



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Miami Bridge-Homestead

on 12/17/2013

## 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

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

### Standard 3: Shelter Care

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

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

### Standard 2: Intervention and Case Management

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

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

### Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

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

### Rating Definitions

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

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

### Review Team

#### Members

Marcia Tavares, Lead Reviewer, Forefront LLC

Marie Boswell, Prevention Specialist, Department of Juvenile Justice

Ivonne Fusco, Senior Administrative Assistant, Lutheran Services Florida Southeast

Rosby Glover, Executive Director, Mount Bethel Human Services Corporation



Ben Kemmer, Chief Learning and Evaluation Officer, Florida Keys Children's Shelter

**Persons Interviewed**

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

**Documents Reviewed**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports                        | <input checked="" type="checkbox"/> Fire Prevention Plan             | <input checked="" type="checkbox"/> Vehicle Inspection Reports |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Grievance Process/Records        | <input type="checkbox"/> Visitation Logs                       |
| <input checked="" type="checkbox"/> CCC Reports                       | <input type="checkbox"/> Key Control Log                             | <input checked="" type="checkbox"/> Youth Handbook             |
| <input type="checkbox"/> Confinement Reports                          | <input checked="" type="checkbox"/> Logbooks                         | 3 Health Records   |
| <input type="checkbox"/> Continuity of Operation Plan                 | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 3 MH/SA Records  |
| <input checked="" type="checkbox"/> Contract Monitoring Reports       | <input type="checkbox"/> PAR Reports                                 | 9 Personnel Records  |
| <input type="checkbox"/> Contract Scope of Services                   | <input checked="" type="checkbox"/> Precautionary Observation Logs   | 8 Training Records/CORE  |
| <input checked="" type="checkbox"/> Egress Plans                      | <input checked="" type="checkbox"/> Program Schedules                | 3 Youth Records (Closed)                                       |
| <input type="checkbox"/> Escape Notification/Logs                     | <input type="checkbox"/> Sick Call Logs                              | 6 Youth Records (Open)   |
| <input type="checkbox"/> Exposure Control Plan                        | <input checked="" type="checkbox"/> Supplemental Contracts           | 0 Other  |
| <input checked="" type="checkbox"/> Fire Drill Log                    | <input checked="" type="checkbox"/> Table of Organization            |  |
| <input checked="" type="checkbox"/> Fire Inspection Report            | <input type="checkbox"/> Telephone Logs                              |  |

**Surveys**

- |         |                     |         |
|---------|---------------------|---------|
| 3 Youth | 3 Direct Care Staff | 0 Other |
|---------|---------------------|---------|

**Observations During Review**

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

**Comments**

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

Rating Narrative

Shift Exchange on 12/17/13

Facility Manual

Department of Health Inspection Report

## Strengths and Innovative Approaches

### Rating Narrative

Miami Bridge Homestead Shelter (MB Homestead), located in the city of Homestead in the southern Miami-Dade County, is a Child in Need of Services and Family in Need of Services (CINS/FINS) program operated by Miami Bridge Youth and Family Services, Inc. The program's administrative office is located in North Miami, Florida, along with its north CINS/FINS shelter. The program serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The emergency shelter offers a variety of services to meet the need of its target population. These services include: 24 hours a day, seven days a week shelter services; formal on-site education program with certified Miami-Dade County Public School teachers; structured daily living programs employing positive behavior modification techniques; mental health counseling; life skills groups to promote responsibility and independence; substance abuse prevention services; family reunification services and case management; positive youth development through recreation, arts, crafts and music; and health care coordination services to insure access to medical treatment.

MB Homestead has established partnerships with various businesses and receives support in the form of in-kind donations and volunteer services from Lennar Home Builders, Team Nike Clearance Store, Good Hope Equestrian/Horse Therapy, Home Team Barber Shop, Art South, and various DJs/entertainers. Youth are engaged in a variety of activities to learn leadership, self-dependency, and employability skills. Good Hope, until recently losing some of its funding, had utilized youth volunteers from MB as Ranch Hands to help them conquer their fear and learn the value of hard work. Employees from Team Nike volunteer their time once per month to play games with the youth and give away prizes. They also conduct a toy drive to provide Christmas toys/gifts for the youth in the shelter including Nike shoes, clothing, and gift cards. The Home Team Barber Shop has a barbeque each month and provides free haircuts to the youth as an incentive to reinforce positive behavior. A couple of DJs extend free services monthly to the youth in the program by role modeling and coaching youth to display their artistic talents while overcoming their fears of communicating/performing in front of an audience. Art South is a well sought out program in the community that provides in-kind art classes in graphic design, painting, fashion, and drawing to the program youth after school, three times per week.

