MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Health Care Services and Responsible Health Authority**	**Policy Number: 2**
Number of Pages: 4	**Section: XI**
Attachments None	**Related Standards & References** ACA Juvenile Healthcare Performance Based Standards 2009: 4-JCF-4C-34
Effective Date: 06/09/06 **Revised Date: 03/01/07, 04/22/08, 06/26/09, 05/01/11, 11/01/13**	**Approved:** James V Maccarone **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard guidelines are established for the delivery of comprehensive health care services by qualified health care personnel to all youth confined to the facility.

The Division of Youth Services shall employ a Director of Medical Services as the Health Authority. The Health Authority is responsible for developing the division's medical policies that direct, and guide related procedures for youth within the facility (4-JCF-4C-34). The division's medical policies shall:

- Define the division's scope of health care services and provide a framework for the delivery of quality care by health care personnel at the facility;
- Provide guidelines for the development of systems for quality review and statistical data collection essential to the planning and evaluation of facility's youth health care services;
- Promote a system-wide, comprehensive approach to health care services; and
- Provide guidelines and initial standardized requirements of the individual healthcare record in order to facilitate the efficient and accurate exchange of information as needed.

The division's medical policies and procedures shall cover but not be limited to the following:

- Health Care Personnel Qualifications
- Medical Facilities, Equipment and Supplies
- Health Records and Confidently

- Authorization to Treat and Consent
- Medical Notification of Injury, Illness or Death
- Access to Health Care
- Admission Health Screening
- Health Care Appraisals and Examinations
- Medical Treatment Plans
- Youth participation in Medical Research
- Medical Consultation and Hospitalization
- Pharmaceutical Management
- Health Education, Prevention, and Specialized Health Programs
- Emergency Response and Health Services
- Communicable Disease Management and Exposure Control Plan
- Quality Assurance

The facility shall employ a Director of Medical Services, an individual, with the responsibility for ongoing health care services.

The Director of Medical Services is responsible for making decisions about the deployment of health resources and the day-to-day operations of the facility's medical clinic.

Final clinical judgments at the facility rest with the Physician. (4-JCF-4C-36)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel- an individual whose primary duty is to provide health services to youths in keeping with their respective levels of education, training, and experience. The individual shall be licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

Director of Medical Services- an individual employed by the MDHS, who is responsible for the provision of health care services at the facility.

Health Authority – an individual employed by the MDHS, who is responsible to establish, direct, monitor, and review health services in order to protect the health and well being of youth within the facility.

III. PROCEDURE

A. The Division Health Authority is the Director of Medical Services.

The Director of Medical Services shall develop policies and procedures for the medical department

Medical policies and procedures shall be revised as needed to ensure that each policy and procedure in the health care delivery system is sufficient to provide care that meets current accepted standards. When revised these policies and procedures are submitted for training of the medical department staff. Training will be accomplished via self study module. (4-JCF-4C-34)

The Director of Medical Services shall collaborate with the Facility Administrator as needed to assist in responding both to medical and facility emergencies.

The Director of Medical Services shall when needed, assist in the appropriate classification of youths with special medical needs and assist in the placement of these youths to relevant specialty units.

The Director of Medical Services shall at least annually identify the type of health care personnel needed for the medical clinic to provide health services. (4-JCF-4C-35)

The Director of Medical Services meets with Facility Administrator as needed, to submit any problems or issues pertaining to the health care delivery system and the health environment. (4-JCF-4C-37)

B. The facility medical department staff consists of the following health care personnel positions:

- Registered Nurse(s)
- Licensed Practical Nurse(s)
- Certified Medical Assistant(s)

Medical, dental and psychiatric coverage is provided by contract services with a Physician and/or Nurse Practitioner, Dentist and Psychiatrist.

C. The responsibility of the Director of Medical Services includes, but is not limited to:

Ensuring the defined scope of health care services is put into practice in accordance with the facility's mission and function. (4-JCF-4C-34)

Implementing healthcare programs and establishing systems for the coordination of care between multi-disciplinary healthcare personnel.

Developing mechanisms, including written agreements, when necessary, to assure that the scope of services is provided and properly monitored. (4-JCF-4C-34)

Reporting any condition that poses a danger to staff or youth health and/or safety to the facility administrator/designee. (4-JCF-4C-41)

Providing orientation to new health care personnel and ongoing training for staff development.

Completing weekly and monthly reports and submitting to the facility administrator. Refer to policy XI.39, Quality Assurance Monitoring and Reporting, and attached Health Care Service Statistical Data Report Form XI.39.C. These reports shall minimally address: (4-JCF-4C-38)

- Statistical data indicating the use of health services by category of care, operative procedures, referrals to specialists, medication usage, laboratory and x-ray tests completed, off-site medical transport, hospital admissions, ambulance services, serious injuries, illnesses, suicide attempts or deaths, and others if requested.

Attending the facility department head meetings.

D. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Health Care Personnel Qualifications**	**Policy Number: 3**
Number of Pages: 2	**Section: XI**
Attachments Health Care Personnel Licensure Verification Form XI.3.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-35, 4-JCF-4C-51, 4-JCF-4C-53; 4-JCF-4C-54, 4-JCF-4C-57,
Effective Date: 06/09/06 **Revised Date: 03/01/07, 04/22/08, 06/26/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that a team of licensed health care personnel be employed to deliver health care or mental health services for the medical, dental and emotional well-being of youth confined to the facility. The Director of Medical Services shall determine the essential positions needed at each facility to perform health care services. (4-JCF-4C-35)

The division of youth services requires that personnel who provide health care and mental health services to youth comply with applicable federal and state licensure, certification or meet registration requirements and restrictions that may apply. (4-JCF-4C-53) The specific duties and responsibilities of health care personnel shall be governed by written job descriptions or contractual agreement, which are approved by the Director of Medical services and Facility Administrator. (4-JCF-4C-51) Concerns about incompetence and/or professional misconduct shall be managed in accordance with state law, agency policy, and relevant professional ethical code. (4-JCF-4C-53)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health care personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

Contract Physician/Dentist/Psychiatrist - a Physician, Dentist or Psychiatrist who agrees to provide health care services for OYDC youth as outlined in a personal service contract.

III. PROCEDURE

A. As determined by the Director of Medical Services, each facility shall provide the following services at a minimum either through contract or state personnel:

- Nurses
- Physician
- Dentist
- Psychiatrist

Annually, the Director of Medical Services shall review the facilities staffing plan to determine if the number and type of staff is adequate for essential positions to perform health care services. The Director of Medical Services shall review this staffing request with the Facility Administrator. (4-JCF-4C-35)

B. The personal service contract, statement of service, approved by the Director of Medical Services and Division Director shall govern the relationship and the activities of Physicians, Dentists and/or Psychiatrists working with the youth in the facility in lieu of job descriptions since these individuals are independent contractors.(4-JCF-4C-51)

C. Verification of current licensure, credentials and job descriptions is on file in the facility. (4-JCF-4C-53) Licensure is documented on the Health Care Personnel Verification Form XI.3.A by the appropriate supervisor. The Director of Medical Services/designee shall annually review any medical, nursing and dental personnel's license and/or certification and maintain a file copy.

D. Youth are prohibited from performing health care duties or activities of any kind in the facility. (4-JCF-4C-57)

E. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

HEALTH CARE PERSONNEL
LICENSURE VERIFICATION FORM

Oakley

The professional licenses of the following health services personnel have been reviewed by the undersigned and determined to be current:

Name	Position	Licensing Body	License Number	Expiration Date
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
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		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
		Mississippi Board of Nursing		
	Nurse Practitioner	Mississippi Board of Nursing		
	Physician	Mississippi Medical Board		
	Physician	Mississippi Medical Board		

	Physician	Mississippi Medical Board		
	Physician	Mississippi Medical Board		
	Dentist	Mississippi Dental Board		
	Dentist	Mississippi Dental Board		
	Dental Hygienist	Mississippi Dental Board		
	Dental Hygienist	Mississippi Dental Board		

_____ Date: _____

Director of Medical Services

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Medical Facilities, Equipment and Environmental Monitoring**	**Policy Number: 4**
Number of Pages: 4	**Section: XI**
Attachments Dental X-Ray Log Form XI.4.A Autoclave Log Form XI.4.B Medical Equipment Check List Form XI.4.C.1 Medical Equipment Check List, Blank Form XI.4.C.2	**Related Standards & References** ACA Juvenile Healthcare Performance Based Standards 2009: 4-JCF-4C-49, 4-JCF-4C60, 4-JCF-4C-62
Effective Date: 06/09/06 **Revision Date: 03/01/07, 04/22/08, 06/26/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that the facility maintains a designated clinic with a private examination area so that health care encounters, including medical, dental and mental health interviews, examinations, and procedures can be conducted, respecting the youth's privacy. (4JCF-4C-49)

Equipment, supplies, and materials shall be provided and maintained as determined by the Director of Medical Services, in consultation with the Physician/Dentist, for the performance of health care services. (4-JCF-4C-60) Medical equipment monitoring, by health care personnel, shall be completed at least monthly.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

III. PROCEDURE

A. The facility shall maintain a medical clinic with an examination room to allow for the private examination of youth. (4-JCF-4C-49) The level of clinical care shall be commensurate with the youth's health care needs, and the capabilities of the assigned health care personnel.

B. To facilitate appropriate service provision, the medical clinic shall, at a minimum, maintain the following health care manuals and reference materials as determined by the Director of Medical Services in conjunction with contract Physician:

- Medical policy and procedures manual
- Copy of all currently used medical forms
- Adolescent Medicine Textbook
- Textbook on Nursing Procedures
- Medical Dictionary
- Physicians Desk Reference
- Nursing Drug Handbook
- Control of Communicable Disease Manual

C. The basic medical/dental equipment list at the facility shall include, but not be limited to, the following as determined by the Director of Medical Services in conjunction with the Physician/Dentist: (4-JCF-4C-60)

Medical Clinic:

- Thermometer
- Blood pressure cuff
- Stethoscope
- Otoscope
- Opthalmoscope
- Glucometer
- Scale
- Examination table
- Exam light
- Oxygen Equipment
- Suction machine
- Doppler
- Autoclave
- Refrigerators, with freezers, (one for medications and one for Specimens)
- Transportation equipment, (i.e. wheelchair)
- Eye Wash Station
- Pulse Oximeter
- Reflex Hammer
- Nebulizer
- Peak Flow Meter
- First Aid kits, Spill Kits and AED (Automated External Defibrillator) shall be available in designated areas within the facility as determined by the Director of Medical Services and the Facility Administrator. The Director of Medical Services shall approve the contents, number, location and procedures for monthly inspection of the kits and procedures for use by non-medical staff. (4-JCF-4C-59) Refer to policy XI.5, First Aid Kits/Spill Kits and AED.

Dental Equipment:

- Dental chair
- Air/water unit
- Overhead light
- High/low speed hand pieces
- High/low speed suction
- X-ray unit
- X-ray view box
- X-ray developer
- Cavitron
- Rotary Endo machine
- Ultrasonic scaler
- Auto clave
- Air compressor
- Vacuum machine
- Curing light
- Amalgamator
- Lead apron
- Doctor's chair
- Assistant's chair

D. Clinic medical and dental supplies shall be maintained to provide for the health care needs of the youth and are securely stored, controlled and perpetually inventoried. Refer to policy XI.7 Medical Supplies Inventory Management. (4-JCF-4C-61)

E. Radiation (Dental X-Ray Machine) monitoring: Dental x-ray units shall be in compliance with the Mississippi Department of Radiological Health protection rules and Mississippi Board of Dental Examiners.
The following procedures shall apply:

- Only a licensed dentist or other licensed practitioner may order dental x-rays.
- Only a licensed dentist, dental hygienist or certified dental assistant may operate dental x-ray equipment
- The facility contractual dentist/s shall describe any restriction in the operating technique of radiology equipment that shall be required within the clinic.
- Health care professionals who handle dental x-ray equipment shall comply with any and all rules and regulations set forth by the Mississippi Department of Radiological Health and the Board of Dental Examiners.
- The average weekly workload of each X-ray tube and the Panoramic X-ray machine (number of dental x-rays taken on each youth) shall be documented on the X-ray Log form XI.4.A, or Dental Visit Log form XI.19.B. This log shall be maintained in the Dental clinic area.

F. Infectious waste monitoring: the State of Mississippi has specific regulations regarding the disposal of biohazardous infectious waste. Biohazardous waste transporters must be registered. When untreated waste is being transported to a licensed facility the transporting company is responsible for establishing "shipping papers". The clinic shall maintain a copy of the shipping papers. (4-JCF-4C-62)

G. Medical equipment monitoring, by health care personnel, is completed at least monthly and as needed to ensure optimal working order. Equipment that is in need of repair or replacement shall be immediately reported to the Director of Medical Services/designee.

1. Designated health care personnel shall complete the Medical Equipment Check Sheet form XI.6.C and C.1 at least monthly. This form shall be maintained in the medical department files.

2. Autoclaving

a. In order for proper sterilization to occur the following minimum conditions shall exist: a temperature of 250 Degrees Fahrenheit at a pressure of 150 pounds for at least 15 minutes, and these conditions shall be obtained uniformly for all packages within the autoclave run.

b. Maintenance of all autoclaves shall be listed in the operator's manuals. Any autoclave that appears non-operable shall not be used until repaired. It is suggested that autoclaves be covered on a preventive maintenance schedule.

c. The designated health care professional shall send a Bacterial Spore Biological Indicator Test Strip to a Biological Monitoring Service at least monthly or in accordance with the Mississippi Department of Health requirements. This test strip is a monitor for proper sterilization of the autoclave. A control result along with the package I.D. number shall be documented by the designated health care professional on the Autoclave Log for Bacterial Spore Biological Indicator Test Strip Results Log XI.6.B

3. Refrigerator/Freezer temperature monitoring

a. Refrigerators and Freezers in the medical clinic shall be equipped with thermometers. Temperature range for the refrigerators shall be 35-45 Degrees Fahrenheit. The temperature range for the freezers shall be 0-5 Degrees Fahrenheit

b. The designated health care professional shall check and record the temperature twice daily on the vaccine temperature log.

H. The Director of Medical Services shall consult with the Facility Administrator and the Director of Operations before implementing any physical plant changes or relocation of the medical clinic area.

I. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Youth Services
Medical Services
Oakley Youth Development Center

Dental X-Ray Log

Month: _____ **Year:** _____

Name	DOB	Date	No. of X-rays	Signature

Personnel operating x-ray equipment must log all x-rays taken. This information is kept by the Dentist to determine the number of youth radiographed and the number of films taken on each youth.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

AUTOCLAVE LOG FOR SPORAMPULE BIOLOGICAL INDICATOR TEST RESULTS

Oakley Youth Development Center **Year:** _____

Date Test Completed	Staff Signature	Test Results (Results)	(Date)	Comments

Reviewed by Director of Medical Services: _____
Signature Date

Mississippi Department of Youth Services
Division of Youth Services

Medical Equipment Check Sheet

Year: _____

Equipment Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1. Refrigerator (Medication Room)												
▪ Clean												
▪ Temperature 35 – 40 degree Fahrenheit												
2. Refrigerator (Lab Room)												
▪ Clean												
▪ Temperature 35 – 40 degree Fahrenheit												
3. Refrigerator (Food)												
▪ Clean												
▪ Temperature 35 – 40 degree Fahrenheit												
4. Suction Machine												
▪ Charged												
▪ Suction Present When Active												
▪ Tubing Accessible												
5. Oxygen Equipment												
▪ Accessible												
▪ Cylinder Level												
6. Glucometer												
▪ Calibration Checked												
▪ Function Checked												
7. Trauma Kit												
▪ Accessible												
▪ Content Intact												

Nurses Name	Initials	Nurses Name	Initials	Nurses Name	Initials	Nurses Name	Initials

Checks are to be completed within the first week of every month. Initial and date each box as you complete your checks. If problems are noted place an asterisk (*) in that box and explain problem on the back of the form. Notify the Health Services Supervisor of any problems noted.

Date	Time	Problem:	Reported to:	Signature

Mississippi Department of Youth Services
Division of Youth Services

Medical Equipment Check Sheet

Year: _____

Equipment Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Nurses Name	Initials	Nurses Name	Initials	Nurses Name	Initials	Nurses Name	Initials

Checks are to be completed within the first week of every month. Initial and date each box as you complete your checks. If problems are noted place an asterisk (*) in that box and explain problem on the back of the form. Notify the Health Services Supervisor of any problems noted.

Date	Time	Problem:	Reported to:	Signature

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **First Aid Kits, Spill Kits and Automated External Defibrillator (AED)**	**Policy Number: 5**
Number of Pages: 3	**Section: XI**
Attachments First Aid and/or Spill Kit Usage Form XI.5.A First Aid/Spill Kit Inspection Record Form XI.5.B AED Unit Inspection Form XI.5C	**Related Standards & References** ACA Juvenile Health Care Performance bases Standards 2009: 4-JCF-4C-58
Effective Date: 06/09/06 **Revision Date: 03/01/07,05/07/08, 06/26/09, 05/01/11, 11/1/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines are established to ensure that first aid kits, spill kits and automated external defibrillator(s) (AED(s)) shall be available to staff. (4-JCF-4C-59)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. First Aid Kits (4-JCF-4C-59)

1. The facility's medical department staff shall maintain first aid kits in the following designated locations as approved by the Health Authority:

- Intake Area
- Control Center
- Security
- Food Service Area
- Gymnasium
- Living units (cottages and PODs)
- Off campus transport vehicles
- Maintenance Office
- Administration Office
- School Office
- Vocational areas
- Chapel
- Recreation Hall (if applicable)

a. The facility first aid kits shall be locked by a snap-on lock and contain the following items as determined by the Health Authority (4-JCF-4C-58)

- One roll of one-inch tape
- One roll of Kling or Coban wrap
- Two packages of 4x4's
- Two pair non-latex gloves
- CPR mask with one (1) way valve
- First Aid and Spill kit Usage Form XI.5.A
- No Medications shall be placed in the first aid kits

b. Any first aid kit with a broken or missing lock shall be delivered to medical department staff as soon as possible.

i. The medical department staff shall be notified when a staff member opens a first aid kit to provide first aid care to a youth. The staff member opens the kit shall document the usage and incident on the First Aid and Spill Kit Usage Form XI.5.A. The first aid kit and completed form shall be taken to the clinic for restocking, resealing and redistribution.

ii. The medical department staff receiving the opened/used first aid kit shall restock, reseal and return the kit to the appropriate location promptly. The nurse shall also complete the First Aid and Spill Kit Usage Form XI.5.A and forward to the Director of Medical Services for review. This form shall be maintained in the medical department files.

iii. Medical department staff shall be responsible for ordering first aid supplies and maintaining the kits.

