers. The shelter supervisor or designee oversees staff scheduling responsibilities and monitor and review this process. Staff schedule issues are usually resolved by the shift leader. The shelter has at least one Youth Activity Worker on duty for every six youth during times when youth are scheduled to be awake. During the time youth are asleep, one Youth Activity Worker, of the same gender, is assigned and stationed at each of the dormitories where they can visibly be seen on camera providing adequate supervision of youth and conducting bed checks.

Documentation reviewed confirmed the program has a process in place to ensure adequate safety and security of youth and staff and a policy in place that meet the general staffing ratio requirements. A review of the program schedules for the last six months revealed the program maintained a minimum staffing ratio as required by Florida Administrative Code and contract. Overnight work shifts consistently maintain a minimum of two staff present of the same gender as the youth on each work shift including all overnight work shifts. A review of the program log books for the last six months indicated staff observe youth at least every fifteen minutes while they were in their sleeping rooms. The program schedule was observed posted in places visible to staff and is provided to each staff member. Interview with the program director and documentation reviewed indicate the program has a holdover rotation roster that includes contact numbers to reach these staff when additional coverage is needed. Observation confirmed the program has thirty-two surveillance motion cameras well positioned that capture coverage of at least thirty days.

Exception:

No exceptions are documented for this indicator.

3.07 Special Populations- completed or report as is

☒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, Probation Respite, or Intensive Case Management during the review period.

There were three files reviewed for this indicator: two (2) DV respite youths and one (1) FYRAC youth. One of the two files reviewed met the minimum requirements for this indicator. Youth was admitted to DV Respite placement having a pending DV charge, youth stay exceeded 21 days; however, youth was transition into CINS/FINS. Service Plan reflected all goals/objectives. In the other DV file reviewed, the youth was discharged before completion of Service Plan. All other DV requirements were met.

In the one FYRAC file reviewed, it was documented that the youth was arrested, thus, interrupting service delivery and forcing the agency to dismiss the case.

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.

The program has cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. The program ensures that while footage access is available via web and on cellular telephones, any use is authorized by the Chief Executive Officer (CEO) and it is not use for covert operations and/or misused by authorized personnel. Cameras will not be placed in bathrooms or sleeping quarters. The program ensures supervised use or viewed internally by Law Enforcement if such a request is authorized by a Chief Officer. Under

no circumstances should a footage be given to a Law Enforcement agency or officer. If subpoenaed, it will be sent directly to the court. The program has a method to retain video and images in a hard drive or designated secured network storage. Access is restricted to personnel determined by the CEO. The program ensures recorded video is stored for a minimum of thirty days unless video is associated with a specific incident that is requested for review. In that case, video shall be stored for the length of time needed to complete investigation. Video clips which could become evidence in civil or criminal proceedings are kept indefinitely unless otherwise directed by the Department of Juvenile Justice and/or the Florida Network. The program has staff trained to handle the equipment and monitor or review footage in a professional, ethical, and legal manner.

A complete tour of the interior and exterior of the program and interviews with the shelter supervisor and the quality improvement (QI) coordinator confirmed the program has a video surveillance system that is in operation twenty-four hours a day, seven days a week. The Miami Bridge camera system is new and consists of 32 cameras, 16 inside the facility and 16 outside. The cameras are visible in the interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit, and in the first stop for families (FSFF) building. No cameras are placed in any bathrooms or sleeping quarters. The program system can record date, time, location and store video for a minimum of thirty days. The program's cameras can operate during a power outage since the program has a generator. The shelter supervisor review of videos weekly instead of every fourteen days and noted in the logbook. The review assesses the activities of the program and includes a review of a random sample of the overnight shifts. The program has a process for third party review of video recording after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.

A review of random sample of three different dates of overnight shifts confirmed that staff observes youth at least every fifteen minutes while they are in their sleeping rooms.

Exception:

No exceptions are documented for this indicator.

Standard 4: Mental Health/Health Services

Overview

Rating Narrative

MB Homestead has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate room 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.

The policy states that upon admission the residential staff or Registered Nurse will complete the intake form using information from the youth and parent/guardian. The preliminary health screening will include current or past medications, allergies, existing medical conditions, evidence of recent injuries or illnesses, presence of pain, and observation of scars, tattoos or skin markings. There are procedures to ensure medical care for youth with chronic medical conditions through a referral process. Typical conditions are not limited to asthma, pregnancy, seizure disorders, diabetes and hemophilia. Parent/guardian will sign medication consent forms which clearly define specific responsibilities for medications and medical treatment and medical treatment forms allowing access to medical services in the event of a serious or life threatening emergency.