MB Homestead promotes volunteerism and community service with the youth in the program who are involved in activities such as assisting in the afterschool program at a local Charter School, outreach events with the Miami Chapter of Florida Youth Shines, and clean-up and/or beautification services at Miami-Dade parks. The youth also participate in various local "Walks" to bring awareness to issues such as autism, domestic violence, and breast cancer. In June 2013, the City of Homestead made a televised tribute to the MB Homestead program for outstanding volunteer efforts.

Miami Bridge is currently accredited by the Council on Accreditation (COA) through August 31, 2017. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. Miami Bridge has licensed mental health professionals employed with the agency to review and provide oversight over its counseling services in both the residential and non-residential CINS/FINS programs at both program locations in Miami and Homestead. The National Safe Place Program designates the MB Homestead Shelter as a Safe Place site which, along with other safe place sites in the community, networks to provide help and access to run away and homeless youth.

## Standard 1: Management Accountability

### Overview

#### Narrative

MB Homestead, located at 326 NW 3rd Avenue, Homestead, Florida, is under the leadership of a Board of Directors, Executive Director, Chief Operations Officer, Chief Financial Officer, Chief Administrative Compliance Officer, and Chief Clinical Officer. Mary Andrews, Executive Director oversees the Miami Bridge program and the services provided through its two (2) service locations in Miami and Homestead, Florida. There are separate program supervisors in place for the shelter and non-residential components of the program as well as shift leaders for each shift. MB Homestead has hired seven (7) new staff since the last QI Review in January 2013. At the time of this Quality Improvement review, the program had one staff vacancy, a Master's level Counselor. 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, 2014.

The agency handles all personnel functions of its 2 service locations through its Human Resources division located at the Central office in Miami, Florida. This office processes all state and local background screenings and human resource functions including staff development and training. Annual training is tracked according to the employee's date of hire. An individual training file is maintained for each employee, which includes supporting documentation such as sign-in sheets and certificates and an attendance form. The provider agency conducts orientation training to all personnel through a combination of training sources that include the Florida Network, local area and in-house trainers.

The Florida Network received the program's emergency response plan and hurricane plan that was revised for the current Fiscal Year. A Universal Agreement for Emergency Disaster Shelter is also in force and was signed by the agency's Executive Director.

### 1.01 Background Screening

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a policy and procedures in place that address the background screening of all employees and volunteers. The policy requires all staff and volunteers to complete a DJJ Background Screening in accordance with FS 985.407 that includes good moral character documentation, background history checks, criminal record checks, and juvenile record checks. All employees are also required to be re-screened after completing five years of employment. In addition, the provider conducts a background check with the Division of Motor Vehicles prior to the hiring of all staff.

A total of nine (9) applicable personnel files were reviewed for seven (7) staff and two (2) volunteers. Six (6) of the staff were hired after the last onsite QI visit and all of the new staff received eligible screening results that were conducted by the Department of Juvenile Justice (DJJ) Background Screening Unit prior to hire. The remaining one (1) staff file reviewed was eligible for a 5-year re-screening. Similarly, the five re-screening was conducted within the required timeframe prior to the staff's five-year anniversary date.

The program has two volunteers during the review period. The two (2) volunteers received their eligible screening results from DJJ prior to their start dates.

In addition to the DJJ Background Screening, the agency also requires employees to pass a drug screening and conducts local law enforcement check, a driving record history check, and verifies previous employment history, and contacts up to three references. The Annual Affidavit of Compliance with Good Moral Character Standards was completed and faxed to the DJJ Background Screening Unit on January 2, 2013, prior to the January 31st deadline.

### 1.02 Provision of an Abuse Free Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has a current policy and procedure in place for the provision of an abuse free environment. The provider accomplishes this with staff training and supervision on how to report suspected or alleged abuse. Upon hire, employees acknowledge receipt of the agency's code of conduct. Employees are required to report all known or suspected abuse. In addition, the agency has a drug-free workplace policy to provide a safe place for its employees and clients and a Whistleblower Policy.

During our tour of the facility we observed the posting of the Abuse Hotline telephone number in the dorm rooms and hallways among other important phone numbers and information such as youth rights and responsibilities. There is no visible graffiti. A Monthly Abuse Registry Log is kept. During the last year there were six reports, three of the Abuse Registry Log Sheets used by the staff when reporting abuse were not fully completed by the client's assigned Residential Counselor.

Regarding grievances, the program has developed a grievance policy and process, all youth is informed of their right to file a grievance during admission, and a grievance confidential box and forms are accessible to youth in the facility. In the past six months there were fifteen grievances with final resolution and management review.

Three of the Abuse Registry Log Sheets were not fully completed in the section to be completed by client's assigned Residential or FSFF Counselor.

### 1.03 Incident Reporting

Satisfactory

Limited

Failed

#### Rating Narrative

The Agency has a written policy and procedures for Incident Reporting with a detailed practice on how to proceed for different types of incidents. The provider's policies comply with the procedures and guidelines of the Quality Improvement indicator and the Florida Network's policies and procedures.