B. Spill Kits (4-JCF-4C-61)

1. The facility's medical clinic staff shall maintain spill kits with each first aid kit. The spill kit contents shall be used when cleaning any area that has been contaminated with blood or body fluids. The contents of each spill kit shall include at a minimum:

- 2 pair of latex gloves
- 1 red biohazard bag
- 1 package absorbent material
- 1 plastic scoop
- 1 pouch of disinfectant
- First Aid and Spill Kit Usage Form XI.5.A

* Should the need arise to make a disinfectant; the dilution is one (1) part bleach to nine (9) parts water. This solution shall be labeled and cannot be kept for more than 24 hours.

2. Any spill kit with a broken seal shall be delivered to the medical department staff as soon as possible.

a. The medical department staff who opens the spill kit shall document the usage and incident on the First Aid and Spill Kit Usage Form XI.5.A. The completed Spill Kit usage Form and kit shall be taken to the clinic for restocking, resealing and redistribution.

b. The medical department staff receiving the opened/used spill kit shall restock, reseal and return the kit to the appropriate location promptly. The nurse shall also complete the First Aid and Spill Kit Usage Form XI.5.A and forward to the Director of Medical Services for review. This form shall be maintained in the medical department files.

C. Inspections (4-JCF-4C-58)

1. A designated medical department staff member shall complete a monthly inspection all first aid and spill kits.

2. Documentation of the inspection shall be completed on the First Aid/Spill Kit Inspection Record Form XI.5.B.

3. These records shall be maintained in the medical department files.

D. Automated External Defibrillator (AED) (4-JCF- 4C-58)

1. The facility shall have at a minimum of three (3) AED units. The AED units shall be located in the following areas:

   - One (1) unit shall be located in the clinic,
   - One (1) unit will be located in the central control room,
   - One (1) unit will be located in the school

2. The AED units will be inspected on a monthly for battery integrity and expiration date of the monitor pads.

3. Staff training to include protocols for use by non-medical staff. Refer to training policy IV.1 Training Management.

E. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

FIRST AID and/or SPILL KIT USAGE FORM

First Aid Kit

To be completed by person opening the Kit (Please complete below)

- First Aid Kit Number: _____
- First Aid Kit Location: _____
- Item(s) used:

☐ TAPE ☐ KLING/COBAN WRAP ☐ 4X4'S ☐ GLOVES ☐ CPR SHIELD

Explain reason for use: _____

_____

Employee Signature: _____ **Date**: _____

Spill Kit:

To be completed by person opening the Kit (Please complete below)

- Spill Kit Location: _____

Explain reason for use: _____

_____

Employee Signature: _____ **Date**: _____

To be completed by the Nurse

- Item(s) replaced:

☐ TAPE ☐ KLING/COBAN WRAP ☐ 4X4'S ☐ GLOVES ☐ CPR SHIELD ☐ SPILL KIT

Comment: _____

Nurse Signature: _____ **Date**: _____

Mississippi Department of Human Services
Division of Youth Services
Medical Services

FIRST AID KIT AND SPILL KIT INSPECTION RECORD

Month: _____ **Year:** _____

No.	First Aid Kit/Spill Kit Locations	Date Checked	Sealed/ Unsealed	Lock Number	Comments	Inspector Initials

Initials	Signature of Inspector	Initials	Signature of Inspector

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Oakley Youth Development Center

AED UNIT INSPECTION RECORD

(Automatic External Defibrillation unit)

Year: _____

No.	AED Locations	Date Checked	Pad Expiration Date	Battery Charging	Comments	Inspector Initials

Nurse Signature	Initials	Nurse Signature	Initials	Nurse Signature	Initials

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Medical Supplies Inventory Management**	**Policy Number: 6**
Number of Pages: 2	**Section: XI**
Attachments Supply Control Form XI.6.A; Non-Prescription Supply Control Monitoring Form XI.6.B	**Related Standards & References** ACA Juvenile Healthcare Performance Based Standards 2009: 4-JCF-4C-60
Effective Date: 06/09/06 **Revision Date: 03/01/07, 04/22/08, 06/26/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that guidelines shall be established so that adequate stock and supplies necessary for clinic operations are always on hand and to address staff responsibilities for medical and dental supplies inventory management, storage and monitoring within the facility setting as determined by the Director of Medical Services. (4-JCF-4C-60)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

III. PROCEDURE

A. The Medical Department shall maintain an inventory of needed medical and dental supplies.

1. When a medical or dental supply is received in the clinic the assigned health care personnel shall verify the items and quantity received by comparing the packing slip and the purchase invoice.

2. A receiving report shall be completed for all medical and dental supplies delivered to the clinic area. This form is forwarded to the business office.

B. All medical and dental supplies shall be stored in designated locked areas with the medical and dental staff having the only keys.

C. A perpetual inventory shall be maintained for all medical and dental supplies to make sure that needed stock and supplies are always at hand. These supplies shall be listed on the Supply Control Form XI.6.A. Health Care Personnel shall sign-out supplies in a timely manner to document their use.

D. Medical and dental instruments and sharps (syringes, needles, and other sharps) are securely stored, controlled and perpetually inventoried. Refer to policy XI.7, Medical and Dental Instrument and Sharps Management and policy XI.31 Pharmaceutical Receipt, Storage, Inventory and Disposal Management. (4-JCF-4C-61)

E. The assigned health care personnel shall complete the Supply Control Monitoring Form XI.6.B monthly. Any discrepancies shall be reported to the Director of Medical Services/designee for review and investigation.

F. The Director of Medical Services shall revise this policy as necessary

Mississippi Department of Human Services
Division of Youth Services
Medical Services
Oakley

SUPPLY CONTROL FORM

Product Description: _____

Lot Number: _____ **Expiration Date:** _____ **Package Size:** _____

Health Care Personnel Completing Form: _____ **Date:** _____

Date	Balance	Amount Removed from Stock	Amount Added to Stock	Balance	Comments	Nurse's Signature

Reviewed by Director of Medical Services: _____
Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services
Oakley Youth Development Center

SUPPLY CONTROL MONITORING FORM

Supply Item Name	Actual # Present	Actual # Recorded	Discrepancy/Comments

Health Care Personnel Completing Monitoring Form: _____

Date: _____ **Time:** _____ **Accountability accurate:** ☐ **Yes** ☐ **No**

Reviewed by Director of Medical Services: _____

Signature Date

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Medical and Dental Instruments and Sharps Management**	**Policy Number:** 7
Number of Pages: 4	**Section:** XI
Attachments Sharps Inventory Control Form XI.7.A (25) count Sharps Inventory Control Form XI.7.B (50) count Medical Instrument/Sharps Inventory Daily Count Form XI.7.C Dental Instrument/Sharps Inventory Count Form XI.7.D Medical Instrument Sign-Out Form XI.7.E Dental Instrument Sign-Out Form XI.7.F	**Related Standards & References** ACA Juvenile Healthcare Performance Based standards 2009: 4-JCF-4C-61
Effective Date: 06/09/06 **Revision Date: 03/01/07, 04/22/08, 06/26/09, 05/01/11 , 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that guidelines shall be established to address staff responsibilities for the secure storage, control and perpetual inventory of medical and dental instruments, supplies (syringes, needles, scalpel blades and other sharps) and other medical/dental materials that may pose a threat to the security of the facility. (4-JCF-4C-61)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

Closed Stock Inventory- inventory that is sealed, not in current use, and counted at least monthly.

Medical or Dental Instruments- durable equipment or instruments used for clinical procedures or medical and dental purposes. These instruments are the most secure class of tools and can only be used by health care personnel.

Medical or Dental Sharps- disposable equipment or instruments (i.e., needles, syringes with needles, scalpels) used for clinical procedures or medical and dental purposes. These sharps are the most secure class of tools and can only be used by health care personnel.

Open Stock Inventory- inventory that is opened, available for current use and is counted each shift or as indicated.

III. PROCEDURE

A. Medical and Dental Sharps Management: Health care personnel shall adhere to the following: (4-JCF-4C-61)

1. All medical and dental sharps shall be securely stored in locked cabinets located in the medical and dental areas. Only health care personnel shall have key access to these storage areas.

   a. All medical and dental sharps shall be counted through a continuous inventory listing.

   b. Upon receipt of medical and dental sharps, health care personnel shall count and verify all items. Medical and dental sharps are then repackaged and sealed in lots of twenty-five (25) or fifty (50) count. The item name and number counted is placed on the Sharps Inventory Control Form XI.7.A for twenty-five (25) count or XI.7.B for fifty (50) count.

   c. When a sharp is removed from open stock, the health care personnel shall sign out each sharp on the Sharps Inventory Control Form XI.7.A for twenty-five (25) count or XI.7.B for fifty (50) count. Discrepancy in any inventory count shall be reported immediately to the Director of Medical Services/designee.

   d. Nursing personnel shall count open stock inventory of medical sharps each shift. The nurse shall document on the Medical Instrument and Sharps Inventory Daily Count Form XI.7.C.

   e. Dental personnel shall count open stock inventory of dental sharps before and at the end of each dental clinic. Dental personnel shall document on the Dental Instrument and Sharps Inventory Count Form XI.7.D.

   f. The assigned nursing personnel shall inventory closed stock inventory using form XI.6.B Supply control monitoring form monthly to verify that the count on hand is correct. This form shall be forwarded to the Director of Medical Services/designee for review and signature.

2. Medical and dental sharps are considered potentially infectious and are handled with precautions. Refer to policy, XI.4, Medical Facilities, Equipment and Environmental Monitoring and XI.38, Exposure Control and Standard Precautions.

   a. Disposable sharps shall be placed in a puncture-resistant biohazardous container that shall be readily available and securely maintained.

   b. Needles, syringes with needles, or scale blades shall not be recapped, purposely bent, broken, removed from disposable syringes or otherwise hand manipulated.

c. When the puncture resistant container is full, the container shall be sealed and placed in a biohazardous storage box. The bio-hazardous storage box shall remain in a locked area until removed by an approved waste handler.

B. Medical Instrument(s) Management: Health care personnel shall adhere to the following: (4-JCF-4C-61)

1. All medical instruments shall be securely stored in locked cabinets located in the medical area. Only health care personnel shall have key access to storage areas.
2. Medical instruments shall be inventoried to verify count on each shift by nursing personnel. The assigned nursing personnel shall sign and date the Medical Instrument and Sharps Inventory Daily Count Form XI.7.C indicating accurate count.
3. Medical instruments used during the shift shall be signed-out by health care personnel. Medical Instrument Sign-Out Form XI.7.E shall be utilized when an instrument is removed from the locked cabinet.
4. An instrument that has been used that requires sterilization is placed in a covered container until re-sterilized. The container shall be placed in a locked area. Once re-sterilized, the health care personnel shall note on the Medical Instrument Sign-Out Form XI.7.E that the instrument is returned to inventory. Medical instrument not requiring sterilization shall be placed back in inventory and noted on this form.
5. Any discrepancy in medical instrument count shall be reported immediately to the Director of Medical Services/ designee. If the discrepancy is not resolved immediately, the Director of Medical Services/designee shall notify the Facility Administrator/designee.

C. Dental Instrument(s) Management: Dental personnel shall adhere to the following: (4-JCF-4C-61)

1. All dental instruments shall be securely stored in locked cabinets located in the dental area. Only health care personnel shall have key access to storage areas.
2. Dental instruments shall be inventoried on the Dental Instrument and Sharps Inventory Daily Count Form XI.7.D.
3. The Dentist shall be responsible to verify counts of all dental instruments at the beginning and end of each dental clinic. The dentist shall sign and date the Dental Instrument and Sharps Inventory Daily Count Form XI.7.D indicating accurate count.
4. Any dental instrument(s) removed from the dental clinic area shall be signed out on the Dental Instrument Sign-Out Form XI.7.F.
5. An instrument that has been used is placed in a covered container until re-sterilized. The container shall be placed in a locked area. Once re-sterilized, the dental personnel shall document that the instrument has been returned to inventory.

6. Any discrepancy in dental instrument count shall be reported immediately to the Director of Medical Services/designee. If the discrepancy is not resolved immediately, the Director of Medical Services/designee shall notify the Facility Administrator /designee.

D. Lost Medical or Dental Tools

1. When a medical or dental instrument is lost the Director of Medical Services/designee shall be immediately notified. The Director of Medical Services/designee shall notify the Facility Administrator /designee.
2. The staff discovering a broken medical or dental instrument shall notify the Director of Medical Services/designee. The broken medical or dental instruments shall be secured in the clinic until appropriate and secure disposal is made.

E. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Sharps Inventory Control

Item: _____

#	Date	Used	Wasted	Initials	#	Date	Used	Wasted	Initials
25					12				
24					11				
23					10				
22					9				
21					8				
20					7				
19					6				
18					5				
17					4				
16					3				
15					2				
14					1				
13									

Initials	Signature	Initials	Signature	Initials	Signature

Form Completed and filed by: _____
Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services
Oakley
Sharps Inventory Control

Item: _____

#	Date	Used	Wasted	Initials	#	Date	Used	Wasted	Initials
50					25				
49					24				
48					23				
47					22				
46					21				
45					20				
44					19				
43					18				
42					17				
41					16				
40					15				
39					14				
38					13				
37					12				
36					11				
35					10				
34					9				
33					8				
32					7				
31					6				
30					5				
29					4				
28					3				
27					2				
26					1				

Initials	Signature	Initials	Signature	Initials	Signature

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Medical Instrument and Sharps Inventory Daily Count Sheet

	Date			Date			Date			Date			Date			Date			Date		
Shift	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N
Medical Instruments and Sharps Inventory																					
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
7.																					
8.																					
9.																					
10.																					
11.																					
12.																					
13.																					
14.																					
15.																					
Signature & title																					

Code:	D = Day	E = Evening	N = Night

Mississippi Department of Human Services
Division of Youth Services
OYDC

Dental Instrument and Sharps Inventory Daily Count Sheet

	Date		Date		Date		Date		Date		Date	
Dental Instruments and Sharps Inventory	Inventory	Count	Inventory	Count	Inventory	Count	Inventory	Count	Inventory	Count	Inventory	Count
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
11.												
12.												
13.												
14.												
15.												
16.												
17.												
18.												
19.												
20.												
Dentist Signature	_____		_____		_____		_____		_____		_____	

Medical Instrument Inventory Sign-Out Form

Month: _____Year: _____

No	Medical Instrument or Number of Signed Out	Date Signed Out	Time Signed Out	Youth Name, if applicable	Nurses Signature	Date Signed In	Time Signed In	Nurses Signature
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Dental Instrument Inventory Sign-Out Form

Month: _____Year: _____

No	Dental Instrument or Number of Signed Out	Date Signed Out	Time Signed Out	Youth Name, if applicable	Dentists Signature	Date Signed In	Time Signed In	Dentists Signature
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Health Record: Structure, Documentation and Confidentiality**	**Policy Number: 8**
Number of Pages: 5	**Section: XI**
Attachments Interdisciplinary Progress Notes Form XI.8.A Health Records Index Form XI.8.B Medical Abbreviations for Nursing Services XI.8.C Vital Signs Form XI.8.D	**Related Standards & References** ACA Juvenile Healthcare Performance Based Standards 2009: 4-JCF-4C-07,4-JCF-4C-08,4-JCF-4C-31,4-JCF-4C-32,4-JCF-4C-33, 4-JCF-4C-41
Effective Date: 06/09/06 **Revised Date: 05/01/07, 02/04/08, 04/22/08, 02/25/09, 06/25/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that all youth have a health record. Guidelines shall be established to ensure that a structured health record is maintained on each youth admitted to Oakley. Information about a youth's health status is confidential. All employees are required to uphold the principle of confidentiality of the health records and support the following requirements:
(4-JCF-4C-31)

- All active health records shall be maintained separately from the confinement case records.
- Access to the health record shall be in accordance with state and federal law. The Director of Medical Services controls access to the health record.
- The Director of Medical Services shall approve the method of recording entries in the records, the forms and format of the records and procedures for their maintenance and safekeeping.
- The Director of Medical Services/designee, physician, dentist and/or psychiatrist shall share with the Facility Administrator information concerning a youth's medical management when necessary to preserve the health and safety of a youth, other youth, staff, volunteers, and/or visitors and within the guidelines of confidentiality. Information provided to staff shall address only the medical needs of the youth as they relate to housing, program placement, security, and transport.
  (4-JCF-4C-41)

The Director of Medical Services shall establish and approve the method of recording entries in the record, forms, and procedures for record maintenance and safekeeping.

The health record shall be made available to and shall be used for documentation by all health care personnel.
The health record file shall contain the following: (4-JCF-4C-32)

- Patient identification on each sheet;
- Receiving screening form;
- Health appraisal data and examination forms;
- Record of immunizations;
- Problem list;
- Diagnoses, treatments, and dispositions;
- Individualized treatment plan, when applicable;
- Progress reports;
- Place, date and time of health encounters;
- Record of prescribed medications and their administration records, if applicable;
- Laboratory, x-ray, and diagnostic studies;
- medical release summaries; and

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

Qualified Mental Health Professional (QMHP)- Qualified Mental Health Professional (QMHP)- include Psychologist, and licensed mental health professionals who by virtue of their education, credentials and experience are permitted by law to evaluate and care for the mental health needs of patients.

Health Record- The youth specific MDYS record that contains all medical, dental and psychiatric assessments, diagnoses, treatment summaries, clinic visits, progress noted, doctors' orders, laboratory reports, and any other information pertaining to the youth's medical, dental and mental health and treatment.

Narrative Charting Format- A format of documentation in the progress note. The narrative progress note includes at a minimum: complaint, assessment and treatment given.

Psychology Record- The youth specific MDYS record that contains pertinent mental health documentation

SOAP Charting Format- A format of documentation in the progress note. The progress note includes:

- *Subjective data:* Information the youth imparts, such as the chief complaint and other impressions.
- *Objective data:* Factual, measurable data gathered during the assessment process, such as observed signed and symptoms, vital signs, and laboratory test values.

- *Assessment data:* Conclusions based on the collective subjective and objective data and formulated patient problems and/or diagnosis. This dynamic and ongoing process changes, as more or different subjective and objective information becomes known.
- *Plan:* The strategy for relieving the youth's problem. The plan should include both immediate or short-term actions and long-term measures.

III. PROCEDURES

A. A health record shall be established upon admission on all youth. All medical related court documents shall be maintained within the youth's health record.

1. The active health record shall be maintained separate from the confinement case records.

2. The health record shall be maintained in a locked area in the medical department as a confidential document. Only health care personnel shall have key access to this area.