Two open and one closed client file was reviewed in which a preliminary healthcare screening was completed and signed off by the Registered Nurse. The healthcare screening form encompasses past and current illnesses, injuries and medications. The screening forms also contain chronic medical conditions not limited to asthma, hepatitis, high blood pressure, sexually transmitted diseases, pregnancy and chronic pain. All medical consent forms were signed by parent/guardian and placed in the files.

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.

The program's policy encompasses the statewide Suicide Risk Response Protocol. Suicide risk screenings are to be completed at the time of intake. Further risk assessment is conducted within 24 hours if warranted and must be conducted by a licensed professional or a mental health professional under the direction of a licensed professional. If the screening occurs between 5:00 pm on Friday and 9:00 am on Monday and there is no access to staff to conduct an assessment within the 24 hour window, the assessment must be done on the morning of the first business day. If the initial screening indicates a risk of suicide, youth will remain under constant sight and sound supervision until the assessment is conducted by a licensed professional. All observations of youth on a heightened supervision are documented and placed in the agency's observation log.

Two open and one closed file was reviewed in which the youth answered yes to suicide risk questions. In all three cases the youth were placed on sight and sound. Documentation of youth's activities was placed in the agency's observation log and signed by clinical staff. Documentation is noted every 15 minutes on each youth. In each file the youth were placed on an appropriate supervision level and removed by a 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 programs policy requires that all medications are stored in a Pyxis med station and maintain at least two super users for the machine. Only staff designated with user permission will have access to medication cart. All topical medications must be stored separately from oral medications. Controlled substances must be inventoried with running balances as well as a shift-to-shift count verified by witness. There must be a written distribution of medication log for non-licensed and licensed staff. The monthly

review of medication management practice via Knowledge Portal or the Med Station is completed. All meds are verified using one of four methods accepted by FNYFS.

All medications were locked in the Pyxis machine which is stored in a locked nurse's office. The program has 15 staff with user permission to the Pyxis machine and two super users. Medications are verified by phone call to the pharmacy that filled the medication to include the name of the pharmacist with whom it was verified. The program keeps a perpetual inventory of all medications from shift to shift in a binder. The program has a locked refrigerator in the locked nurse's office that maintains a temperature between 36 and 46 degrees F as evidenced by the thermometer stored inside.

Oral medications are stored in a locked cabinet in the locked intake office and are stored separately from topical medications in the cabinet. Individual client medication distribution forms are kept for each youth and used to document distribution of medications by staff to youth. A binder is maintained yearly with the monthly medication management reviews conducted by the program via the knowledge portal or med-station as required. The program keeps a binder with shift to shift counts and running balances for each prescribed medication. There is a sharps inventory completed and signed off on weekly. One youth was on medications at the time of the review and all medication was distributed as prescribed and signed off on.

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's policies maintain that the program has developed and implemented a medical, substance, nutritional and mental health alert system to ensure information to include allergies, prescribed medication, common side effects, food/medications contradictions and other treatment information is documented and communicated to staff. This alerts the staff to youth on prescription drugs, any current mental health diagnosis, previous suicide attempts and current substance abuse issues. Staff are trained to recognize and respond to emergency care and treatment due to identified

medical or mental health problems. There is adequate staff for client supervision during a mental health emergency. Community resources are indemnified for mental health and substance abuse referrals and a plan is in place for notification of program administrators, parents/guardians or outside authorities during emergencies.

The program keeps a Client Alert Binder/Youth Alert/Special Nutrition binder that lists clients alphabetically with allergies, medications, and other alert, available for staff's review. There is a board in the intake office that utilizes the alert system through a confidential color alert system.

Two open and one closed file was reviewed and each file made use of the alert system for mental health substance abuse and nutritional allergies. These youth were correctly placed in the Alert Binder and on the program's alert system. Medication distribution records include all medication side effects, precautions and allergies.

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's policy provides that all appropriate emergency medical and dental care for clients will be identified and appropriately provided through resources. The parent/guardian will be contacted when an injury, assault or other emergency medical or dental condition is identified by the RN or Shift Leader/Supervisor to get direct assistance and/or approval for services. If necessary the Shelter Supervisor Clinical Director or Counselor will be contacted to provide direction or assistance. 911 will be called in extreme emergencies or life-threatening situations. All staff are trained in CPR and First Aid may provide temporary and immediate care to stabilize the client's injuries as well as in the use of the knife for life and AED. Referrals will be made to appropriate medical or dental professionals to ensure the client's safety. Clients' case files will have all activities thoroughly and accurately documented along with the program's log book.

The program had one instance of emergency off/site care for youth needing emergency services during the review period. Upon review, an incident report was written and included documentation of parental contact, discharge paperwork from the hospital as

well as copies of the logbook pages pertaining to the incident. The incident was called into the CCC in a timely manner.

Exception:

No exceptions are documented for this indicator.