In a review of the CCC incident documentation for the past six months, there were 6 (six) incidents reported between 6/1/13 and 12/16/13; all incidents were called in within the two hour frame required. However, one CCC report has no documentation onsite, one incident is not reported in the program log book, and one has a wrong incident classification.

This reviewer acknowledges that all documentation is maintained very well and there is a good system in place, the only recommendation is to keep the incident report binder in chronological order.

### 1.04 Training Requirements

Satisfactory

Limited

Failed

#### Rating Narrative

The agency has a written policy outlining Training Requirements for first year and in-service staff. The written policies comply with the procedures and guidelines by the Quality Improvement indicator and the Florida Network's policies and procedures.

Of the 4 (four) First Year Training files that were reviewed, two didn't complete 40 hours of Program Orientation, CINS/FINS Core and Fire Safety training. All four files didn't have Universal Precautions and Cultural Competency trainings that are recommended, two of them recently entered into the second year of service, but the other two have time to have these trainings done.

Of the 4 (four) in-service training files reviewed, one file didn't complete the 40 hours training required by policy, all four files are missing Universal Precaution and Cultural Competency.

The Program Manager indicated that the individual who was assigned to monitoring the training files was not doing an effective job and was removed from this task. The deficient orientation training identified occurred in the earlier part of the review period and appeared to have improved in the recent months.

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sing-in sheets and agendas for each training attended.

Exceptions:

Two new staff didn't complete 40 hours or Program Orientation or CINS/FINS Core. All eight files didn't have Universal Precautions and Cultural Competency Training that are not required but are recommended.

### 1.05 Analyzing and Reporting Information

Satisfactory

Limited

Failed

#### Rating Narrative

The program has a written policy and procedures for analyzing and reporting data for case record review, incidents, accidents, grievances, customer satisfaction, outcome data and monthly review of Netmis data. It is the responsibility of the Chief Administration and Compliance Officer (CACO) and designated QI Manager or Coordinator to oversee and coordinate the activities and functions of the program.

This year Miami Bridge was re-accredited by COA. In practice, they hold monthly meetings for the Risk Management Team, Case Review and Customer Satisfaction. Each quarter there are CQI Committee Meetings that reviews data. The program's CQI program includes many activities that are conducted by various staff to ensure all aspects of analyzing and reporting data are consistently implemented and documented. Internal monitoring is conducted by the QI team along with the CQI Committee and sub-committees. Quality improvement goals are established by

the committees and progress is documented in the CQI minutes. The CACO coordinates quarterly meetings to assess information/data documented and discuss the findings with the various CQI workgroups: risk management, clinical, and service delivery. Activities being monitored include: client records filing, incidents and grievances, health and safety, outcome data, human resources deployment and training, customer satisfaction and Netmis.

Quarterly case record reviews are conducted by the program clinical committee as directed by the QI Manager and/or Coordinator. Items identified for corrective action are presented along with the challenges and corrective actions and are followed-up by the Administrative staff. A review of the Third Quarter Case Record Review Report included key information such as key personnel, methodology, performance benchmarks, results, summary of the findings and an aggregate tabulation of the cases and items reviewed.

The program's Risk Management Committee is responsible for risk identification and analysis. The identification of risk exposures is conducted through review of policies, procedures, practices and project plans inspection of operational areas and locals as well as analysis of external incidents through legal and consultative sources that may impact the program. The CQI team reviews and tracks incidents, accidents and grievances on a quarterly basis and a report and tables are generated showing detailed results of these items. In addition, the program conducts grievances on a quarterly basis and a report and tables are generated showing detailed results of these items. In addition, the program conducts a health and safety walk through twice a year to assess the shelter/facility and vehicle operation and maintenance in accordance with contract regulations. The report is tabulated and includes a summary of the trends and analysis for the period and year to date.

Annually, the COO conducts a staff satisfaction survey and the results are aggregated and presented to the CEO and the management team for discussion and analysis. The findings are presented to the staff team and the Board of Directors for recommendation on changes for improvement. Staff training and stakeholder surveys are conducted annually and reported as part of the Quality Improvement and Risk Prevention and Management overview of the agency.

An analysis of Netmis data is conducted and reports are completed monthly and quarterly. This information is reported at the management team meetings and forms part of the QI report to the Board of Directors.