3. The health record shall be maintained under hard cover. The front outside cover shall be stamped "Confidential."

4. Medical information about a youth's health status is confidential and may be shared by approval of the Director of Medical Services in accordance with state or federal law. The following personnel may have designated and unimpeded access to the health records and/or information

   - Division Director
   - Director of Institutions
   - Facility Administrator
   - Internal investigative staff
   - Departmental and accrediting body audit staff
   - Departmental Legal Counsel or other attorneys representing the Division
   - Persons authorized by an order or judgment of a court with appropriate jurisdiction
   - Psychology staff and, qualified mental health professionals. This shall include any interns or psychiatry residents that are directly supervised by one of the professionals aforementioned.
   - Psychology staff and qualified mental health professionals shall record the health record reviews in the appropriate log book located in the health record file room located in the medical clinics.

5. All other access to medical information while the youth resides in a facility shall be governed by the following specifications:

   a. When a facility receives a written request for release of information from a Physician or medical facility in the community for continuity of care only, the written request must specify the information requested, be accompanied by a

release of information signed and dated by a parent, guardian or legal custodian, and include the name and address to whom the records are to be sent.

b. Health records shall be shared with the approval of the Director of Medical Services.

c. When a youth is released from a facility and requires medical follow-up, the nurse shall copy related medical information and send it to the health care provider for continuity of care.

d. Documentation of shared information shall be completed in the youth's health record, Interdisciplinary Progress Notes XI.8.A

B. Continuity of care shall be required from admission to release from the facility, including referral to community-based providers when indicated. (4-JCF-4C-07,4-JCF-4C-08)

1. A medical summary shall be completed, when appropriate, on all youth when released to maintain the provision of continuity of care. (4-JCF-4C-08)

2. Inactive health records shall be retained as permanent records in compliance with the legal requirements of the jurisdiction and are shared with the approval of the Director of Medical Services. Medical and mental health records shall be shared with specific and designated physicians or medical/mental health facilities in the community for continuity of care only when written request and authorization of youth's parent, guardian or legal custodian. The written request for release of information from outside sources must specify the address of the Physician or mental health agency to which the records are to be sent. (4-JCF-4C-33)

C. The health record structure shall be divided into the following sections and chart tabs:

- Immunizations
- Psychiatry Notes
- Psychology notes and tests results
- Health History
- Problem List
- Medication Administrative Records
- Medical Release Summary
- Dental Record
- Special Health Care Plans
- OB Records
- Physician Orders
- Interdisciplinary Progress Notes
- Informed Consent
- Injury Assessments
- Exams and Assessments
- Consultations and Reports
- Miscellaneous

1. The health record shall contain the youth's name, date of birth, admission date and allergies on the outside cover.

2. Filing shall be completed in reverse chronological order. Only approved forms shall be filed in the medical record. All forms shall be filed within twenty-four (24) hours of receipt.

3. Refer to the Medical Record Index Form XI.8.B for proper form maintenance.

4. The following psychology department forms shall be forwarded to the medical clinic in a timely manner to be filed under the psychology tab in section one of the health record.
    - Sleep logs
    - For youth on suicide precautions
        - Suicide interview form
        - Suicide re-assessment form

D. Physicians, Dentists, Psychiatrists and Nurses shall document in the youth's health record, Interdisciplinary Progress Notes Forms XI.9.A by using the SOAP or narrative format. Heath care personnel shall:

1. Document a straightforward chronological account of the patient status, the nursing interventions performed, and the patient response to those interventions. The Nurse shall record specific and descriptive notes whenever the following is observed:
    - A change in the youth's condition (progression, regression or new problems)
    - A youth's response to a treatment or medication
    - The youth's response to teaching

2. Document exactly what is heard, observed, inspected, done or taught. Include as much specific, descriptive information as possible.

3. Read the interdisciplinary progress notes written by other health care personnel prior to charting. Document an event immediately after it occurs.

4. Date, time and signature, including the title, of the individual who is charting all entries in the medical record.

5. Document the youth's name, date of birth, and living unit on each form/document.

6. Document allergies on the Doctor's Order Form, the Medical Administration Record, Interdisciplinary Progress Notes and where otherwise indicated.

7. Vital Signs Form XI.8.D is used to document the youth's temperature, pulse, blood pressure, oxygen saturation, and peak/flow meter.

E. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services

Oakley Youth Development Center

INTERDISCIPLINARY PROGRESS NOTES

Date & Time	Discipline	Document significant events during youth course of treatment, implementation of treatment plan, and response to treatment. SIGN AND TITLE ALL NOTES.

Youth Name: _____ **DOB**: _____ **Living Unit:** _____

Mississippi Division of Youth Services
Medical Services

Health Record Index

First Section	Second Section	Third Section	Fourth Section	Fifth Section	Sixth Section
Vital Signs Form (XI.8.D)	Medical Problems List Form (XI.20.A)	Medication Administration Records (MARs) Form (XI.30.A)	Medical Release Summary Form (XI.9.A)	Dental Record Form (XI.19.A)	Admissions Screening Form Welcome Letter Form (XI.13.D)
Growth Chart	Health Care Plans and Medical Instructions Form (XI.20.B)	Prescriptions		Dental X-Rays Bitewing & Pan	**Physician Orders Tab**
Immunization Tab	Nursing Care Plan Form (XI.20.D)	Medication/Treatment Refusal Forms (XI.30.C)			Doctors Orders Form (XI.14.A)
Immunization Form	Special Diet Request Form (XI.23.A)				**Progress Notes Tab**
TB Testing Record Form (XI.36.A)	Asthma Flow Sheet Form (XI.20.C)				Interdisciplinary Progress Notes Form (XI.8.A)
Immunization Records (School, Parents, Health Dept Web)					**Informed Consent**
Health Department Notification					Psychotropic Medications Form (XI.32.A)
Psychiatry Tab					**Injury and Assessments Tab**
Psychiatry Discharge					Youth Injury and Assessments Form (XI.26.A)
Psychiatry Progress Notes					**Exam and Assessmenrts**
Psychiatry Evaluation					Physical Examination Forms (XI.16.A.1& XI.16.A.2)
Treatment Team Notes					Nursing Intake and Assessment Forms (XI.15.A.1-4)
Psychology Tab					Hearing and Vision Screening Form (XI.15.C)
Admission Screening/ Testing					
Psychology Notes					
Typed Notes					**Consultations and Reports**
Therapy Notes					Medical Consultation Form (XI.25.B)
Suicide Assessments					Laboratory Reports
Risk Behavior Assessment					New ROI's (Medical Records Since Admit)
					Elective & Surgical Review Form (XI.11.B)

First Section	Second Section	Third Section	Fourth Section	Fifth Section	Sixth Second
Health History Tab					**Miscellaneous Tab**
Child Health Inventory					Allergy Release
Social History					Medical Transportation and Instructions Form (XI.25.C)
Medical Insurance Information					Letters to Parents
Court Related Medical Documents					
Past Medical Records					

Mississippi Department Human Services
Division of Youth Services

Medical Services

MEDICAL ABBREVIATIONS; NURSING SERVICE

A & 0 x 3	alert and oriented to person, place, and time
ā	before
@	at
abd	abdominal
a.c.	before meals
ad lib	as required
adm	admitted/admission
admin	administered
approx.	approximately
ASA	aspirin
ATC	around-the-clock
B	bilateral, bilaterally
BM	bowel movement
BP	blood pressure
BR	bed rest
BRP	bathroom privileges
b.i.d.	twice a day
B.S. X 4 quads.	bowel sounds present in all four abdominal quadrants
c̄	with
cap., caps.	capsule
cc	cubic centimeter
cm	centimeter
CTA	clear to auscultation
c\o	complains of
crm.	cream
DOB	date of birth
dc, D\C	discontinue
DDS	dentist
disp.	dispense
DSD	dry sterile dressing
dx.	diagnosis
EENT	eyes, ears, nose and throat
elix.	elixir
ED	emergency department
ER	emergency room
Etoh	alcohol
FROM	full range of motion
Gm.	gram

gr. _____ grain
GSW _____ gun shot wound
gtt., gtts. _____ drop, drops
f\u _____ follow-up
HA _____ head ache
HBV _____ hepatitis B virus
H_20_2 _____ hydrogen peroxide
HIV _____ Human Immunodeficiency Virus
H_20 _____ water
HOLD _____ hold (must document reason for hold)
hr. _____ hour
h.s. _____ bedtime
ht. _____ height
hx. _____ history
I.D. _____ intradermal
I.M. _____ intramuscular
I.V. _____ intravenous
LL _____ lower lobe (lung)
L., l. _____ liter
L (circled), Lt. _____ left
liq. _____ liquid
L.O.C., loc _____ level of consciousness
mcg. _____ microgram
meds. _____ medications
mEq. _____ milliequivalent
mg. _____ milligram
ml. _____ milliliter
M.O.M. _____ milk of magnesia
MMR _____ measles, mumps, and rubella
MVA _____ motor vehicle accident
N\A, n/a _____ not available
NG., N\G _____ nasogastric
NHC _____ nursing health call
NKA _____ no known allergies
NKDA _____ no known drug allergies
NPO _____ nothing by mouth
No., # _____ number
N/V/D _____ nausea, vomiting, and diarrhea
N/V _____ nausea and vomiting
0_2 _____ oxygen
O.D. _____ right eye
oint. _____ ointment
O.S. _____ left eye
OTC _____ over the counter
O.U. _____ each eye
oz. _____ ounce

$\overline{p}$ _____ after
p.c. _____ after meals
PCN _____ penicillin
PE _____ physical exam
PERRLA _____ pupils equal, round, reactive to light, accommodation
PMH _____ past medical history
p.m. _____ afternoon, evening
p.o. _____ by mouth
PPD _____ purified protein derivative of tuberculin
p.r. _____ per rectum
prn, PRN _____ as needed
PT _____ physical therapy
Q., q. _____ every
q.d. _____ every day
q.o.d. _____ every other day
q. (4, 6, 8, etc.) h. _____ every (4, 6, 8, etc.) hour
q.i.d. _____ four times a day
qt. _____ quart
Rt (circled), Rt. _____ right
R (circled) _____ refuse
RE _____ regarding
TB _____ tuberculosis
Td _____ tetanus-diphtheria
Tdap _____ tetanus, diphtheria Pertussis
Rec. _____ recreation
ROM _____ range of motion
RTC _____ return to clinic
Rx _____ prescription
$\overline{s}$ _____ without
S.C. _____ subcutaneously
S.L. _____ sublingual
S.O.B. _____ short of breath
SO per s/o _____ standing order
S.Q., Sub-Q _____ subcutaneously
s/p _____ status post
STAT _____ immediately
St. _____ strength
s/s _____ signs and symptoms
syr. _____ syrup
sx. _____ symptoms
TAO _____ triple antibiotic ointment
tab., tabs _____ tablet, tablets
t.i.d. _____ three times a day
tinc. _____ tincture
TO _____ telephone order
TPR _____ temperature, pulse, respiration

tsp. _____ teaspoon
tbs. _____ tablespoon
tx. _____ treatment
UA, u/a_____ urinalysis
vs _____ vital signs
vss _____ vital signs stable
WNL _____ within normal limits
wt. _____ weight
x _____ time
YIAF _____ youth injury assessment form
♀_____ female
♂_____ male
↑ _____ up, upper
↓ down, lower

Local Hospital Abbreviations:_____

_____

_____

Mississippi Department of Human Services
Division of Youth Services
Oakley Youth Development Center

VITAL SIGNS FORM

Date	Time	Temp	Pulse	Resp	B/P	Sats	Peak/ Flow	HT	WT	Waist Circ	Hip Circ	Nurses Initials

Initials	Nurses Signature

Initials	Nurses Signature

Youth Name: _____ **DOB:** _____ **Living Unit:** _____

Allergies: _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Medical Release Summaries**	**Policy Number: 9**
Number of Pages: 2	**Section: XI**
Attachments Medical Release Summary Form XI.9.A Release Log Form XI.9.B	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-08
Effective Date: 06/09/06 **Review Date: 04/28/08, 04/21/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services that in keeping with health records and confidentiality, standard procedural guidelines shall be established to ensure that medical release summaries are completed on all youth to maintain the provision of continuity of care. (4-JCF-4C-4C-08)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. Continuity of care shall be required from admission to release from the facility, including referral to community-based providers when indicated. A medical release summary shall be completed on all youth who are released. (4-JCF-4C-08)

1. When a youth is released from the facility the nurse shall complete the Medical Release Summary Form XI.9.A to maintain the provision of continuity of care. (4-JCF-4C-08)
2. The Nurse completing the Medical Release Summary Form XI.9.A shall place the form in the youth's health record. A copy shall be sent with the student upon discharge.
3. The Nurse completing the Medical Release Summary Form XI.9.A shall also document the following information in the youth's health record, Release Log Form XI.9.B and complete any required pharmacy documents and forms.

   - Interdisciplinary Progress Notes: Date of youth's release and Signature of nurse.

- Release Log Form XI.11.B, which is located in the Nurse's Station. The Nurse shall document the youth's name, date of birth, release date, medical release summary completed and if released on a medication.

4. The nurse shall refer to policy XI.30, Pharmaceutical Management and policy XI.31, Pharmaceutical Prescribing, Procurement, Administration and Documentation for requirements when a youth is released on medication/s.
5. The Nurse shall refer to policy XI.25, Medical Consultations and Hospitalization and policy XI.26, Emergency Medical Response and Services for Referral for continuity of care requirement from community-based providers.

B. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services - Division of Youth Services
MEDICAL RELEASE SUMMARY

Name: _____	**Institution:** Oakley Youth Development Center
DOB: _____ HT: _____ WT: _____	**Admission Date:** _____ **Release Date:** _____

Aftercare Medical Follow-up: Yes ☐ No ☐ N/A ☐	**Psychiatry Follow-up**: Yes ☐ No ☐ N/A ☐
Immediate ☐ Within 30 Days ☐ Advise Parents ☐	Immediate ☐ Within 30 Days ☐ Advise Parents ☐

Allergies: Yes ☐ No Known Allergies ☐ **Note: N/A = Not Applicable**

Allergy: _____/Symptom(s): _____

Allergy: _____/Symptom(s): _____

Current Medications: Yes ☐ No ☐ Comment: _____

Medication	Dose	Prescription	Refills	Prescription Distribution (Sent/Faxed/Given to Parent)
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	
		Yes ☐ No ☐ N/A ☐	No ____ Refills ____	

Parent's signature: (receipt of any Rx's and copy of this form): _____

Health Problems (history and current): Yes ☐ No ☐ _____

_____

_____

_____ Last Physical Exam Date: _____ Last Dental Exam Date: _____

_____

Medical/Dental Referral(s) Scheduled: Yes ☐ No ☐ _____

Medical/Dental Referral(s) Needed: Yes ☐ No ☐ _____

_____

_____

Immunizations: Please see attached Immunization Record

TB Skin Testing: Date: _____ Results: _____mm Chest X-Ray Date/Results (Positive PPD only): _____

Health Department Notified: Yes ☐ Date: _____ Location: _____ No ☐ N/A ☐

Vision: Visual Screen Date: _____ Screening Results: OD _____ OS _____ OU _____

Optometry Exam Date: _____ N/A ☐ Glasses: Yes ☐ No ☐ N/A ☐

Hearing: Right Ear: ☐ PASS ☐ FAIL LEFT EAR: ☐ PASS ☐ FAIL Audiologist Exam: ☐ YES ☐ NO ☐ N/A

Physical Aids: Yes ☐ List: _____ No ☐

Special Diet: Yes ☐ List: _____ No ☐

Nurse's Signature: _____ **Date:** _____

Mississippi Department of Hunan Services
Division of Youth Services
Medical Services

RELEASE/LOG

Oakley Youth Development Center

Youth Name	DOB	Release Date	Date Summary completed	Released on Rx.	Nurses Initials

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Medical Department Shift Report**	**Policy Number: 10**
Number of Pages: 2	**Section: XI**
Attachments Medical Department Shift Report Form XI.10.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-49
Effective Date: 06/09/06 **Revised Date: 03/01/07, 04/22/08, 05/01/11,08/15/13, 11/01/13**	**Approved:** James V. Maccarone **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that regarding health records and confidentiality, standard procedural guidelines shall established to provide for the information sharing between Nurses on youth who were assessed during each shift and/or youth who require follow-up care to maintain the provision of continuity of care and general clinic communications. (4-JCF-4C-49)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. Every day Nurses shall complete the Medical Department Shift Report Form XI.10.A. The form shall be located at the nursing station.

1. Nurses shall document on the Medical Department Shift Report Form XI.10.A the following:
   - Youth seen during unscheduled visits
   - All Emergency transports
   - Youth requiring follow-up evaluation or care
   - Other pertinent nursing shift communications

2. The Medical Department Shift Report Form XI.10.A shall be reviewed and signed by all on-coming Nurses.

B. The Director of Medical Services shall review all Medical Department Shift Report Forms XI.10.A and maintain the original copy in the Medical Department files. The current Medical Department Shift Report Forms shall be maintained at the nursing station.

C. The Director of Medical Services shall revise this policy as necessary.

MEDICAL DEPARTMENT SHIFT REPORT – CONFIDENTIAL

Date: _____ **Shift:** _____

Nurse(s): _____

_____

No. seen by Physician _____ No. seen by Psychiatrist: _____
No. seen by Dentist: _____ No. seen by Optometrist: _____
No. Seen by OB/GYN: _____

Unscheduled Youth Visits	Unit	Time	Complaints/Treatment	Charted	Nurses Initials
No. seen during Health Call				**Total:**	
No. seen during unscheduled visits				**Total:**	

Emergency Transport Youth Name	Location	Complaint/Treatment	Transport Mode	Parents Notified	HSA Notified

MEDICAL DEPARTMENT SHIFT REPORT

Youth Follow-ups

Nursing Shift Communications

Shift report reviewed by on-coming nursing staff:

Nurse(s): _____ **Date:** _____ **Shift:** _____

_____

Supplemental Page

Nursing Shift Communications

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Consent and Authorization to Treat**	**Policy Number: 11**
Number of Pages: 3	**Section: XI**
Attachments Release of Medical Information Form XI.11.A Elective Procedure and Surgical Review Form XI.11.B	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-10, 4-JCF-4C-44
Effective Date: 06/09/06 **Revision Date: 03/01/07, 07/01/07, 04/22/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that all informed consent standards in the jurisdiction are observed and documented for medical care. The informed consent of parent, guardian, or legal custodian shall be obtained where required by law. The youth, guardian, or legal custodian shall be informed about medical care in a language that is easily understood. When health care is rendered against the youth the care shall be delivered in accordance with state and federal laws and regulations. (4-JCF-4C-44)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Emergent care/procedure – Necessary for the physical/psychological well being of an individual and has to be provided in a particular time frame.

Non-Emergent care/procedure – Necessary for the physical/psychological well being of an individual but does not have to be provided at a particular point in time.