## Standard 2: Intervention and Case Management

### Overview

#### Rating Narrative

Miami Bridge Homestead is contracted to provide both shelter and nonresidential services for youth and their families in South Miami-Dade County. The program provides centralized intake and screening twenty-four hours per day, seven days per week for status offenders that include runaways, truants, ungovernable and lockout youth. The program has a Director of Admissions who is responsible for Intake and Admissions. Additionally, trained staff members are available to determine the needs of the family and youth. Residential services include individual youth, family and group services. Case management and substance abuse prevention education are also offered. Aftercare planning includes referring youth to community resources, on-going counseling and educational assistance. At the time of this review, according to agency's Organization Chart, the Chief Clinical Officer, the Director of the Homestead Shelter, and the Director of Community Based Services oversee all Counseling and Direct Care staff. The staff roster shows that the program employs two Masters level Residential Counselors; two Non-Residential Counselor/Case Manager, one Master's and one Bachelor's level; and 10 FTE and 5 PTE Direct Care Workers which includes a Food Service Coordinator and a LPN Health Care Specialist. Each shift is assigned a Shift Leader who is responsible for overseeing all of the activities on the shift, participating in team conferences, and relating shift exchange information.

The counselors are responsible for providing case management services and linking youth and families to various community services. The non-residential program is responsible for coordinating the Case Staffing Committee, a statutorily-mandated committee that develops a treatment plan for habitual truancy, lockout, ungovernable, and runaway youth when all other services have been exhausted or upon request from the parents/guardians. The Case Staffing Committee can also recommend the filing of a CINS Petition with the court.

### 2.01 Screening and Intake

Satisfactory                       Limited                       Failed

#### Rating Narrative

The program has a policy and procedure detailing the availability of centralized intake services twenty four hours a day, seven days a week which includes emergency intake and referrals. Youth and parents/guardians sign forms stating they have received available service options, rights and responsibilities of youth and parents/guardians, possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

Three nonresidential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received: available service options, rights and responsibilities of youth and parents/guardians, a parent brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

Three residential files were reviewed. All three had screenings completed within seven days of referral. All three files had documentation that the youth and parents/guardians signed forms stating they received: available service options, rights and responsibilities of youth and parents/guardians, a parent brochure containing possible actions occurring through involvement with CINS/FINS services, and grievance procedures in writing during intake.

### 2.02 Psychosocial Assessment

Satisfactory                       Limited                       Failed

#### Rating Narrative

The program has policy stating the Psychosocial Assessment is initiated within 72 hours of admission if the youth is in shelter care (or updated if most recent psychosocial is over six months old) or completed within three face-to-face contacts following the initial intake if the youth is receiving non-residential services (or updated if most recent psychosocial is over six months old).

Three nonresidential files were reviewed. All three had the Psychosocial Assessments completed within three face to face contacts and all three were completed by at least a bachelor's level staff and contained a supervisor's signature for review.

Three residential files were reviewed. All three had the Psychosocial Assessments initiated within 72 hours of submission and all three were completed by at least a bachelor's level staff and contained a supervisor's signature for review.

### 2.03 Case/Service Plan

Satisfactory                       Limited                       Failed

#### Rating Narrative

The program has policy stating a service plan is developed with the youth and family within seven working days following completion of the Psychosocial Assessment and details what is to be contained in a service plan as well as that the plan is reviewed every 30 days.

Three residential youth files were reviewed. All were developed with the youth and family within seven working days following completion of the assessment. All plans contained identified needs and goals; type, frequency, and location of services; persons responsible; target dates for completion and actual completion dates; date the plan was initiated; and signatures of youth, parent/guardian, counselor, and supervisor. When the parent was not available in one case/service plan it was documented on the last page of service plan.

Three nonresidential youth files were reviewed. All three were developed with the youth and family within seven working days following completion of the assessment. All plans except one contained identified needs and goals; type, frequency, and location of services; persons responsible; target dates for completion and actual completion dates; date the plan was initiated, and signatures of youth, parent/guardian, counselor, and supervisor. The one plan was missing "person responsible" for working with the client to achieve the goal.

Program policy 2.03.01 states service plans will be reviewed every 30 days, policy 2.03.01 states the review of the plan will be made every 30 days and initialed by the client, parent and counselor. One youth file did not have staff, client or parent initials in the service plan review boxes for a 60 day period although a note on the last page of the plan states mother was unable to make it to the shelter to sign but would do so at a later date. One nonresidential client file did not specify person responsible.

## 2.04 Case Management and Service Delivery

Satisfactory
  Limited
  Failed

### Rating Narrative

The program has policies relating to family involvement and referrals to outside agencies.

Three nonresidential youth files were reviewed. All files had coordinated service plans implemented, very detailed progress notes reflected counselors monitored youth's and family's progress in services and provided support for families. The program has many outside agencies with which to refer youth and families. The program makes multiple referrals and tracks them on their service plans as well as in their progress notes. The program provided case monitoring and review of court order in the one file. The program also provides follow-up services after discharge.

Three residential youth files were reviewed. All files had coordinated service plans implemented, very detailed progress notes reflected counselors monitored youth's and family's progress in services, provided support for families. The program has many outside agencies with which to refer youth and families. The program makes referrals and tracks them on their service plan as well as in their progress notes.

## 2.05 Counseling Services

Satisfactory
  Limited
  Failed

### Rating Narrative

The program has a policy to provide multiple services to preserve the unity and integrity of the family. The policy also includes supervisory review. In addition the program has a staff directive that further defines required timelines for supervisory review.

Three nonresidential youth files were reviewed. All three files showed coordination between presenting problems, the psychosocial assessment, the service plan, the service plan reviews, case management, and follow-up. Chronological case notes on the youth's progress were maintained in all files. All files contained signatures of supervisory review by a licensed clinician.

Three residential youth files were reviewed. All three files showed coordination between presenting problems, the psychosocial assessment, the service plan, the service plan reviews, case management, and follow-up. Chronological case notes on the youth's progress were well documented and maintained in all files. All files contained signatures of supervisory review by a licensed clinician.

## 2.06 Adjudication/Petition Process

Satisfactory
  Limited
  Failed

### Rating Narrative

The program has a policy detailing the CINS petition process including the case staffing committee. This includes that a case staffing committee is convened within seven 7 working days from receipt of the written request from the parent/guardian; within 7 seven working days of the meeting, a written report is provided to the parent/guardian outlining the committee recommendations. The program does have an established case staffing committee as well as an internal procedure for scheduling case staffing meetings as needed. Three nonresidential youth files were reviewed. However, no case staffing meetings have been scheduled and no petitions have been filed for any of these files or any youth dating back to the last onsite QI Review.

## 2.07 Youth Records

Satisfactory

Limited

Failed

### Rating Narrative

The Program has a policy detailing the confidential nature of case files. Agency policy and procedure corresponds with the QI Indicator 2.07.

The policy and procedures specify how cases are opened, how they are closed, where they are kept and how they are stored, whose responsibility it is to keep the files maintained, how they are organized, requirement to be marked confidential, and file retention.

Three nonresidential and three residential files were reviewed. All six files were marked "confidential" and files are kept in a secure room. All three file records were organized in a neat and orderly manner so that staff can quickly and easily access information. All files were marked "confidential" and files are kept in a secure room.

## Standard 3: Shelter Care

### Overview

#### Rating Narrative

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

Staff members in the Residential Program include: Director of Admissions, Residential Counselors, Youth Activity Workers, a Health Care specialist, a Food Specialist/Cook, and a Facilities Coordinator that is shared between the two shelters. The Direct Care workers are responsible for completing all applicable admission paperwork, orientating youth to the shelter, and providing necessary supervision. The youth activity workers are also responsible for processing new admissions, and providing orientation of youth to the shelter; the supervision of youth. Health and medication related activities are the responsibility of the Health Care Specialist who maintains inventories on all sharps and medications, provides distribution of prescribed and over-the-counter medications, administer first aid when needed, and coordinates all offsite appointments to medical providers. Disaster plans, knife-for-life, wire cutters, and first aid kits are located in multiple locations throughout the facility, to include the staff station, medication office, and kitchen. All medications are stored in a locked cabinet in the staff office.

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

### 3.01 Shelter Environment

Satisfactory

Limited

Failed

#### Rating Narrative

The shelter was clean and well maintained, considering its age. Though an older building, it appears that the maintenance staff does a good job in maintaining its upkeep. While taking the initial tour, the fire extinguishers were strategically located throughout the building and they were all updated with appropriate dates. The grounds were well manicured and the garbage cans were emptied and had fresh linings in them. The camera security system was operational and records were appropriately kept.

The agency's Fire Permit was up-to-date and expires March/2014 for each building. Building A, Permit #04124-00173 expires March 2014. Building B, Permit #09126-01703 expires March 2014. Building C, Permit #09126-01704, expires March 2014. The Range Hood in the kitchen was inspected on August 23, 2013. The Sanitation certificate from the Florida Department of Health was up-to-date and expires on 09/13/2014.

Monthly Fire Drills were performed; however, staff participating in the drills was not signing the log to indicate their participation; their names were either typed or written on the sheet. Emergency drills were conducted in accordance with policies; there was a minimum of one mock emergency drill per shift, per quarter.

The facility is divided between male and female beds. At the time of review there were 9 clients in the shelter, six females and three males. The dormitories were well maintained and equipped with clean linen. The youth had access to lockers through staff. The living areas were spacious and accommodating.

During the tour, the youth were participating in school. The facility has its own building used for school which is separate from the main living area. The atmosphere was conducive for learning and instructions were provided by a certified Miami Dade instructor. The facility also employs a Recreation Coordinator to ensure structured activities are offered to youth. Due to limited activity space, the library and video game center is located in the same area with no closed door for quiet reading. However, there were books located in the dormitory areas to accommodate reading time.