Elective (Cosmetic) care/procedure- Not necessary for the physical/psychological well being of an individual. Procedure is desired by an individual for a perceived flaw that in actuality may not exist.

III. PROCEDURE

A. Health care personnel shall inform the youth in a language that is easily understood prior to initiation of medical, dental or psychiatric care and treatment. (4-JCF-4C-44)

1. Documentation of the condition and proposed medical, dental or psychiatric treatment shall be made in the youth's health record, Interdisciplinary Progress Notes XI.8.A by the facility Physician, Dentist or Psychiatrist.

2. The health care personnel shall complete a Medication/Treatment Refusal Form, XI.30.C to document a youth's refusal of treatment.

   - The Nurse shall immediately notify the Director of Medical Services/designee, the Facility Administrator and the Physician of the youth's refusal when there is clear danger to the health and well being of the youth or that of the general youth population. The Facility Administrator shall consult with the Division Director for guidance on possible course(s) of action.

B. Emergency Medical and Surgical Services

If an immediate life-threatening situation exists, the medical staff, with authorization from the Facility Administrator/designee, shall ensure that necessary medical services are provided. (4-JCF-4C-44)

1. When a youth is in need of emergency treatment, the Nurse shall call and notify the emergency room at the appropriate hospital.

   a. It is the responsibility of the Director of Medical Services/designee to notify the Facility Administrator/designee.

   b. The Facility Administrator/designee is responsible for authorization of treatment not approval for the emergency referral.

   c. The Facility Administrator/designee, health care personnel or designee shall inform the youth's parent, guardian, or legal custodian in a language that is easily understood when emergency medical services are required. Refer to policy XI.12, Medical Notification of Designated Individuals.

C. Surgical Procedures (Non-Emergent or Elective {Cosmetic})

The Director of Medical Services/designee shall inform the youth's parent, guardian, or legal custodian in language that is easily understood for non-emergent or elective surgical intervention consent. Documentation of the conversation with the youth's parent, guardian or legal custodian shall be noted in the youth's health record, Interdisciplinary Progress Notes XI.8.A.

1. When an elective {cosmetic} surgical procedure is recommended post evaluation by the contract physician and/or a specialist, refer to the Surgical Review Form XI.11.B. (4-JCF-4C-10)

2. If the parent/guardian has questions regarding permission to be present for the procedure refer phone call to Facility Administrator/designee.

3. The Facility Administrator/designee, by court order is the youth's designated legal guardian; the consent for treatment/surgery will be presented to the Facility Administrator for signature.

   a. The nurse present shall sign as the witness and fax the consent form to the surgeon/surgery center.

   b. The consent form shall be maintained in the youth's health record.

D. Medical/Dental Appointments/consults

The facility Physician/Dentist shall write an order when a youth needs to be scheduled for an off-campus medical/dental appointment.(4-JCF-4C-44) The Facility Administrator/ designee is responsible for authorization for treatment not approval of the appointment.

E. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Health Services

Oakley Youth Development Center- Health Clinic

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient listed below to:

Requestor Name: Oakley Medical Clinic
Requestor Address: 2375 Oakley Road
Raymond, Ms 39154
Phone Number: 601-857-7647 Fax Number: 601-857-5469

Patient Name:_____

Patient DOB:_____

Patient Social Security Number:_____

Patient Address:_____

Disclose the following PHI for treatment dates _____ to _____
_____Abstract/Pertinent____History & Physical____Discharge Summary_____X- Ray____Operative Report
_____Progress Notes_____Physicians Orders_____Consult_____Nurses Notes_____ ER Report
____Lab _____Entire Chart _____Other Specified _____

The above information is disclosed for the following purpose: **Continuation of medical and psychiatric care while at Oakley Youth Developmental Center.**

_____I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug abuse, psychiatric, HIV, or genetic information.

This authorization shall expire on this date:_____***If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present written to Oakley Youth Development Center. I understand that the revocation will not apply to information that has already been released to the authorization.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected. I authorize the disclosure of the PHI as stated.

_____
Signature of Legal Representative/ Relationship to patient: Guardian Date

_____
Signature of Witness Date

Mississippi Department of Human Services
Division Youth Services
Medical Services

PROTOCOL FOR ELECTIVE PROCEDURES AND/OR SURGICAL REVIEW

Non-Emergent or Elective Surgical Procedures require pre-authorization, or approval, by the facility physician, similar to any managed care system. The guidelines that govern elective procedures or surgeries are not controversial and favor those procedures needed to correct a substantial functional deficit or a pathological process that threatens the well-being of the Juvenile. The following steps are completed:

Step 1 Appropriate subspecialty consultation is obtained.

- The specialist documents a diagnosis and treatment plan on the Consultation Form XI.25.B.
- If a non-emergent procedure or surgery is recommended post evaluation, the specialist shall designate whether the procedure or surgery is elective or cosmetic.

Step 2 The facility Physician shall review the Consultation Form. A recommendation based on the review, patient symptoms, and findings noted in the youth's medical record is made.

Step 3 The Health Services Supervisor or designated nurse shall notify the Health Services Coordinator of the elective procedure or surgical request.

Step 4 The Health Services Coordinator shall review the elective procedure or surgery to determine:

- If said Juvenile would be otherwise adversely affected during his/her stay in a MDYS Facility;
- If the time period remaining before youth release is small enough to allow service to be preformed in the community;
- If the elective procedure or surgery is Cosmetic or Experimental;
- If the youth has received disease based health education; and
- If the youth's parent or legal guardian has been notified of the necessary community medical or surgical appointments or referrals.

Step 5 After reviewing the consultation documentation the Health Services Coordinator in consultation with the facility physician shall make a discussion to complete the elective procedure or surgery.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Medical Notification of Designated Individuals**	**Policy Number: 12**
Number of Pages: 2	**Section: XI**
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-42, 4-JCF-4C-43
Effective Date: 06/09/06 **Revision Date: 05/01/07, 04/22/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that prompt notification is provided to a youth's parent, guardian, responsible agency, or the legal custodian in case of serious illness, surgery, major incident resulting in injury that requires medical care or treatment outside the facility, or death. (4-JCF-4C-42, 4-JCF-4C-43)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. Whenever a youth becomes seriously ill, is injured and requires medical care or treatment outside the facility, or requires surgery, the Facility Administrator/designee shall promptly notify the youth's parent, guardian, responsible agency, or legal custodian. (4-JCF-4C-42) The Facility Administrator/designee is responsible for notifying the DYS Director.

1. The Facility Administrator/designee shall refer all questions of a medical nature that the parent, guardian, or custodian may have to the Director of Medical Services/designee.

2. The nurse shall document in the youth's health record, Interdisciplinary Progress Notes XI.8.A, any conversation with the youth's parent, guardian, responsible agency, or legal custodian.

3. If telephone notification unsuccessful; the youth's counselor shall be notified to assist with the efforts to notify the youths parent, guardian, responsible agency, or legal custodian.

B. When significant medical treatment is refused by the youth; the parent, guardian, custodian of the youth is notified by telephone. The Administrator/designee shall receive verbal notification of the refusal from the Director of Medical Services/designee

1. Documentation of the nurse's telephone conversation with the youth's parent, guardian, responsible agency, or legal custodian is noted in the youth's health record, Interdisciplinary Progress Notes XI.8.A.

2. If telephone notification unsuccessful; the youth's counselor shall be notified to assist with the efforts to notify the youth's parent, guardian, custodian.

C. In the event a youth dies while in the custody of DYS, the Facility Administrator/ Director of Institutions, DYS Division Director shall ensure that the parent, guardian, responsible agency, or legal custodian is notified promptly, as soon as reasonably possible.
(4-JCF-4C-42)

D. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Access to Health/ Mental Health Care**	**Policy Number: 13**
Number of Pages: 4	**Section: XI**
Attachments Health Call Form XI.13.A Health Call Log XI.13.B Physician Health Call Referral Log XI.13.C Welcome Letter Form XI.13.D	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-05, 4-JCF-4C-06, 4-JCF-4C-36, 4-JCF-4C-40, 4-JCF-4C-46
Effective Date: 06/09/06 **Revision Date: 03/01/07, 04/16/08, 07/2/09,05/01/11,11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to provide a mechanism for unimpeded access to health care and for a system for processing concerns and/or complaints regarding health care. This mechanism shall be communicated orally and in writing to youth on arrival at each facility, and conveyed in a language that is easily understood by each youth. When literacy, language problem, or physical handicap prevents a youth from understanding oral and written information, a staff member or translator shall assist the youth. (4-JCF-4C-05, 4-JCF-4C-40)

There shall be a process in place for all youth to initiate requests for health services daily. The Health Call Form XI.13.A shall be readily available to all youth. Requests shall be monitored and responded to daily. (4-JCF-4C-06) Decisions to refer students off campus for consultations shall be the sole province of the physician or dentist and not countermanded by non-health care personnel. (4-JCF-4C-36)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice Nursing, Medicine, Dentistry, or Psychiatry.

Health Call: A system of structured inquiry and observation, by health care personnel, designed to assess and provide treatment for the youth.

III. PROCEDURE

A. The Director of Medical Services shall develop a facility specific instruction sheet that educates youth to the process of accessing medical, mental health and dental services upon their arrival to the facility. (4-JCF-4C-05) This form Welcome Letter XI.13.D shall be signed by the youth and is maintained in the health record.

1. These instructions shall be provided both orally and in written form conveyed in a language that is easily understood during the intake process. (See Policy XIII.1)

   a. The written form shall be provided to all youth at their initial medical/dental screening.

   b. Each youth shall sign and date this form acknowledging receipt of the instructions.

   c. This form then shall be filed in the youth's health record.

2. When literacy, language problem, or physical handicap prevents a youth from understanding oral and written information, a staff member or translator shall assist the youth.

B. Youths' medical concerns are monitored and responded to daily by health care personnel. Facility staff shall not prevent a youth's access to health care. (4-JCF-4C-05)

1. Scheduled Health Call for non-emergency health care needs, conducted by qualified health care personnel in the medical clinic, shall be available to each youth daily. (4-JCF-4C-06).
   When a physician does not conduct Health Call, a physician shall be available at least two (2) days per week to respond to youth concerns and/or complaints regarding service that they did or did not receive from other health care personnel (4-JCF-4C-06)

   a. Youth requesting to be seen by health care personnel for non-emergency medical services shall sign-up for Health Call with any health-related concern or complaint.

   b. The Health Call Form XI.13.A shall be located on each living unit and readily accessible to the youth. Medical department staff shall be responsible for maintaining blank health call forms and facility staff shall be responsible for ensuring the forms are available to youth daily.

   c. Each youth shall sign his/her name and health concern or complaint to the Health Call Form XI.13.A to access scheduled health call.

   d. Youth shall place the Health Call Form XI.13.A in an envelope marked "Medical" and place in the medical/grievance drop box, located on each living unit. If a medical drop box is not available on the living unit, the Juvenile Care Worker (JCW) shall submit the Health Call Form XI.13.A to a nurse.

e. The youth's name, who signed up for health call, is placed on the Health Call Log Form XI.13.B by the nurse. This log is used for tracking and statistical purposes.

f. Following nursing assessment and triage performed in the medical clinic, Non-emergent or non-urgent youth requests shall be referred to scheduled healthcare practitioner clinics. All health care requests of an urgent or emergent nature shall be addressed in a timely manner.

g. The Nurse assessing the youth's concern or complaint and subsequent treatment shall document in the youth's health record, Interdisciplinary Progress Notes XI.8.A.

h. Any youth referred to be seen by the healthcare practitioner shall be placed on the appropriate Health Call Referral Log XI.13.C

i. Any youth who requests to see the Psychiatrist via the health call form shall be referred first to counseling and/or psychology staff for evaluation.

i. All other campus-based referrals to the Psychiatrist must be approved by the appointed qualified mental health professionals,

ii. And a completed referral form must be provided before the appointment is made. Form XI.13.D.

2. Youths in non-medical isolation shall have access to medical care and such placement shall not adversely effect their medical treatment. The youth in isolation may complete a health call form and shall be transported to the medical clinic for triage and treatment. (4-JCF-4C-46)

The Director of Medical Services shall ensure provision of, and access to, health call for youth in isolation. This facility specific procedure shall address:

a. Health call forms shall be maintained on the unit which houses youth in isolation.

b. Timely assessments appropriate to the individual health care needs of each youth in isolation.

c. If a physical assessment is warranted the youth shall be transported, securely to the medical clinic.

d. Documentation of the nurse's assessment shall be noted in the Interdisciplinary Progress Notes.

C. Youth complaints regarding health care services shall be handled by the facility grievance officer/designee personnel refer to DYS policy XV.2 Youth Grievance. (4-JCF-4C-40)

D. Special Medical/Dental consultations ordered by the responsible clinician shall not be countermanded by non-health care personnel.

1. All clinical decisions belong to the clinicians.
2. Any consultation deemed "necessary" by a clinician shall be provided by a community provider.
3. If the community provider consultation results in the recommendation of an elective procedure or diagnostive test, the procedure outlined in policy XI.11 Consent and authorization to treat shall be followed to gain approval. The Facility Administrator must approve all elective, non-emergent procedures.

D. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Health Call Form

ALLERGIES:_____

Date:_____**Time:**_____

Name:_____

Living Unit:_____**DOB:**_____

What is wrong with me:_____

_____

_____

_____

Student Signature:_____

See Interdisciplinary Progress Notes for assessment and treatment documentation.

_____

Nurse Signature /Title Date Time

Mississippi Department of Human Services
Division of Youth Services
Medical Services

HEALTH CALL LOG

Youth Name	DOB	Date Youth Signed up	Date/Time Seen by Nurse	Charted	Nurse Comment
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	
				Initials _____	

Mississippi Department Human Services
Division of Youth Services
Medical Services

PHYSICIAN HEALTH CALL REFERRAL LOG

Youth Name	DOB	Date Entered by Nurse	Reason for Referral	Date Seen by MD	Comment

Welcome From Medical Staff

Welcome to Oakley Youth Development Center, The Health Services staff wants to make sure that you understand how to let us know when you are sick and want to see the Nurse, Doctor, Dentist, Psychiatrist, or Psychologist. Health Call Forms are available in each cottage or pod, and all areas visited often by students.

This is what you need to do. Write your name and how you are feeling or what is wrong with you on one of the Health Call Forms, put it in an envelop that has HEALTH CALL or MEDICAL on the front and drop into one of the secure drop boxes.

Health Calls will be addressed at the nurses' discretion beginning as early as morning medication time.

It is very important that unless it is a true emergency you stay in school and visit the clinic during health call only.

If it is an emergency then tell the staff person you are with at the time and they will call the clinic for you.

Here at Oakley, we a have a medical doctor, dentist, psychiatrist, psychologist and nurses to take care of all of your health and mental health needs.

Please sign this form so that the staff knows that you understand how to get your health and mental health care needs taken care of.

Signed: _____ Date:_____

Witness: _____ Date: _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Administration of Medical Treatment**	Policy Number: **14**
Number of Pages: **3**	Section: **XI**
Attachments Doctor's Order Form XI.14.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-10
Effective Date: 06/09/06 Revised: 03/01/07, 04/22/08, 05/01/11, 08/15/13, 11/01/13	Approved: James V. Maccarone, Director

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to provide treatment by health care personnel other than a physician, dentist, psychiatrist, or other independent provider pursuant to written standing orders, medical protocols or direct orders by personnel authorized by law to give such orders. (4-JCF-4C-10)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Medical Order: A written or telephone order by a licensed physician/dentist/psychiatrist written on the Doctor's Order Form containing over-the-counter's (OTC) and prescription drugs.

Medical Protocol: Treatment for a specific condition; activated in an emergency situation; may contain both OTC's and prescription drugs, when approved by a physician.

Standing Orders: A listing of preferred treatment for a specific condition, approved by a physician/dentist/psychiatrist, containing over-the-counter (OTC) medication only

III. PROCEDURE

A. Medical/Dental/Psychiatric Orders (4-JCF-4C-10)

1. The contract physician, dentist, or psychiatrist on the Doctor's Orders Form XI.14.A shall document all written medical orders. Doctor's orders shall be in compliance with state and federal drug laws.

2. All verbal orders from a physician, dentist, or psychiatrist shall be limited to telephone orders. These orders shall be signed on the practitioner's next site visit.

The nurse initiating a telephone order shall ensure the following is documented in the youth's health record, Doctor's Orders Form XI.14.A and Interdisciplinary Progress Notes XI.8.A:

- Date and time of call
- The name (last name, first name) and title of the person called
- The order given by the person called
- Treatment initiated after the call
- Signature of person taking the call

3. Nurses shall ensure that orders are transcribed properly. Refer to MDYS Policies XI.30-Pharmaceutical Management, and Prescribing Procedures and Documentation, for documentation requirements and medical order transcription guidelines.

B. Standing Orders (4-JCF-4C-10)

1. The contract physician/dentist/psychiatrist shall develop standing orders. These orders, developed within the guidelines of applicable state laws, are activated by licensed nurses for treating specific medical problems in the absence of the facility's contract physician.

   a. Standing orders shall be reviewed with the contract physician/dentist/psychiatrist annually changes shall be made as needed.

      The contract physician/dentist/psychiatrist's signature shall be on the last page of the orders.

   b. Standing orders shall be reviewed with each licensed nurse annually and as orders are updated.

   c. A copy of the standing orders shall also be located at the Nurses Station.

   d. Any medical complaint not covered by standing orders shall be referred to the appropriate practitioner for evaluation and treatment.

   e. All standing orders shall be reviewed and revised annually by the contract physician/dentist/psychiatrist and the Director of Medical Services.

2. Nurses shall ensure that standing orders are processed properly. Refer to MDYS Policy XI.30, Pharmaceutical Prescribing, Procurement, Administration, and Documentation Procedures for documentation requirements and order transcription guidelines.

C. Medication or treatment recommendations from consulting physicians shall be approved, disapproved, or changed by the appropriate facility physician. If the practitioner is not present in the facility, he/she shall be notified by phone for a telephone order. The practitioner shall sign the order on their next visit to the facility.

1. When a youth is received on medication and/or a prescribed treatment, the current order shall continue pending a physician/dentist/psychiatrist review. The nurse shall notify the facility physician/dentist/psychiatrist with any questions regarding the current order. The physician/dentist/psychiatrist shall be responsible for continuing, discontinuing or "holding" the prescribed medication or treatment.

2. Refer to MDYS Policy XI.30, Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures for documentation requirements and order transcription guidelines.

E. The Director of Medical Services shall revise this policy as necessary.

Name: _____

DOB: _____ **Living Unit**: _____

Drug and/or Food Allergies: Yes ☐ No ☐

_____

_____

MISSISSIPPI DEPARTMENT HUMAN SERVICES
DIVISION OF YOUTH SERVICES

DOCTOR'S ORDER SHEET

Date Order Written	Time Order Written	ORDERS (Note: Stopping of an order is to be written as a specific new order. When restarting a Medication it must be written as a new order)

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Admission Health Screening and Assessment**	**Policy Number: 15**
Number of Pages: 5	**Section: XI**
Attachments Nursing Intake FormXI.15.A Admission Log XI.15.B Hearing / Vision Screen Form XI.15.C Medical Record Request Log XI.15.D Initial Admission Screening Tool XI.15.E	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-01, 4-JCF-4C-16, 4-JCF-4C-41
Effective Date: 06/09/06 **Revision Date: 03/01/07, 04/16/08, 09/10/08 ,05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services that an intake medical, dental and mental health screening commences upon the youth's arrival at the facility by health care personnel.

The responsible physician/dentist/psychiatrist in cooperation with the Health Authority establishes written procedures and screening protocols. All findings shall be recorded on a form approved by the Director of Medical Services. The Nursing Intake Form XI.15.A includes at least the following: (4-JCF-4C-01)

Inquiry into and assessment:

- History of chronic illness and serious infectious or communicable diseases, including symptoms and treatment;
- Obstetrical/Gynecological history and current pregnancy status;
- Use of alcohol and other drugs, including types of drugs used, mode of use, amounts used, frequency used, date or time of last use;
- Current illness and health problems, including infectious or communicable diseases;
- Current medications;
- Current or history of dental problems;
- Surgery History
- Hospitalization History
- Family Health History
- Physical Description
- Identifying Marks
- Allergies
- Recording of height, weight, and vital signs (pulse, blood pressure, pulse oximetry and temperature);

- The possibility of pregnancy;
- Mental health problems including history of self-injurious and/or suicidal behavior, inpatient and outpatient psychiatric treatment, alcohol and other drug use, and/or treatment for alcohol and other drug use; current suicide ideation, mental health complaint, treatment for mental health problems, and/or prescribed psychotropic medication.

Observation of:

- Behavior, including state of consciousness, mental status, general appearance, conduct, tremor, and sweating;
- Body deformities and ease of movement;
- Condition of skin to include any trauma markings, bruises, lesions, jaundice, rashes and infestations, recent tattoos, and needle marks or other indications of drug abuse; and
- Current symptoms of psychosis, depression, anxiety, and/or aggression.

Disposition of youth:

- Cleared for general population;
- Cleared for general population with appropriate referral to medical and/or mental health services;
- Referral to appropriate medical and/or mental health care service for emergency treatment; and/or
- Youths, who are semiconscious, bleeding, or otherwise obviously in need of immediate medical attention upon admission, are directed to an emergency department or personal physician. When they are referred to an emergency department, their admission or return to the facility is dependent on written medical clearance from the emergency department's physician report.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

III. PROCEDURE

A. At the time of intake to the facility, each youth shall receive a health screening and health history by nursing personnel. This shall be documented on the Nursing Intake form XI.15.A. (4-JCF-4C-01)

The nurse shall also place the youth's name on the Admission Log XI.15.B

1. The admission nurse shall also document the youth's arrival and any significant medical findings in the youth's health record, Interdisciplinary Progress Notes XI.8.A

2. The admission nurse shall complete a female health history on all female youth admitted.

   A urine pregnancy test upon arrival, seven (7) days after admission and the day of parole shall be performed.

3. Youth presenting with medical, dental and mental health findings shall be referred to the facility physician, dentist, psychiatrist, for a timely evaluation and/or emergency treatment. (4-JCF-4C-01)

   a. Indications of a significant level of psychological distress in a youth shall result in immediate referral to mental health staff.

   b. Positive responses to questions concerning suicidal/homicidal ideation shall result in immediate referral to mental health staff for a risk assessment pursuant to the Policy Suicide Prevention and Response.

   c. Youth who are currently taking or are supposed to be on psychotropic medication shall be referred to and be seen by the psychiatrist within seven (7) business days.

      i. Any youth who arrives with a current supply of medications, the medication shall be continued, using the medications brought by the student (after an identification of the medications is completed) until which time the student is evaluated by the psychiatrist and a decision is made to either stop, continue or change the medication.

      ii. If a student claims to be currently on psychotropic medication yet brings no medication or prescription a phone call shall be made to the parent/guardian for confirmation. Then if appropriate a phone call will be made to a facility psychiatrist for orders.

4. The admission nurse reviews all health records that are received from the Court, parent or guardian.

   a. If the necessary medical information is not received from the Court, the clinic staff shall be responsible for contacting the community counselor and requesting this documentation. Documentation of this request is noted in the youth medical record, Interdisciplinary Progress Notes.

   b. Immunization history shall be printed from the Mississippi Department of Health Immunization website. Refer to policy XI.36, Immunization Program

   c. Pertinent medical, dental and psychiatric records shall be ordered by; completing a Release of Information Form XI11.A, documented on the medical records request log (Form XI.15.D) a follow up request sent in 14 days if records not received.

5. Vision screening shall be completed by nursing personnel on all youths during the intake process. The nurse completing the screen shall document results on the Hearing and Vision Screening Form XI.15.C. Refer to policy XI.18, Optometry Services.

   a. When a referral is made by the facility physician refer to policy XI.25, Medical Consultation and Hospitalization.

   b. The facility physician shall review, sign and date the Hearing and Vision Screening Form.

   This form shall be maintained in the youth's medical record.

6. Hearing screening shall be completed by nursing personnel on all youths during the intake process. The nurse completing the screen shall document results on the Hearing and Vision Screening Form XI.15.C.

   a. The facility physician shall review, sign and date the Hearing and Vision Screening Form.
   This form shall be maintained in the youth's medical record.

      i. If the youth fails any part of the hearing screen, the test must be repeated in 2 (two) weeks.

      ii. If the youth fails any part of the repeat hearing screen, the nurse who performed the hearing screen shall present the health record to the facility contract physician for appropriate referral.

   b. When a referral is made by the facility physician refer to policy XI.25, Medical Consultation and Hospitalization.

7. Dental screening shall be completed by nursing personnel on all youths during the intake process. Refer to policy XI.19, Dental Screening and Examination.

B. The Director of Medical Services/designee shall be notified when a youth reports any of the following conditions, regardless of the youth's condition, upon admission:

- Asthma requiring scheduled medications
- Blood Disorders
- Cardiovascular Disorders
- Cancer
- Diabetes
- Hepatitis A, B, or C
- Hypertension
- Immunodeficiency
- Pregnancy
- Recent Head Injury (actual or suspected)
- Renal Disorders
- Seizure Disorder
- Severe Allergies

- Other severe chronic or critical medical conditions requiring close medical supervision
- History of Tuberculosis or currently undergoing treatment (youth with symptoms of active disease shall not be placed in general population until procedures have been followed to determine whether additional clinical testing is necessary).

The nurse shall initiate the Medical Problem List Form XI.20.A, when a youth presents with a chronic problem as outlined above. Refer to policy XI.20, Special Health Needs Programs and Health Care Treatment Plans.

C. Upon arrival at the facility, all youth shall be informed about how to access health services. This information shall be communicated orally and in writing to youths on arrival at the facility, and conveyed in a language that is easily understood by each youth. When literacy, language problem, or physical handicap prevents a youth from understanding oral and written information, a staff member or translator shall assist the youth. Documentation of instructions given shall be maintained in the youth's health record. (4-JCF-4C-05) Refer to policy XI.13, Access to Health/Mental Health Care.

D. Directions for facility personnel regarding their roles in the care and supervision of the youth is in written form. The nurse shall complete the Health Care Plan and Medical Instructions Form and distribute to all appropriate staff areas. (4-JCF-4C-16) The nurse shall only provide information to staff that address the medical needs of the youth as it relates to housing, programming, placement, security, and transport. (4-JCF-4C-41) Refer to policy XI.20, Special Health Needs Programs and Health Care Treatment Plan.

F. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES

NURSING INTAKE FORM

Name: _____	**Admission Date:** _____ **Completion Date:** _____
DOB: _____ **Commitment Number:** _____	**County:** _____
Social Security Number: _____	**Previous Commitment(s):** Yes ☐ No ☐
	Date of Last Parole: _____

Male ☐ **Female** ☐ **Ethnicity:** _____ **Religion:** _____

Emergency Notification:

Name: _____ Relationship: _____ Phone (____)_____ Other (____)_____

Address: _____ City _____ State _____ Zip Code _____

Vital Signs:

Temp: _____ O2 sat_____ Pulse: _____ Respirations: _____ BP: _____/_____

Physical Description: Hair Color: _____ Eye Color: _____ Height: _____ Weight: _____

ANATOMICAL FRONT	ANATOMICAL BACK	ANATOMICAL NOTATION
		_____
		_____
		_____
		_____
		_____
		_____
		_____
		_____
		_____

Graphic: **A**=Abrasion, **B**=Birthmark, **B2**=Burn, **B3**=Bruise, **C**=Cut, **K**=Keloid, **L**=Lesions, **N**=Needle Marks, **R**=Rash, **S**=Scar, **S2**=Scratches, **S3**=Sutures, **T**=Tattoo

Food and/or Drug Allergies: Yes ☐ No ☐ Don't Know ☐

Allergies:			
Symptoms:			

Current Medications: Yes ☐ No ☐ (Drug, Dose, Frequency, Duration, Reason & Last Dose): Medications brought with Youth: Yes ☐ No ☐

Dental Screening: Last Dental Visit: _____ Visual Screening Completed: Yes ☐ No ☐ Current Complaints: Yes ☐ No ☐

Nurse Signature: _____ Date: _____ Time: _____ Physician's Initials _____

Name: _____

DOB: _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES

Nursing Intake Form

Hospitalizations/Surgeries: Yes ☐ No ☐ Don't Know ☐ (Reason, Hospital and/or Surgery Date)

Health History: (Check the Problems that Apply with a **P** for Past, **C** for Current or **NA** for Not Applicable)

No	Problem List	P/C/NA
1	Anemia/Blood	
2	Asthma/Respiratory Disorders	
3	Bedwetting/UTI/ Kidney Problems	
4	Body Deformities/ Physical Disability	
5	Cancer	
6	Chicken Pox	
7	Constipation/Diarrhea/Colitis/Ulcers	
8	Diabetes	
9	ENT Problems (Hearing Loss)	
10	Eye Problems (Vision Loss)	
11	Fainting/Dizziness	

No	Problem List	P/C/NA
12	Fractures	
13	Headaches (Frequent/Severe)	
14	Head Injuries (Concussion)	
15	Heart Condition/Murmur	
16	Hemophilia	
17	Hemorrhoids	
18	Hernia	
19	Hypertension	
20	Joint Discomfort/Ease of Movement	
21	Arthritis	
22	Liver Disease/ Hepatitis	

No	Problem List	P/C/NA
23	Scoliosis	
24	Seizure Disorder	
25	Sickle Cell (Trait/Anemia)	
26	Skin Conditions/Acne	
27	HIV/AIDS	
28	Sexually Transmitted Diseases	
29	Thyroid Disorder	
30	Tuberculosis (Disease/Infection)	
31	Other	
32	Sexual Intercourse: Yes ☐ _____ No ☐ If Yes: Protected ☐ Unprotected ☐	

Comments (by number):

Mental Health Screening:

Yes ☐ No ☐ History of Psychiatric Disorder — Diagnosis: _____
Yes ☐ No ☐ History of inpatient mental health treatment — Where: _____
Yes ☐ No ☐ Current mental health complaint/treatment — **For:** _____
Yes ☐ No ☐ History of outpatient mental health treatment — Where: _____
Yes ☐ No ☐ History/Current thoughts of Suicide — Comment: _____

Substance Use Screening: Use of alcohol and other drugs, including type, mode, amounts, frequency and date last time used.

Family History: (Parent, grandparent, sibling had any of the following)

Condition		Relative
Asthma	Yes ☐ No ☐ Don't Know ☐	
Bleeding Disorder	Yes ☐ No ☐ Don't Know ☐	
Cancer	Yes ☐ No ☐ Don't Know ☐	
Diabetes	Yes ☐ No ☐ Don't Know ☐	
Heart Trouble	Yes ☐ No ☐ Don't Know ☐	
High Blood Pressure	Yes ☐ No ☐ Don't Know ☐	

Condition		Relative
Liver Disease	Yes ☐ No ☐ Don't Know ☐	
Psychiatric Disorder	Yes ☐ No ☐ Don't Know ☐	
Seizures	Yes ☐ No ☐ Don't Know ☐	
Sickle Cell Anemia	Yes ☐ No ☐ Don't Know ☐	
Stroke	Yes ☐ No ☐ Don't Know ☐	
Tuberculosis	Yes ☐ No ☐ Don't Know ☐	

Nurse Signature: _____ Physician's Initials _____

Name: _____
DOB: _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES

Nursing Intake Assessment Form

General Observation and Assessment:

1. Visible signs of trauma, abuse or illness requiring immediate medical intervention: Yes ☐ No ☐

If yes, describe:

2. Presence of fever, swollen lymph glands, jaundice, rash, or any other signs of infection or parasitic infestation: Yes ☐ No ☐

If yes, describe:

3. **Behavior** (verbal interaction, mental status, appearance, conduct, tremor, and sweating) **and/or General Comments**:

4.

Assessment	**Documentation**
Level of Consciousness (LOC)	
Breath Sounds	
Heart Sounds	
Abdomen	
Skin Turgor	
Peripheral Pulse	
Range of Motion (ROM)	

5. **Additional Comments**:

- **Youth instructed on how to access health care Services; Signed Welcome Letter**: Yes ☐ No ☐
- **Youth cleared for general population**: Yes ☐ NO ☐
- **Youth cleared for general population with medical, dental, mental health referral made**: Yes ☐ NO ☐ N/A ☐
- **Youth Referral for emergency medical and/or mental health treatment**: Yes ☐ NO ☐ N/A ☐

Nurse Signature: _____ Date: _____ Physician's Initials _____

Name: _____

DOB: _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES
Nursing Intake Form

FEMALE HEALTH HISTORY

1. Age at onset of menses: _____ Date of last menses: _____
   - Interval between menses: _____
   - Duration of menses: _____
   - Quantity of flow: Heavy ☐ Normal ☐ Light ☐
   - Do you have pain with menses? Yes ☐ No ☐ If yes, is pain: Low ☐ Moderate ☐ High ☐
   - Is your menses regular? Yes ☐ No ☐
     If no, explain: _____
2. Have you had any unusual vaginal discharge? Yes ☐ No ☐
   If yes, when? _____
3. Have you been treated for any female disorders? Yes ☐ No ☐
   If yes, explain: _____
4. Are you or have you recently been on any birth control? Yes ☐ No ☐
   If yes, what type _____
5. Date of last intercourse: _____ Protected: Yes ☐ No ☐ Type Birth Control : _____

6. Do you think you might be, or are you, pregnant? Yes ☐ No ☐
   If yes, your expected date of delivery: _____
   - Number of past pregnancies: (**G**) _____
   - Any problems with pregnancies: Yes ☐ No ☐
     If yes, explain: _____

     _____

   Number of Term (**T**) {37-42 weeks}deliveries _____; premature (**P**) {25-36 weeks} _____;

   (**A**)abortions {planned or natural loss up to 25 weeks} _____; (**L**) Living children_____

   - Are you currently receiving pre-natal care? Yes ☐ No ☐
     If yes, where? _____

7. Do you do monthly self-breast exams? Yes ☐ No ☐
   - Do you have, or have you had, any problems with your breasts? Yes ☐ No ☐
     If yes, explain: _____

     _____

Comments:

Nurse Signature: _____ Date: _____ Physician's Initials _____

Mississippi Department of Human Services
Division of Youth Services
Medical Services

ADMISSION LOG

Oakley

Youth Name	DOB	Facility Intake Date	Admitted From	Nursing Assessment Date	Nurses Signature	Physician Review Date

Mississippi Department of Human Services
Division of Youth Services

Hearing & Vision Screening Form

Name: _____	**Allergies**: _____
DOB: _____	_____

Vision Screening Results: Left eye_____ Right eye_____ Both _____

Referral to Optometrist/Ophthalmologist : ☐ Yes ☐ No ☐ N/A Nurse Initials: _____

1st Screening Date: _____

Audiogram	Right Ear *	Left Ear *
1000 Hz (20 dB)		
2000 Hz (20 dB)		
4000 Hz (20 dB)		

2nd Screening Date: _____ **N/A** ☐

Audiogram	Right Ear *	Left Ear *
1000 Hz (20 dB)		
2000 Hz (20 dB)		
4000 Hz (20 dB)		

* Place a (+) mark in the above boxes if the youth raised hand indicating that the sound was heard. Place a (-) mark in the above boxes if the youth did not respond to the sound.

☐ **Passed** (Check marks in all of the above boxes)
☐ **Recheck** (Suggested in two weeks)
☐ **Refer to Physician**
Comments: _____
_____
_____
_____
Nurse Signature: _____

☐ **Passed** (Check marks in all of the above boxes)
☐ **Refer to Physician**
Comments: _____
_____
_____
_____
_____
Nurse Signature: _____

Physician Review: _____ **Date**: _____
Recommendations: _____
_____

Division of Youth Services
Medical Services
Oakley
MEDICAL RECORDS REQUEST LOG

NAME	DOB	Records Requested	Date Requested	Records Received	Initials

Mississippi Division of Youth Services

Medical Services

Initial Admission Screening Tool

To be completed by Registered Nurse

This form shall be utilized at the youth's initial arrival at OYDC. It provides information that will determine whether OYDC will authorize admission.