The daily point system update was located in the office window for clients to see and the daily schedule was strategically located. The youth were taken to the Key Gate Charter School in Homestead to perform volunteer services after group services for their recreational activity and this Reviewer was informed that they would be attending "Teen Court" later that day as their structured activity. A review of the log on Wednesday indicated that they did.

Exceptions:

One issue was noted in that the male bathroom contained an old glass mirror. Once replaced, a consideration for aluminum or plexi-glass mirrors is recommended.

During the tour there was a panel outside the school building with exposed wiring.

While observing group activity, a staff member left their keys, glasses and an ID on the air hockey table unattended. The Shift Leader took them to the control room/office.

The sign in the hallway that has the bathrooms on it need to have an arrow indicating the direction. This was remedied prior to the conclusion of the onsite visit.

### 3.02 Program Orientation

Satisfactory

Limited

Failed

### Rating Narrative

The agency has an Orientation Policy that covers all details of the youth stay at the shelter. A review of three client files revealed that the Orientation process was begun on the date of intake and each client signed their orientation sheet. Each youth was given a list of contraband items, an explanation of disciplinary actions, the grievance procedure was explained, emergency disaster procedure, rules on contraband, a layout of the facility was explained, they were oriented on room assignments, and suicide prevention. Additionally, they received a review of daily activities; they were given and shown postings of the abuse hotline and a tour of the facility.

The Shelter Staff realizes that oftentimes, teens forget what they're told in the initial process so a posting of all rules, daily activities, abuse hotline number and other pertinent shelter rules are located throughout the shelter on a large poster board in conspicuous places.

### **3.03 Youth Room Assignment**

Satisfactory                       Limited                       Failed

### Rating Narrative

During the Orientation Process, the youth are informed of their bed assignments. A process is in place to ensure separation of identifiable issues. Several factors are considered before placing a youth in a room. A review of the youth's history is done and considered along with age, gender, disabilities, physical size, gang affiliation, and other risk factors that may interfere with the smooth operation of the shelter.

The dormitories are broken down into two separate modules. Module A is for the younger, more vulnerable client while Module B is for the better adjusted youth. There is an island containing lockers, separating the two sides in the dorm and the staff supervising the unit is stationed on the Module A side for maximum supervision whenever youth are in their sleeping quarters.

### **3.04 Log Books**

Satisfactory                       Limited                       Failed

### Rating Narrative

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

A review of the log book showed where recording errors were struck through with a single line and late entries were indicated as LE. The entries were legible and captured the overall shelter operation.

While reviewing the log book an important entry was missing. Apparently, one of the clients was transported to the Central location from Homestead the prior day but there was no entry made in the logbook to verify that information. It is recommended that a separate Transportation Log be implemented to show when any youth is transported off of the facility for any reason.

### Rating Narrative

The Behavioral Management System being used by Miami Bridge-Homestead is a positive reinforcement model that accentuates and promotes acceptable behaviors by the youth. The system consists of four levels. Orientation, Level I, Level II, and Level III. A client has to accumulate 100 points to advance to each level (i.e. it takes 100 points to advance from orientation to level I, 200 points from I to II and 300 points to advance to level III).

An advancement in levels means the client receives more incentives. The shelter maintains a small Canteen filled with items for the clients to purchase with their earned points. It's equipped with clothing items, name brand shoes, and an assortment of items that the youth can use.

As a management model, the system has been an excellent tool to promote homeostasis within the shelter. The limited amount of incidents reported is a testament to its success.

### **3.06 Staffing and Youth Supervision**

Satisfactory                       Limited                       Failed

### Rating Narrative

The agency has a policy for staffing and youth supervision to ensure adequate staffing is provided that optimizes the safety and security of all youth and staff. The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.

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

The program has an on-call roster that includes the names and telephone numbers of four staff who may be accessed when additional coverage is needed at the Homestead Shelter and six staff for the Central Shelter.

A review of the program logbook shows that staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or when youth are in their sleeping rooms.

The program accepts both males and females. All of the staff schedules reviewed demonstrate the staffing of male and female staff on duty on each shift at all times.

On three separate occasions during the review period, the schedule does not reflect a 1:6 ratio; this occurred between 7 a.m. - 8 a.m. The schedules showed 2 youth care staff were scheduled from 6:30 a.m. to 3:00 p.m. with an overlap to 7:00 a.m. by the 2 overnight staff and two additional staff, the Healthcare Specialist and Cook, reporting to work at 8:00 a.m. The Program Manager indicated that he usually comes in earlier or makes arrangement for the Cook to report to work earlier when the census increases. It is recommended that these schedule changes be documented on the schedule to demonstrate actual staff coverage.