Youth Name	DOB	Sex	Date/Time

Temp:_____ O2 Sat:_____ Pulse:_____ Respirations:_____ BP: _____/_____

OBSERVATIONS

	No	Yes	Describe
1. Is the Youth Unconscious?	☐	☐	_____
2. Does the Youth have obvious injury (ies)	☐	☐	_____
3. Does the Youth appear to be under the influence of alcohol and or drugs?	☐	☐	_____
4. Does the Youth exhibit visible signs of alcohol and/or drug withdrawal? e.g. profuse sweating, vomiting, shakes, doubled over with cramps?	☐	☐	_____
5. Does the Youth exhibit Bizarre or unusual behavior? e.g. .confused, incoherent or violent	☐	☐	_____

Questions

	No	Yes	Describe
1. Are you thinking of hurting &/or killing yourself now?	☐	☐	_____
2. Are you thinking of hurting &/or killing anyone now?	☐	☐	_____
3. Are you bleeding?	☐	☐	_____
4. Do you have a serious injury?	☐	☐	_____
5. Do you currently have a communicable disease? e.g. Mumps, Chicken Pox, TB	☐	☐	_____
6. Do you have a serious Dental problem?	☐	☐	_____
7. Do you, an arresting and/or transporting officer Have information that indicates the youth is a Medical, mental health or suicide risk now?	☐	☐	_____

Intake Referral

_____ OK for admission

_____ Needs Immediate referral for potential Psychological problem

_____ Referred to Facility Administrator, for admission decision

Signed: _____ Date: _____ Time:_____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Health Care Appraisal and Examination**	**Policy Number: 16**
Number of Pages: 3	**Section: XI**
Attachments Physical Exam Form (Boys) XI.16.A.1 Physical Exam Form (Girls) XI.16.A.2	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-03, 4-JCF-4C-04, 4-JCF-4C-63
Effective Date: 06/09/06 **Revision Date: 07/07, 04/16/08,05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that an intake medical appraisal and examination for each youth be completed by a physician/practitioner within fourteen (14) days after arrival at the facility. Additionally, all youth receive an annual medical examination completed by the facility's contract physician/practitioner. (4-JCF-4C-03, 4-JCF-4C-04)

The Director of Medical Services and a qualified physician shall approve health appraisal and examination data collection and documentation format. The health appraisal is completed by health care personnel and includes at least the following: (4-JCF-4C-03)

- Review of the earlier receiving screening
- Review of the results of the previous medical examination, test, and identification of problems;
- Recording of height, weight and vital signs (pulse, blood pressure, respiration, pulse oximeter and temperature);
- Collection of additional data to complete the medical, dental, mental health, and immunization histories; and
- Consultation with a physician or other health care practitioner licensed pursuant to federal and state law as appropriate.

A physician, or other health care practitioner, licensed pursuant to federal and state law completes the health examination and includes at the following: (4-JCF-4C-03)

- Review of the earlier admission screening results, appraisal data, previous medical examination, testing and health problems;
- Physical examination, documented on either Form XI.16.A.1 or Form XI.16.A.2,
- Request for any additional data to complete the medical, dental, mental health, and immunization histories;
- Order for laboratory and/or diagnostic tests to detect communicable disease, including sexually transmitted diseases and tuberculosis

- Other test and examinations, as appropriate;
- Initiation of therapy, when appropriate; and
- Development and implementation of treatment plan, including recommendations concerning housing and program participation.

II. DEFINITION

As used in this policy and procedure, the following definitions apply:

Physical Exam – A thorough evaluation of a patient's current physical condition and medical histories conducted by Physician (MD), Osteopathic Physician (DO) or licensed health care practitioner.

III. PROCEDURE

A. At the time of intake to the facility, each youth shall receive a health screening and assessment by a Nurse. Refer to policy XI.15, Admission Health Screening and Assessment. (4-JCF-4C-03)

B. The facility Physician/practitioner shall complete a physical exam on all youth within than fourteen (14) days of arrival.(4-JCF-4C-03)

1. The examination shall be documented by the physician/practitioner on the Physical Exam Form XI.16.A1 (Boys) or XI.16.A.2 (Girls). (4-JCF-4C-03) Additional medical findings shall be documented in the youth's health record, Interdisciplinary Progress Notes XI.8.A.

2. All female health care appraisal and examinations shall also include:
   - Pelvic exam,
   - Pap smear, if indicated,
   - A urine pregnancy test upon admission, seven (7) days after admission and the day of parole,
   - A board-certified Obstetrician shall be contracted to provide appropriate pre, peri and post-partum services.

3. The Physician/practitioner shall review earlier receiving admission screening results, appraisal data, previous medical examinations, tests, and health problems to determine if additional collection of data and/or laboratory or diagnostic tests is required, as appropriate. (4-JCF-4C-03)

4. The Physician/practitioner shall develop a written individual medical treatment plan with directions for health care and other personnel regarding their roles in the care and supervision of the youth requiring close medical supervision. Refer to policy XI.20, Special Health Needs Programs and Health Care Treatment Plans.

5. The Physician/practitioner shall complete a physical exam on all youth annually. Annual physical examinations for female students shall include breast

examinations and pap smears, if indicated. The examination shall be documented by the physician/practitioner on the Physical Exam Form XI.16.A.1 (Boys) or XI.16.A.2 (Girls).(4-JCF-4C-03) Additional medical findings shall be documented in the youth's health record, Interdisciplinary Progress Notes XI.8.A.

C. At any time during the youth's commitment, there is reason suspect that a student may be hiding contraband in a body cavity and a need arises to perform a manual or instrument inspection of a body cavity, authorization by the Facility Administrator/ designee in consultation with the facility's contract physician/practitioner shall be required.(4-JCF-4C-63)

1. An X-Ray shall be ordered by the physician/practitioner if the evidence of need is there. (4-JCF-4C-63)

   a. If the physician/practitioner is on campus at the time of the request he/she may decide to forego the emergency room and perform the cavity inspection.

   b. If the student is sent to the emergency room for X-Ray, inform the emergency room staff (when report is called and write on the consult form) that if a foreign object/s, item/s and/or substance if found removal is requested to be performed at the time of the consultation if possible.

      i. Request that a copy of the X-Ray be returned to campus with the student.

      ii. Request that foreign object/s, item/s and or substance removed be transferred to the possession of DYS personnel.

2. This process will be followed from admission to release.

D. The facility psychiatrist shall complete an assessment on all youth that are on psychotropic medication, those who have a history of mental health treatment and those referred to the psychiatrist thorough qualified mental health professionals on staff. Refer to policy XI.32 Use and Management of Psychotropic Medication.

E. The facility Dentist shall complete a dental exam on all youth within fourteen (14) days. Refer to policy XI.19, Dental Screening and Examination.

F. Laboratory tests shall be drawn and/or obtained by nurses on all youth admitted as ordered by the facility physician. Refer to policy XI.17, Laboratory Services.

G. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Oakley Youth Development Center
PHYSICAL EXAMINATION FORM I

Name: _____	Height: _____ Weight: _____ Date: _____
Admission Date: _____ **DOB**: _____	
Allergies: _____	T: _____ P: _____ R: _____ B/P: _____
_____	

TO BE COMPLETED BY PHYSICIAN

Head:	Eyes:	Fundi:

Hearing:	Ears:	Nose:

Throat/Mouth:	Neck/Thyroid:

Chest/Lung/Heart:

Pulses:

Spine:

Abdomen:

Genitalia:	Lymph nodes:

Extremities/Back:

Neuromuscular:	Skin:

Name: _____ Admission Date: _____ DOB: _____ Allergies: _____ _____	Mississippi Department of Human Services Division of Youth Services **HEALTH ASSESSMENT PROBLEM SUMMARY AND PLAN OF CARE II**

Diagnosis/ Problems (Name and Discuss):

Medical Treatment/ Plan For Each Problem:

Comments:

As best can be determined by this Physical Exam, this youth is ok for:
☐ Full Activity
☐ Limited Activity – Describe:
☐ No Physical Activity until further testing or review - Describe:

Physician's Signature _____ **Date** _____

Mississippi Department of Human Services
Division of Youth Services-Oakley Youth Development Center
PHYSICAL EXAMINATION FORM I

Name: _____	Height: _____ Weight: _____ Date: _____
Admission Date: _____ **DOB**: _____	T: _____ P: _____ R: _____ B/P: _____
Allergies: _____	OD: _____ OS:_____ OU:_____
_____	

TO BE COMPLETED BY PHYSICIAN

Head:	Eyes:	Fundi:

Hearing:	Ears:	Nose:

Throat/Mouth:	Neck/Thyroid:

Chest/Lung/Heart:

Pulses:

Breast/Genitalia:	Tanner Stage:

Abdomen:

Pelvic:	Lymph nodes:

Spine:

Extremities/Back:

Neuromuscular:	Skin:

Name: _____ **Admission Date**: _____ **DOB**: _____ **Allergies**: _____ _____	**Mississippi Department of Human Services** **Division of Youth Services** **HEALTH ASSESSMENT PROBLEM SUMMARY AND PLAN OF CARE II**

Diagnosis/Problems (Name and Discuss):

Medical Treatment/ Plan For Each Problem:

Comments:

As best can be determined by this Physical Exam, this youth is ok for:
☐ Full Activity
☐ Limited Activity – Describe:
☐ No Physical Activity until further testing or review - Describe:

Physician's Signature _____ **Date** _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Laboratory Services**	**Policy Number:** 17
Number of Pages: 2	**Section:** XI
Attachments Laboratory Log Form XI.17.A	**Related Standards & References** ACA Juvenile HealthCare Performance Based Standards 2009: 4-JCF-4C-03
Effective Date: 06/09/06 **Revised Date: 04/23/08, 05/12/09, 05/01/11, 11/01/13**	**Approved:** James V. Maccarone, Director

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that guidelines shall be established to ensure youth shall receive appropriate diagnostic laboratory services as ordered by the physician/practitioner and dentist. The contract Laboratory Services Manual shall be adhered to for instructions delineating specific testing and documentation guidelines. (4-JCF-4C-03)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. Admission Lab Testing

Nurses shall obtain intake diagnostic laboratory work on all youth admitted at the time of the admission physical examination.

1. All youth shall receive an admission lab panel consisting of the following:
   - CBC with Differential
   - Urinalysis (Microscopic if indicated)
   - Sexually Transmitted Disease (STD) testing
     - RPR
     - HIV
     - Gonorrhea
     - Chlamydia

2. All laboratory work shall require a physician's order to initiate. The order is written on the Doctor's Order Form, located in the youth's health record.

3. The Director of Medical Services/designee shall institute and maintain a Laboratory Log Form XI.17.A of all lab work collected. The nurse collecting the specimens shall enter the youth's name, DOB, laboratory tests performed, and date of the collection on the laboratory log.

   a. As lab results are returned from a laboratory, a nurse shall document the date received on the lab log.

   b. Critical values and other significantly abnormal lab findings shall be immediately reported to the facility physician, dentist or psychiatrist.

4. The facility physician, dentist or psychiatrist shall review, date, and initial all lab results.

C. The Director of Medical Services shall revise this policy as necessary.

Division of Youth Services
Medical Services
Oakley

LAB LOG

NAME	DOB	Labs Performed	Date Performed	Results Received	Initials

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Optometry Services**	**Policy Number: 18**
Number of Pages: 2	**Section: XI**
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-20
Effective Date: 06/09/06 **Revised Date: 05/13/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established to ensure appropriate optometry services shall be available for all youth.(4-JCF-4C-20)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. Admission Optometry Services

A nurse shall complete a vision test, using the Snellen Alphabet chart or Snellen chart suitable for illiterate or non-English-speaking youth, on all youth.

1. Youth having 20/40 or greater vision deficit in one or both eyes during the testing process shall be referred to a community optometrist.
2. Appointments to optometrist shall be made when vision screen is completed per standing orders and made available to facility practioners at next visit so that signature can be obtained.
3. The optometrist shall complete the appropriate optometric prescription.(4-JCF-4C-20)
4. Eye glasses shall be ordered using the approved eyeglasses provider using their ordering procedures.
5. The nurse shall document in the youth's health record, Interdisciplinary Progress Notes XI.8.A when the youth receives their glasses.

B. Youth with vision complaints and/or trauma while at the facility shall be assessed and an appropriate referral(s) made.

C. Annual vision screening shall be complete on all youth and documented in the youth's health record, Interdisciplinary Progress Notes XI.8.A.

D. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Dental Screening, Examination and Services**	**Policy Number: 19**
Number of Pages: 3	**Section: XI**
Attachments Dental Record Form XI.19.A Dental Visit Log XI.19.B Dental Referral Log XI.19.C Dental Hygienist Referral Log XI.C.1	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-15, 4-JCF-4C-20, 4-JCF-4C-61
Effective Date: 06/09/06 **Revision Date: 05/01/07, 04/24/08, 05/13/09,05/01/11,11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to provide routine and emergency dental care to each youth under the direction and supervision of a dentist licensed in the state of Mississippi. The defined scope of available dental services shall include the following: (4-JCF-4C-15)

- Dental screening conducted upon admission by a nurse;
- Dental examination by a dentist within fourteen (14) days of admission unless documentation of dental examination completed within the past six (6) months, diagnostic x-rays are to be taken if necessary;
- Preventive care by a dentist or dental hygienist within fourteen (14) days of admission unless documentation of dental preventative care completed within the past six (6) months;
- The contract dentist determines the conditions for more frequent than annual dental follow-up; with the exception of prophylaxis, which will occur every 6 months
- Development of an individualized dental treatment plan as indicated for juveniles receiving dental care;
- Defined charting system shall be completed that identifies the oral health condition and specifies the priorities for treatment by category; and consultation and referral to dental specialists, including oral surgery, when necessary

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Dental Screening - an assessment, including the youth's dental history, documented by a nurse during the intake process.

Endodontics - a branch of dentistry concerned with diagnosis and treatment of diseases of the dental pulp and its surrounding tissue.

Exodontia - a process of dental practice concerned with the extraction of a tooth.

Oral Hygiene – is the daily maintenance of the teeth and gingival (gums) using a toothbrush and other aids.

Periodontics - a branch of dentistry concerned with study of the normal tissues and the treatment of abnormal conditions of the tissues immediately about the teeth.

Prophylaxis - the removal of calculus and stains from the exposed and unexposed surfaces of the teeth by scaling and polishing as a preventative measure to prevent decay.

Restorative - care of the teeth, gums and mouth that are presently necessary to prevent the risk of either further serious deterioration of the condition, significant reduction of the chance of possible repair after release or required due to significant pain or discomfort.

III. PROCEDURE

A. Admission Dental Services (4-JCF-4C-15)

1. A dental screening shall be completed upon the youth's admission assessment by nursing personnel. Dental screening shall include visual observation of the teeth and gums, noting any obvious or gross abnormalities requiring immediate referral to a dentist. Refer to policy XI.15-Admission Health Screening and Assessment, for dental screening documentation requirements by the nurse. The nurse shall also document significant health information and allergies on the Dental Record Form XI.19.A.

2. A dental exam, oral hygiene instructions, dental cleaning, and dental panoramic and bite-wing x-rays shall be completed by dental personnel within fourteen (14) days of admission. Documentation shall be completed on the Dental Record Form XI.19.A. Documented dental examinations within the past six (6) months need not be repeated.

3. Dental Records Form XI.19.A shall be maintained within the medical record.

4. Emergency services shall include, but not be limited to:

   - Treatment of injuries
   - Acute infection
   - Severe pain
   - Spontaneous bleeding

B. General Dental Services (4-JCF-4C-15)

1. General dental services shall be available to all youth. Services include:

   - Prophylaxis
   - Radiographic examination (bite wings, panoramic and when indicated, periapical

x-rays)
- Oral hygiene instruction
- Routine endodontics, exodontics and periodontics
- Restorative and operative dental services, i.e. amalgam and composite restorations

2. Youth shall have dental examination services at least annually and dental hygiene services at least every six (6) months. The dentist shall determine the conditions for more frequent than annual dental follow-up or the dental hygienist may refer a youth for any complications noted at the time of the prophylactic services.

3. Dental prostheses shall be provided when necessary, as determined by the dentist. (4-JCF-4C-20)

C. Specialized Dental Services (4-JCF-4C-15)

1. The facility dentist shall complete a dental examination to determine the needed services. The youth may be referred to a community dental specialist for consultation.

2. Specialized dental service or treatment shall be provided when the health of the youth would otherwise be adversely affected.

3. Dental Services requiring a specialist include, but are not limited to:

- Removal of impacted teeth
- Third molar extractions
- Treatment of oral/facial fractures
- Residual root removal
- Treatment of oral/facial lesions
- Advanced dental prosthetics required or cosmetic

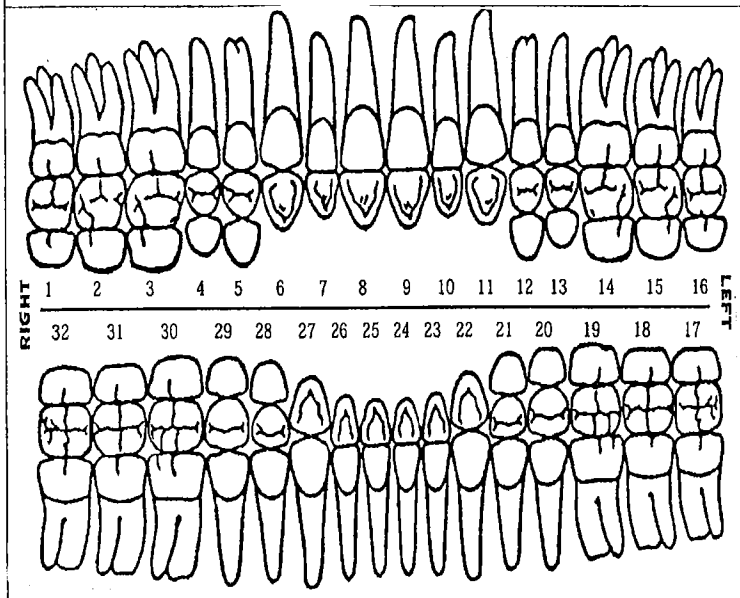
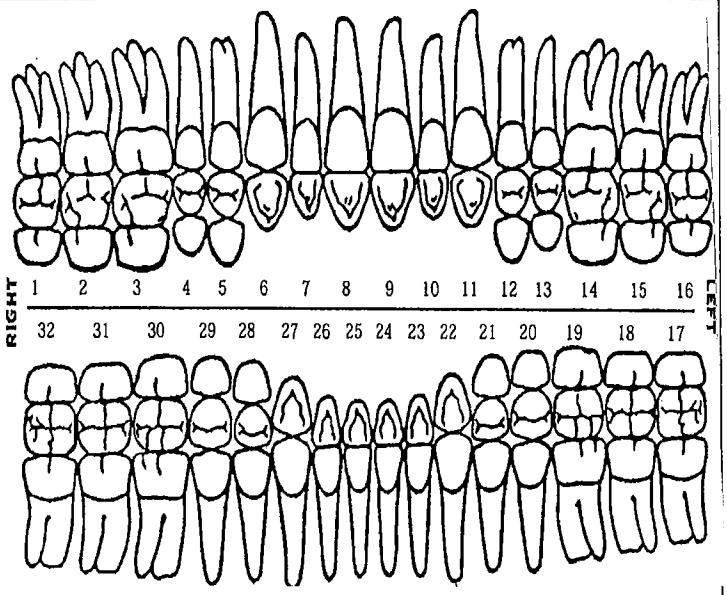
4. The dentist shall complete, when necessary, a special dental report, including estimation of cost for the services.

5. The Director of Medical Services/designee, and Facility Administrator shall review the special dental report to determine the time period such service is needed or can be completed.

D. All dental instruments, needles, syringes with needles, and sharps shall be placed in a locked cabinet located in the facilities' dental area and inventoried as required refer to policy XI.7, Medical and Dental Instrument and Sharps Management. (4JCF-4C-61)

E. The Director of Medical Services shall revise this policy as necessary.

Mississippi Division of Youth Services
Dental Record

Admission Exam	Treatment Done
	
Condition of Gingiva ☐ Good ☐ Fair ☐ Poor Care of Mouth ☐ Good ☐ Fair ☐ Poor	Dentures Full Upper : ☐ Yes ☐ No Full Lower : ☐ Yes ☐ No Partial Upper : ☐ Yes ☐ No Partial Lower : ☐ Yes ☐ No
Occlusion	Treatment Provided/Date:
Calculus ☐ Slight ☐ Moderate ☐Heavy Periodontal or Gingival Disease :_____	
Remarks (include any special precautions to be observed in treatment)	
Recommendations and Treatment Needed :	
Name:_____ **DOB:**_____ **Admit Date:**_____ **ALLERGIES:**_____	Signature of Dentist:_____ Date:_____

Dental Record

Date/Time	Treatment Notes (sign and title all notes)	Tooth #

OAKLEY YOUTH DEVELOPMENT CENTER

Dental Visit Log

Date	Student Name	X-Ray #/Type	Operative Tooth#, Surface, Material	RCT Tooth #, Procedure	Oral SX Tooth #, Procedure	Health Call	RX or F/U	Referral	Admit Date

DENTAL HYGIENE REFERRAL LOG

Youth Name	DOB	Date Entered by Nurse	Reason for Referral	Date Seen by Hygienist	Comment

DENTAL HYGIENE REFERRAL LOG

Youth Name	DOB	Date Entered by Nurse	Reason for Referral	Date Seen by Hygienist	Comment

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Special Health Needs Programs**	**Policy Number: 20**
Number of Pages: 3	**Section: XI**
Attachments Medical Problem List Form XI.20.A Health Care Plan and Medical Instructions Form XI.20.B Dr. Cisse's Asthma Form XI.20.C Nursing Care Plans XI.20.D	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-16, 4-JCF-4C-20, 4-JCF-4C-41
Effective Date: 06/09/06 **Revised Date: 05/01/07, 04/16/08, 07/01/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services that special health programs shall be provided for youth requiring medical supervision and monitoring. (4-JCF-4C-16)

The Director of Medical Services shall share with the administrator information concerning a youth's medical management when necessary to preserve the health and safety of a youth, other youth, staff, volunteers, and or visitors. A written individual treatment plan with directions to health care and other personnel regarding their roles in the care and supervision of the patient shall be developed by the appropriate physician, dentist, or psychiatrist. Information provided to staff shall address only the medical needs of the youth as it relates to housing, program placement, security, and transport. (4-JCF-4C-16, 4-JCF-4C-41)

Medical or dental adaptive devices shall be provided as determined by the physician or dentist. (4-JCF-4C-20)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Acute Illness - A condition that requires care and treatment over a short period of time (less than three months) and is not a chronic Illness.

Chronic Illness - A condition/s that requires care and treatment over a long period of time and usually is/are not curable. The goal is to restore and maintain person's activities of daily living to the extent possible. Examples of chronic illness include but are not limited to: asthma and diabetes.

Medical Treatment Plan – A written, individualized medical treatment regime, developed by the contract physician, dentist for a specific youth, which defines and addresses his/her special health needs.

Special Needs Program(s) – A program(s) that serves a broad range of youth health conditions and chronic illnesses that require health personnel to design a treatment plan tailored to the individual youth's needs.

III. PROCEDURE

A. Youth with special health needs requiring medical supervision and monitoring include, but are not limited to, the following:

- Asthma requiring scheduled medications
- Cardiovascular Disorders
- Cancer
- Diabetes
- Hepatitis A, B, or C
- Hypertension
- Immunodeficiency
- Pregnancy/OB-GYN
- Recent Head Injury (actual or suspected)
- Renal Disorders
- Seizure Disorder
- Tuberculosis, history of, or currently undergoing treatment (youth with symptoms of active disease shall not be placed in general population until procedures have been followed to determine whether additional clinical testing is necessary)
- Other severe chronic and critical medical conditions requiring medical supervision and monitoring
- Acute medical conditions requiring medical supervision and monitoring (i.e., fractures, lactations requiring sutures, wisdom teeth removal, surgical intervention)

B. When a youth presents with any of the conditions listed above a nurse shall document the condition on the Medical Problem List Form XI.20.A. This Form shall be initiated at admission or when the condition is identified, up-dated as needed, and reviewed on release. The Medical Problem List Form is maintained in the youth's health record.

C. When a youth requires medical supervision and monitoring, including acute, chronic and convalescent care, a written individual medical treatment plan for health care personnel to include periodic care, treatment, monitoring of medications, laboratory testing, and specialist consultation and review, as needed and direction to other personnel regarding their roles in the care and supervision of the youth shall be developed by the appropriate Physician, Dentist or Psychiatrist. (4-JCF-4C-16)

1. The Medical Treatment Plan shall be documented within the youth's health record by use of the Physical Exam Form XI.16.A and/or the Interdisciplinary Progress Notes Form XI.8.A. The physician/practitioner and dentist to document direction for health care personnel shall utilize the Doctor's Order Form XI.14.A. The written order should include periodic care, treatment, monitoring of medications, laboratory testing, and specialist consultation and review, as needed.

a. In developing the medical, dental treatment plan the physician or dentist shall examine all relevant documentation.
b. The Physician, Dentist and Psychiatrist shall have access to all facility documents.

2. Nursing personnel shall review each treatment plan and doctor's order to ensure order transcription and delivery of care.

   a. Directions for the facility staff regarding their roles in the care and supervision of the youth shall be in written form. The nurse shall complete the Health Care Plan and Medical Instructions Form XI.20.B and distribute it to all appropriate staff areas. (4-JCF-4C-16) A copy is maintained in the youth's health record.

   b. The Nurse shall note, any information provided to staff. Information provided shall address only the medical needs of the youth as it relates to housing, program placement, security, and transport. (4-JCF-4C-41)

   c. Nurses shall utilize standard nursing care plans when appropriate. The youth's nursing care plan shall be individualized and shall address the medical/dental problem, the interventions and an evaluation of the outcomes. The nurse initiating the nursing care plan shall document the dated initiated and projected stop date. All nursing care plans shall be updated as needed by a designated nurse.

D. Medical or dental adaptive devices shall be provided as determined by the Physician or Dentist. (4-JCF-4C-20) Refer to policy XI.18, Optometry Services and policy XI.19, Dental Screening, Examination and Services.

F. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Oakley Youth Development Center

Student Name:_____

DOB:_____

MEDICAL PROBLEM LIST

Allergies: Yes ☐ (LIST BELOW) No Known Allergies ☐

Chronic Problem	Date Identified	Nurses Signature	Comments

Appointment Date	Acute Problem	Date Identified	Nurses Signature	Date Resolved	Nurses Signature

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Health Care Plan and Medical Instructions

Name: _____	**Living Unit:** _____
DOB: _____	**Start Date:** _____ **Time:** _____
	Stop Date: _____ **Time:** _____

Cause of Restriction(s): _____

DAILY ACTIVITY RESTRICTIONS

- ☐ Bed rest with bathroom use only
- ☐ Partial bed rest; may be out of bed: _____
- ☐ Diet restrictions: _____

  _____ Must eat in (room/program area)
  _____ Must have carry-back meal
  _____ May go to cafeteria for meals
  _____ May go to Medication Line or Clinic for treatments

PHYSICAL ACTIVITY RESTRICTIONS

_____ No gym activities or work details
_____ No body contact sports
_____ No outdoor activities
_____ Must use sunscreen with outdoor activities
_____ No running, jumping or calisthenics
_____ Upper _____ lower _____ weight training only
_____ Use of: crutches _____ sling _____ brace _____

Further Instructions:

Nurse's Signature: _____ Date: _____

Mississippi Department Human Services
Division of Youth Services

Asthma Management Flow Sheet

Student Name: _____ DOB:_____ Living Unit:_____

Does the Student have: Spacer? _____ Personal best peak flow? _____ Date measured: _____

Date of Encounter						
Encounter Type: R= Routine, **O**= Office Visit, **ER**= Emergency Room, **H**= Hospitalization						
NAEPP Severity Level: I= Mild Intermittent, **P Mild**= Mild Persistent, **P Mod**= Moderate Persistent, **P Sev**= Severe Persistent						
Peak Flow:						
Medications: Fill in medication/dose: **RX**= Prescribed **C**= Continued, **D**= Dose Change **D/C**= Discontinued						
* Short-acting beta-agonist:						
* Inhaled Corticosteroid:						
* Cromolyn/Nedocromil:						
* Leukotriene modifier:						
* Long-acting beta-agonist:						
* Methylxanthine:						
* Systemic corticosteroid:						
* Other:						
Influenza vaccine administered:						
Asthma action plan reviewed with student:						

NAEPP Severity Level Classifications:

Level	**Symptoms**	**Clinical Features** before Treatment Nighttime symptoms	**Lung Function**
Step 1 Mild Intermittent	➢ Symptoms 2 times a week ➢ Asymptomatic and normal PEF between exacerbations	> 2 times a month	▪ FEV, or PEF > 80% Predicted ▪ PEF variability < 20%
Step 2 Mild Persistent	➢ Symptoms > 2 times a week but > 1 time a day, exacerbations may affect activity	> 2 times a month	▪ FEV, or PEF > 60% Predicted ▪ PEF variability < 30%
Step 3 Moderate Persistent	➢ Daily symptoms ➢ Daily use of inhaled short-acting beta agonist ➢ Exacerbations affect activity ➢ Exacerbations > 2 times a week; may last days	> 1 time a week	▪ FEV, or PEF > 60% - <80%Predicted ▪ PEF variability < 30%
Step 4 Severe Persistent	➢ Continual symptoms ➢ Limited physical activity ➢ Frequent exacerbations	Frequent	▪ FEV, or PEF < 60% Predicted ▪ PEF variability > 30%

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES JUVENILE INSTITUTIONS	
Subject: **Female Health Care**	**Policy Number: 21**
Number of Pages: 2	**Section: XI**
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-19
Effective Date: 06/09/06 **Revised Date: 03/01/07, 04/16/08, 05/01/11,11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to provide obstetrical, gynecological, and health education services, as well as comprehensive health maintenance for all female youth. (4-JCF-4C-19) Health care encounters, examinations and procedures shall be conducted in a clinical setting that respects the youth's privacy. Additionally, pregnancy management shall be specific as it relates to the following:

- Pregnancy testing
- Routine and High-risk prenatal care
- Management of the chemically addicted pregnant youth
- Comprehensive counseling and assistance
- Appropriate nutrition; and
- Postpartum follow-up care

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. Health Assessment

1. All female youth shall receive an intake health screen, assessment and medical exam when admitted. Refer to policy XI.15, Admission Health Screening and policy XI.16, Health Care Appraisal and Examination.

   a. All female youth shall, after negative urine pregnancy test is documented, have a delousing treatment during the shower that all students take while in the intake unit

i. Lindane, or equivalent shall be given to the student to shampoo their hair and to be used as a "body wash" after a general cleansing agent (soap) is used.
ii. The water is then to be turned off and a waiting period of 3-5 (three to five) minutes, but never greater than 10 (ten) shall be undertaken so that maximum effectiveness of medication can be reached
iii. The water is to be turned back on and the student instructed to rinse both their hair and body surfaces well.

b. The exception to this rule will be a student that has a history of asthma, the nursing staff will be responsible to notify intake personnel of these cases.

2. All female health care appraisal and examinations shall also include:
   - Pelvic exam
   - Pap smear, when clinically indicated
   - Laboratory tests, as ordered by the health care practioners, to detect sexually transmitted diseases. (STDs)
   - A urine pregnancy test upon arrival, seven (7) days after admission and the day of parole.

3. A board-certified Obstetrician shall be contracted to provide appropriate pre, peri and post-partum services.

B. Health Education

The Director of Medical Services shall develop an ongoing Health Education Program to ensure that female youth receive information to include by not limited to the following areas:

- Family Planning
- Hormonal development
- Menstrual cycle
- The effect of alcohol and other drugs on the unborn
- Pre-natal and post-partum education and counseling

Refer to policy XI.22, Health Education and Prevention.

C. Pregnant youth shall be offered access to comprehensive services in regard to pregnancy options. These options shall be reflective of community standards.
These options shall include:

- Prenatal care
- Participation in placement planning of the unborn child
- Counseling and educational materials on raising the child
- Pre-natal evaluation and counseling by the community Obstetrician

If the pregnant youth voices a desire to terminate her pregnancy the Facility Administrator shall be notified.

D. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Health Education and Prevention**	**Policy Number: 22**
Number of Pages: 2	**Section: XI**
Attachments Teaching Learning Flow Sheet Form XI.22.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-27
Effective Date: 06/09/06 **Revision Date: 04/16/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to promote the provision of health education and wellness information to all youth for the development of sound habits regarding personal hygiene, and safe, healthy choices. (4-JCF-4C-27)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. The health education/wellness program shall reflect identified juvenile health education needs. Health education/wellness topics shall address at a minimum the following: (4-JCF-4C-27)

- Access to health care services
- Personal hygiene and grooming
- Dental care
- Substance abuse
- Self-examinations
- Self care for chronic conditions
- Adolescent nutrition
- Prevention of communicable diseases (to include education on Tuberculosis, Hepatitis A, B and C, HIV/AIDS, and other sexually transmitted diseases)

- Additionally, each program shall include disease-specific education, education related to medications, and any unique health-related issues that arise in a particular setting
- Pregnancy and childbirth

B. Each health care topic shall have a curriculum outlining the teaching methods, content, and participant documentation requirements.

1. Methods of instruction may vary, based on the age of the youth, their individual experience, educational level, and personal motivation. Methods of training may include group discussion, self-directed activities, pamphlets and printed materials and presentation of DVDs.

2. Documentation of all health education training presented by the medical department staff shall be maintained.

   a. If the health education is provided during an individual encounter with licensed healthcare personnel (for example, the youth is given instructions by a Physician/Dentist/Psychiatrist regarding medication, health teaching which is provided to youth with special health needs, or a youth is given instructions regarding symptoms to report) then the health care personnel shall document in narrative format in the youth's health record, Interdisciplinary Progress Notes form XI.8.A.

   b. If group health education classes are provided on-site, the Teaching Learning Flow Sheet form XI.22.A shall be utilized.

   c. Form XI.22.A- Teaching Learning Flow sheet shall be maintained on each youth, shall contain each educational offering that the student has participated in and shall be maintained in the health record under the miscellaneous tab.

C. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Date	Topic	Type (format) DVD, Group discussion-GRP Booklet/hand out- H/O Power Point- PP	Length In Minutes	Presenter
	AIDS			
	Asthma			
	Bone Fractures and Sprains			
	Breast Cancer Screening			
	Contraceptives (choices)			
	Diabetes in Pregnancy			
	Diabetes, Type 1			
	Drug, Smoking, Alcohol-pregnancy			
	Gastroesophageal Reflux Disease			
	Living With Stress			
	Hepatitis A			
	Hepatitis B			
	Hepatitis C			
	Herpes Simplex			
	High Blood Pressure in Pregnancy			
	How To Quit Smoking			
	I Can't Breathe (a smoker's story)			
	Migraine Headache			
	Nutrition (healthy eating for life)			
	Nutrition (restaurant, fast food)			
	Obesity			
	Pap Smear			
	Peak Flow Meter			
	Pelvic Inflammatory Disease			
	Relaxation Exercises			
	Scabies			
	STD'S (Chlamydia)			
	STD'S (human Papilloma virus)			
	STD'S (sexually transmitted)			
	Testicular Cancer Screening			
	Weight Control (keeping it off)			

Youth Name:_____ DOB:_____

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Date	Topic	Type (format) DVD, Group discussion-GRP Booklet/hand out- H/O Power Point- PP	Length In Minutes	Presenter
	Alcohol			
	Common Cold/Flu			
	Drugs			
	First Aid/Spill Kits			
	Growth/Developments			
	Parenting			
	Personal Hygiene			
	Psychotropic Medications			
	Puberty			
	Seizures			
	Self Breast Examine			
	Sickle Cell Anemia			
	Sports Related Injuries/Sprains and Strains			
	Teens Pregnancy			
	Tuberculosis			

Youth Name:_____ DOB:_____

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Teaching Learning Flow Sheet

Teaching Method Codes	Response/Evaluation Codes
A = Audiovisual **D** = Demonstration **G** = Group Class **H** = Handout **I** = Individual **P** = Power Point	**AK** = Applies Knowledge **SI** = States/Identifies **RD** = Returns Demonstration **NL** = No Learning **NR** = Needs Review

Date	Education Plan/Topic (Content Taught)	Length In Minutes	Teaching Method	Response/ Evaluation	Presenter	Comments/Handouts
	Aids					
	Alcohol					
	Asthma					
	Bone Fractures and Sprains					
	Breast Cancer Screening					
	Common Cold/Flu					
	Contraceptives-Choices					
	Diabetes in Pregnancy					
	Diabetes-Type 1					
	Drugs					
	Drugs, Smoking, Alcohol/Pregnancy					
	Gastroesophageal					
	Growth/Developments					
	Hepatitis A,B,C					
	Herpes Simplex					
	High Blood Pressure in Pregnancy					
	How To Quit Smoking					
	I Can't Breathe (A Smoker Story)					
	Migraine Headache					
	Nutrition (Healthy Eating For Life)					
	Nutrition (Restaurant, Fast Food)					

Oakley

Youth Name: _____

Date of Birth: _____

Date	Education Plan/Topic (Content Taught)	Length In Minutes	Teaching Method	Response/ Evaluation	Presenter	Comments/Handouts
	Obesity					
	Pap Smear					
	Parenting					
	Pelvic Inflammatory Disease					
	Personal Hygiene					
	Puberty					
	Relaxation Exercises					
	Scabies					
	Seizures					
	Self Breast Examine					
	Sickle Cell Anemia					
	Sports Related Injuries/Sprains					
	STD'S(Chlamydia)					
	STD'S(Human Papilloma Virus)					
	STD'S(Sexually Transmitted)					
	Teens Pregnancy					
	Testicular Cancer Screening					
	Tuberculosis					
	Living With Stress					
	Infection Control (Hepatitis A,B,C) HIV/AIDs, Handwashing,TB					
	Weight Control(Keeping It Off)					
	Swine Flu					

Oakley

Youth Name: _____

Date of Birth: _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Therapeutic Diets and Diet Referrals**	Policy Number: **23**
Number of Pages: **2**	Section: **XI**
Attachments Special Diet Request Form XI.23.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards: 4-JCF-4C-18
Effective Date: 06/09/06 Revision Date: 03/01/07, 04/25/08,05/01/11, 11/01/13	Approved: James V. Maccarone, Director

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, guidelines shall be established for provision of youth requiring therapeutic diets and/or dietary referrals. Therapeutic diets shall be prepared and served to youth according to the orders of the treating physician/practitioners pursuant to federal and state law. A diet manual shall be available in the medical department and food services areas for reference and information. (4-JCF-4C-18)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Therapeutic Diet: is designed to achieve or maintain an optimal nutritional status in persons who require medical nutrition therapy to treat illness, injury or health condition.