### 3.07 Special Populations

Satisfactory

Limited

Failed

#### Rating Narrative

Miami Bridge Homestead is a designated Staff Secure and Domestic Violence Respite (DV Respite) provider and has a policy 3.09 for Staff Secure Shelter and Staff Secure Beds place. A separate Intake Guideline for referrals of DV Respite youth is maintained by the program that was last revised April 2013. The agency has no record of a Staff Secure youth intake that occurred during the onsite visit or since the last QI review. Staff was interviewed and confirmed not having a recent staff secure youth in the program. If that were the case, the agency's policy provisions meet the requirement for accommodation, supervision, and services to staff secure youth.

Similarly, the program did not have an active DV Respite youth on its census during the visit but the files of three (3) cases that were closed during the past six months were reviewed to ascertain practice. The three files reviewed demonstrate that the youth met the criteria for DV Respite placement. Prior approval was received via email from the Florida Network for Domestic Violence Respite placement. As evidenced by the JAC Screening, all three youth had pending Domestic Violence (DV) charge and were screened by the JAC /Detention or screening unit, but did not meet criteria for secure detention. None of the youth's length of stay in DV Respite placement exceeded the 14 days allowed. Documentation in files demonstrate transition to CINS/FINS via shelter placement court order and/or home (shelter) detention agreement. The Case Plans in two of the three files reflected goals for aggression management, coping skills, or other interventions designed to reduce propensity for violence in the home. Additional services were provided to these youth similar to services that are provided to youth in the CINS/FINS program.

There were five goals listed on the youth's case plan for following shelter guidelines, improving academic performance, substance abuse referral, improving communication, and family reunification. However, none of the case plan goals specifically addressed the youth's anger issue.

## Standard 4: Mental Health/Health Services

### Overview

#### Rating Narrative

MB Homestead has specific procedures related to the admission, interviewing and room assignment of youth to ensure the safety and appropriate supervision of youth admitted in the program. Upon admission, program staff will interview youth. An initial assessment occurs to determine the most appropriate Room Module assignment, Module A or Module B, given the youth's needs and issues, the current population at the facility, physical space available and staff's assessment of the youth's ability to function effectively within program rules and expectations. Staff conducting the initial interview and assessment considers the youth's physical characteristics, maturity level, history including gang or criminal involvement, potential for aggression, and apparent emotional or mental health issues. Based on this information, the youth is assigned a bed which can change after further assessment. Room assignment is documented on the CINS/FINS Intake Assessment page 2.

Staff on duty at the time of admission immediately identifies youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The Chief Clinical Officer and Program Manager 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. Medications are stored in a double locked medication cabinet and topical and/or 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 which ensures that an approved staff is scheduled on each shift. Medication records are maintained for each youth and stored in a MDR Binder.

The agency is very unique in that they are one of only a few that has a full time Health Care Coordinator to oversee the intake health screening, physical health assessment and medical follow-up process. This position plays a critical role in supporting shelter operations during the initial intake and screening process and in making appointments and transporting youth for any follow up medical services. The position is staffed by a certified LPN who was interviewed by the review team during this CQI site visit to verify her assigned duties and responsibilities.

### 4.01 Healthcare Admission Screening

Satisfactory                       Limited                       Failed

#### Rating Narrative

The program has written policy and procedures to address Healthcare Admission Screening for youth admitted to the program. Of the three files reviewed, documentation showed that the program performs preliminary physical health screening for each youth at the time of admission to the shelter and all indicators are addressed during the screening.

The Agency's Policy and procedures include the process for referring youth for medical care for chronic medical conditions. One of the three files reviewed documented the youth requiring offsite transportation due to emergency medical attention. The medical referral is documented on the Client Transported Offsite Due to Emergency Attention form and was logged in the log book and documented in youth's file.

Staff files were reviewed and demonstrated that staff are trained on the intake and admission process.

### 4.02 Suicide Prevention

Satisfactory                       Limited                       Failed

#### Rating Narrative

Agency has policy and procedure to address Suicide Prevention. None of the three files reviewed indicated suicide ideation.

The agency reported that no youth has been placed on sight and sound within the last six months. A review of the Suicidal Ideation Supervision Log shows that there has not been any sight and sound since January 2012. However, in review of two (2) closed files, it is noted that one (1) youth had been placed on sight and sound on 8/23/13 based on the Intake Risk Screening. Suicide Risk Assessment was completed and sight and sound entered into log book at 2:20pm. However, the Reviewed could not locate log book entry removing the youth off sight and sound at 3:30pm and could not locate the Suicide Precautions-Observation Log.

It is recommended that the provider review QI Indicator 4.02 and agency's policy and procedure on Suicide Prevention to ensure agency's compliance and consistency with procedures. The Network's policy requires 30 minute observations and the agency's Suicide Precautions-Observation Log requires observation within 15 minute intervals.

The provider must also ensure that Suicide Ideation Log is updated and ensure all Observation entries and Log book entries are updated as needed.

### 4.03 Medications

Satisfactory                       Limited                       Failed

#### Rating Narrative

Agency has policy and procedures to address Medication Storage, Access, Inventory, Administration, Documentation and Disposal.

Medications are stored in a separate, secure (locked) area in the intake office, stored in a locked box, and kept in a locked cabinet.

Oral medications are not stored with injectable or topical medications. At the time of this review, none of the youth are on injectable medications.

Medications that require refrigeration are stored in a secured (locked) refrigerator located in the nurse's office that is used for medication only. At the time of this review, there was no medication stored requiring refrigeration. The refrigerator was empty.

Narcotics and controlled medications are stored in a locked box in a locked cabinet in the intake office. Only designated staff delineated in writing has access to secured medications. The agency has a nurse on staff that administers medication to youth Monday through Friday during her hours of work. Staff designated to distribute medications to the youth have all been trained in Medication Management and Distribution.

For controlled substances, a perpetual inventory with running balances is maintained and shift-to-shift inventory counts are conducted and documented.

There was one incident where a youth received a double dose of his medication. Youth was to receive two doses of medication. Staff dispensed a third dose. The distribution of the medication was noted on the individual medication distribution log for the youth, entered into the log book but not included on the MDR log. The youth was taken for emergency medical care. The incident was called into the CCC. Staff dispensing the third dose of medication received disciplinary action and has been removed from distribution of medication pending receipt of additional training.

Over the counter medications are inventoried weekly. It is noted that the "Over-the Counter Medication & Supply Inventory and Log contains "Thera-Flu - Honey". Since Theraflu has been removed from the pharmaceutical shelves, the agency was asked why Thera-Flu was included on their inventory log. A review of the inventory does not include Thera-Flu. The inventory includes a Target brand medication, flu and severe cold and coughs relief, honey lemon flavor that includes a statement "compare to active ingredients in Theraflu Severe Cold and Cough".

Agency advised Reviewer that there are no syringes in inventory. Agency also advised Reviewer that razors are not kept on the premises. Females are required to address their shaving needs while on passes and the males' shaving needs are done during visits to the Barber.

Sharps (tweezers and nail clippers) are kept in the nurse's office in a locked box in a locked cabinet and weekly inventory conducted. Knives are kept in a locked box in the kitchen and only are accessed and inventoried weekly by the cook. Knife for Life are inventoried each shift.

A Medication Distribution Log is used for distribution of medication by non-licensed staff. The facility has a licensed nurse that utilizes the Medication Administration Record.

The program must ensure that all staff have a clear knowledge of medication distribution. Also the list of "Staff Authorized to Distribute Medication was not updated as of November 19, 2013 to remove the staff member who was disciplined and is pending his retraining.

#### 4.04 Medical/Mental Health Alert Process

Satisfactory

Limited

Failed

##### Rating Narrative

Agency has a policy and procedure to address medical and mental health alert.

Medical, substance, nutritional and/or mental health alerts are noted in each of the three files reviewed on the Youth Alert System Form which lists behavioral, nutritional, and medical alerts. In addition to checking the appropriate alerts, staff also places a corresponding alert sticker on the right side of the form. The provider's color-coded alert system is used to identify different alerts as follows: RED=medical, BLUE=substance abuse, GREEN=victimization, YELLOW=nutrition, and ORANGE=mental health.

Alerts are also noted on the Census Board in the Intake Office. The medical files note the information relative to the prescription medication issues which staff may be required to recognize and respond to if the need for emergency care is needed.

The survey of staff indicates that medical/mental health alerts are discussed during shift meetings.



#### 4.05 Episodic/Emergency Care

Satisfactory

Limited

Failed

##### Rating Narrative

Agency has a policy and procedure to address Episodic/Emergency Care. The procedures establish the process to access Episodic/Emergency Care. Staff are trained on the process, CPR/First Aid. Agency's procedures include most of the mandatory components of this standard.

Off-site emergencies are documented in the files and in the log book. However, the agency does not utilize a daily log for documenting off-site emergencies.

Knife-for-Life and wire cutters are located as follows: 2 (two) are kept in the Intake Office; 1 (one) is kept in the School in the Locked Closet; 1 (one) is kept in the First Stop Building; and 1 (one) in each of the two vans (grey van and white van).

First aid kit/supplies are located: 1 (one) in the Intake Office; 1 (one) in the kitchen; 1 (one) in the school; 1 (one) in the First Stop Building; and 1 (one) in each of the vans. First Aid kits are inspected weekly.

There was no practice evidence of the implementation of a Daily Medical Care Log during the review. It is recommended that the agency develop and implement the daily log as required in the mandatory components for this standard for off-site emergency services.