III. PROCEDURE

A. Therapeutic diets shall be written as a doctor's order and processed on the Special Diet Request Form XI.23.A (4-JCF-4C-18)

1. The nurse transcribing the physician order shall complete the Special Diet Request Form XI.23.A and forward it to the Food Service Manager.
2. The nurse shall place a copy of the Special Diet Request Form XI.23.A in the youth's health record.
3. When a youth alleges a food allergy and this can not be verified by records on hand, the nurse shall phone the parent or guardian for verification. If verification can not be accomplished at the time of admission the nurse shall instruct the youth to avoid the specific allergen until verification from parent is received.

4. When a youth is ordered a diabetic diet, the nursing personnel shall reference the Mississippi Dietetic Manual for the youth's diabetic diet.
5. When a therapeutic diet, excluding food allergies, has been written for a long duration a physician review shall be required at least every sixty (60) days. Any change to the diet shall require a written physician order.

B. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services

Division of Youth Services

Special Diet Request Form

Name: _____	**Allergies:** _____
DOB: _____ **Living Unit:** _____	_____
	_____

Diet Ordered

Duration of Diet

Special Instructions

If a weight reduction diet, youth's Weight: _____ **Height:** _____

Health Care Personnel: _____ **Date:** _____

CC: Youth Health Record, Dietary, Unit

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Juvenile Participation in Medical Research**	**Policy Number: 24**
Number of Pages: 2	**Section: XI**
Attachments None	**Related Standards & References** ACA Juvenile Healthcare Performance Based standards 2009: 4-JCF-4C-48
Effective Date: 06/09/06 **Revision Date: 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to prohibit the use of youth for medical, pharmaceutical or cosmetic experiments. This policy does not preclude individual treatment of a youth based on his or her need for a specific medical procedure that is not generally available. (4-JCF-4C-48)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Experimental Medical Procedure- is a procedure in which there is the expectation that the patient/subject shall benefit, but the uncertainty about the benefit and risks is typically greater compared with the standard treatment.

III. PROCEDURE

A. The Director of Medical Services shall notify the Physician/Dentist in the event a consulting physician recommends individual treatment of a youth based on his or her need for a specific medical procedure that is not generally available.

1. The Director of Medical Services may, following a thorough clinical evaluation and consultation with the Facility Administrator, Division Director and Legal Counsel, approve use of medications and/or treatments in structured clinical studies which provide individualized treatment options not otherwise available.

2. An individual's treatment with an experimental medical procedure by his/her Physician shall be undertaken only after the youth and the parent or guardian or legal custodian has given consent following an explanation of the positive

and negative features of the treatment and shall comply with all state and federal guidelines.

B. The Director of Medical Services strictly prohibits the use of youth for medical, pharmaceutical, or cosmetic experiments.

C. Clinical research aimed at improving the care or condition of confinement is not prohibited. Research shall be in compliance with all state and federal guidelines. (4-JCF-4C-48)

D. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Medical Consultation and Hospitalization**	**Policy Number:** 25
Number of Pages: 4	**Section:** XI
Attachments Medical Department Off -Campus Log XI.25.A Medical Consultation Form XI.25.B Medical Transportation Instruction Form XI.25.C	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-07, 4-JCF-4C-13, 4-JCF-4C-14, 4-JCF-4C-21
Effective Date: 06/09/06 **Revision Date: 05/01/2007, 7/01/07, 04/25/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that youth who need health care beyond the resources available in the facility, as determined by the responsible Physician Dentist, Psychiatrist or other health care practitioner licensed pursuant to federal and state law, shall be transported under appropriate security provisions to a provider where such care shall be provided. (4-JCF-4C-07, 4-JCF-4C-14)

When the Physician, Dentist, Psychiatrist or other health care practitioner makes a referral for necessary evaluations or emergent procedures, this decision will not be overruled by administrative personnel; however non-emergent elective procedures will granted by the Facility Administrator in consultation with the Division of Youth Services Director after careful review of the recommendations made by the Physician or Dentist.

A written list of referral sources, including emergency and routine care shall be available to clinic staff and reviewed/updated annually. If necessary, a written agreement shall be entered into between the Division Director and a nearby hospital for all inpatient and outpatient medical services, including detoxification from alcohol and other drugs, which cannot be provided within the facility. (4-JCF-4C-07, 4-JCF-4C-13)

Infirmary, chronic, convalescent care, and medical preventive maintenance shall be provided to youth when medically indicated. (4-JCF-4C-21)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Chronic care - a medical service offered to a youth over a long period of time.

Convalescent care - medical service rendered to a youth to assist in recovery from illness or injury.

Detoxification - a medically supervised procedure designed to relieve the symptoms of alcohol or other drug withdrawal.

Inpatient hospital services - health care services, which are provided to a youth following admission to a hospital for an overnight stay or a longer period of time.

Outpatient hospital services - health care services, which are provided to a youth at a hospital that does not involve overnight hospitalization including emergency and/or urgent care.

Medical preventive maintenance - health education and medical services provided to take measures against disease and instruction in self-care for chronic conditions.

III. PROCEDURE

A. OYDC shall use area hospitals, which have been accredited by the Joint Commission on Accreditation of Healthcare Organization, when youths need health care beyond the resources available in the facility. (4-JCF-4C-07)

B. When a youth has been identified by a physician as being in need of detoxification from alcohol and other drugs, the youth shall be referred to a nearby hospital. The detoxification shall be performed under strict medical supervision. (4-JCF-4C-13)

1. Hospitalization for detoxification shall be made by a written physician order.
2. The Director of Medical Services/designee shall complete the arrangements for hospitalization.
3. The Director of Medical Services/designee and Facility Administrator/designee shall be notified of any hospitalizations.

C. Community Medical Appointment Referral and Hospitalization: (4-JCF-4C-07) The Director of Medical Services/designee shall develop a list of resource physicians. This listing is posted within the clinical setting and is reviewed and updated annually.

1. The Physician, Dentist, Psychiatrist or other health care practitioner shall initiate any consultation with a written order for all out-side referrals. The order is written on the Doctor's Order Form XI.14.A.
2. The Director of Medical Services/designee shall schedule medical appointments.
   a. Appointments shall be recorded on the Medical Department Off-Campus Log Form XI.25.A.
   b. For security reasons, the date, time and location of the appointments shall not be communicated to the youth, parent, or guardian unless approved by the Facility Administrator.

3. The Director of Medical Services/designee shall complete the Consultation Form XI.25.B, which contains sufficient health information to allow for a complete evaluation by the community physician.

   a. The consulting physician shall provide to the facility sufficient information pertinent to physical findings, diagnostic test data, clinical impression, treatment recommendations, and a plan of care.

   b. When a youth returns from an outside consult visit, the nurse shall review the Consultation Form XI.25.B, signing their name, the date and the time received.

   c. Recommendations by consultants for youth seen for emergency care shall be initiated per the consultant's orders, however, the facility physician in consultation with the consultant, can choose an alternative treatment.

   d. The facility Physician shall review, sign and date the Consultation Form XI.25.B, on their next visit.

D. When there is reason to conduct a manual or instrument inspection of a body cavity, for security or suspected contraband, authorization by the Facility Administrator/ designee in consultation with the Physician shall be required. (4-JCF-4C-62)

1. An X-Ray shall be ordered by the Physician if the evidence of need is there. (4-JCF-4C-62)

   a. If the Physician is on campus at the time of the request he/she may decide to forego the emergency room and perform the cavity inspection.

   b. If the student is sent to the emergency room for X-Ray , inform the emergency room staff when report is called and write on the consult form that if a foreign object/s, item/s and/or substance if found removal is requested to be performed at the time of the consultation if possible.

      i. Request that a copy of the X-Ray be returned to campus with the student.

      ii. Request that foreign object/s, item/s and or substance removed be transferred to the possession of DYS personnel.

2. This process will be followed from admission to release.

E. A medical or dental referral that is a necessary consultation will not be overruled by administrative personnel. However if the referral is for an elective or non-necessary (elective-cosmetic), non-emergent, elective procedures will granted by the Facility Administrator/ Director of Institutions in consultation with the Division of Youth Services Director after careful review of the recommendations made by the Physician or Dentist after reviewing the Elective Procedure and Surgical Review Form XI.11.B

F. When a youth is in need of hospitalization and/or outside medical appointments, a Juvenile Care Worker (JCW) shall accompany and supervise the youth at all times. Refer to MDYS policy on Transportation of Youth (4-JCF-4C-14). Medically sensitive conditions are addressed prior to transport with the JCW and security officer by nursing. The Nurse shall complete the Medical Transportation Instruction Form XI.25.C. This form shall be provided to the officer prior to any youth transport.

G. The parent, guardian, or the legal custodian of the youth shall be notified of all hospitalizations and urgent hospital related services. Refer to policy XI.12, Notification of Designated Individuals.

H. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department Human Services
Division of Youth Services
Medical Services

MEDICAL DEPARTMENT OFF-CAMPUS LOG

Month: _____ Year: _____

Date	Name	DOB	Transport Location	Appt. Date & Time	Date Seen	Reason for Transport	Return Time	Comments/Findings	Results

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES

CONSULTATION FORM

Date Requested: _____

To:	**From: Oakley Youth Development Center**	**Appointment Date and Time:**
Reason for request (Complaint/Findings): **Current Medications:** **Allergies:**		☐ **See Attached Lab/X-Ray Report(s)** **Tdap Date:** _____
Physician Ordering Consult:		☐ **Routine Referral** ☐ **Emergency**

Consultation Report

Problem:

Pertinent Physical Exam Findings:

Pertinent Lab/X-ray Results:

Diagnosis:

Plan:

Follow-up Appointment: _____ **No Follow-up Needed:** _____

Consultant Signature and Title: _____ **Date:** _____

Name: _____ **DOB:** _____ **Living Unit:** _____ **SS #:** _____	MDYS Contract Physician Review: _____ Date: _____ Nurse Review: _____ Date: _____

To expedite payment, all billing and billing inquiries should be addressed to:
MDYS Facility: Oakley Youth Development Center **Contact** : Business Office **Phone No**: (601) 857-7706,7704
FAX No. (601) 857-8682 **Address**: 2375 Oakley Road Raymond, Mississippi 39154

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Medical Transportation Instructions

Name: _____	Date: _____
DOB: _____ Living Unit: _____	Nurse Completing Form: _____

Juvenile Correctional Officer (JCO) and/or Security Officer

☐ **Youth is being transported to off-grounds Health Care Provider.**

- Name of Health Care Provider: _____
- Address/Location: _____
- Telephone Number: _____
- Appointment Date: _____ Appointment Time: _____ Time to Leave Facility: _____
- Directions: _____

☐ **Youth is being transported to:** _____

Comments: _____

_____

_____

Medical Precautions and Instructions

- Specific precautions or instructions to be taken by transporting officer while en route: ☐ Yes ☐ No

  If yes explain: _____

  _____

- **Always use Standard Precautions when Transporting Youth**
- Youth leaving the campus must be brought to clinic for a brief assessment
- Youth returning to campus must be brought to clinic with the completed consult form for a brief assessment

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Emergency Medical Response and Services**	**Policy Number: 26**
Number of Pages: 5	**Section: XI**
Attachments Youth Injury and Assessment Form XI.26.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-12, 4-JCF-4C-54
Effective Date: 06/09/06 **Revision Date: 03/01/07,02/04/08, 04/25/08, 05/01/11, 11/01/5/13**	**Approved:** James V. Maccarone **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to provide for the availability of 24-hour emergency medical, dental and psychiatric services that include arrangements for the following: (4-JCF-4C-12)

- On-site emergency first aid and crisis intervention
- Emergency on-call 24-hours per day, Physician, Dentist, and Psychiatrist if an emergency facility is not located in a nearby community
- Emergency evacuation and/or transportation of youth from the facility
- Use of one or more designated hospital emergency rooms or other appropriate health care facilities

Direct care staff and other personnel shall be trained to respond to health-related situations within a four-minute response time. The training program established by the facility's training director in cooperation with the Facility Administrator and Health Authority and shall be conducted on an annual basis and shall include instruction on the following: (4-JCF-4C-54)

- Recognition of signs and symptoms, and knowledge of action required in potential emergency situations
- Administration of first aid
- Certification in cardiopulmonary resuscitation (CPR) and operation of the Automated External Defibrillator (AED) in accordance with the recommendations of the certifying health organization
- Methods of obtaining assistance
- Procedures for transporting youth or staff to appropriate medical facilities or health care providers

A Nurse or other health care personnel shall question, outside the hearing of other staff or youth if appropriate, each youth who reports to the medical clinic with an injury,

regarding the cause of the injury. If, in the course of the youth's clinic visit, a health care provider suspects staff-on-youth abuse that health care provider will immediately take all appropriate steps.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Medical Disaster- A scenario in which a significant portion of the student population or staff is either afflicted with an illness or are injured and require care over what the facility medical department can reasonably provide.

Facility Emergency- Any situation that causes the facility to enter into a period in which the facility control in question and the youth have to be contained or evacuated. Examples would be attempted or successful escape, riot or hostage situation.

Disaster- can be man made such as bomb threat or explosion or natural such as severe weather, or a fire that causes the youth to have to be contained or evacuated.

Serious Illness or Serious Injury – Any illness or injury to youth or staff which requires specialized or non-routine treatment by a physician, or which requires hospitalization.

III. PROCEDURE

The facility shall provide all staff and other personnel with emergency first aid and cardiopulmonary resuscitation (CPR) training so that medical and non-medical staff may respond to a potential medical emergency within a four-minute response time.

A. All facility staff shall be certified in CPR and first aid training in accordance with the requirements of the certifying health organization. The training director shall maintain all training records and a copy of first aid and CPR certification. Refer to the Division's training policies.

B. In the Event a youth sustains an injury, is ill, or is involved in any type accident, the facility medical department staff shall be notified immediately. If the youth's condition warrants further assessment or treatment, the youth shall then be referred to the facility Physician, Dentist or Psychiatrist, if requiring immediate medical attention, transported to an emergency room for assessment and treatment.

1. Non-medical staff shall administer first aid as appropriate to the situation and their training until medical staff is available. Refer to policy XI.4, Medical Facility Equipment and Environmental Monitoring and policy XI.5, First Aid Kits, Spill Kits and External Defibrillator.

2. If the youth is unable to move, or to be safely moved to the medical department, the health care professional shall be notified by radio and phone.

a. Nursing staff shall respond to the youth's location and assess the need for on-site treatment or emergency medical referral.

b. Refer to policy XI.25, Medical Consultation and Hospitalization and policy XI.27, Emergency Medical Referral, should a youth require off-site medical care as a result of an injury, illness, accident or experiencing severe,life-threatening intoxication (an overdose) or withdrawal.

3. If a youth or staff requires emergency transport, the facility staff shall utilize "911". The Director of Medical Services/designee shall be notified of all emergency transports as soon as reasonably possible.

4. The Nurse shall document completely, accurately, and timely any assessment and observations, the care provided by the nurse, and the youth's response to that care.

   a. The Nurse shall document in the youth's health record, Interdisciplinary Progress notes XI.8.A. Policy XI.8, Health Record: Structure, Documentation and Confidentiality.

   b. When documenting youth injuries the Registered Nurse shall use the Youth Injury and Assessment Form XI.26.A and the Interdisciplinary Progress Notes XI.8.A.

   c. The Youth Injury and Assessment Form (YIAF) shall be maintained in the youth's health record under the tab Youth Injury and assessments. This form is completed by a Registered Nurse.

      i. Any YIAF that has documentation of allegations or suspicions of child abuse shall be forwarded to the Facility Administrator.

      ii. A copy of the YIAF shall be given to the Shift Supervisor

5. The Nurse shall timely consult and report to, as necessary other nurses and/or practitioners for any follow-up care and treatment. Any significant care and follow-up treatment shall be documented on the Medical Department Shift Report XI.10.A.

6. If a death occurs, the Director of Medical Services, Facility Administrator and Division Director, shall be notified. The Division Director shall request a post-mortem. The results of the post-mortem along with the youth's health record shall be forwarded to the Division Director as necessary.

7. If the youth sustains an injury the Nurse shall interview the youth, outside the hearing of other staff or youth. If during the course of the interview, the youth alleges and/or the Nurse suspects staff-on-youth abuse the nurse shall immediately:

   a. Take all appropriate steps to preserve evidence. Photograph the injury. Print a copy of the photo/s for the youth's health record, a copy for the incident report and preserve the photo/s on the camera/computer hard drive for at least six months.

   b. Report the suspected abuse to the appropriate officials including the Child

Abuse Hotline as stated in the Duty to Report state statute (section 43-21-353).

i. The Mississippi Department of Human Services operates a statewide Child/Adult Abuse/Neglect 24 hour hotline to receive reports.

ii. The Hotline phone number is 1-800-222-8000 or 601-359-4991.

c. Failure to comply with above requirements may result in disciplinary actions up to and including dismissal.

d. Complete a Youth Injury and Assessment Form XI.26.A.

e. Complete an incident report, if the Nurse observed incident.

f. Copy the Facility Administrator on all information.

g. Notify Director of Medical Services/designee as soon as reasonable possible.

8. If the student alleges by words or actions, abuse of a sexual nature the Nurse shall immediately: Refer to policy XV.7 PREA.

a. Notify the Director of Medical Services/designee.

b. Take all necessary steps to preserve/document evidence.

c. In the event that the alleged sexual assault occurred within the last 72 hours the procedure shall be to send student to the appropriate emergency room for a sexual assault evaluation (exam).

d. If the act in question occurred outside of the 72 hour window contact the physician for further orders.

e. Report the suspected abuse to the appropriate officials including the Child Abuse Hotline as stated in the Duty to Report state statute (section43-21-353). For staff reporting responsibilities refer to policy XV.7 PREA.

i. The Mississippi Department of Human Services operates a statewide Child/Adult Abuse/Neglect 24 hour hotline to receive reports.

ii. The Hotline phone number is 1-800-222-8000 or 601-359-4991.

f. Failure to comply with above requirements may result in disciplinary actions up to and including dismissal.

g. Complete a Youth Injury and Assessment Form XI.26.A.

h. Document all findings in the Interdisciplinary Progress Notes Form XI.8.A.

i. Copy the Facility Administrator on all information.

D. In the event of a facility emergency or disaster reference Policy XI.30 Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures- Procedures F, H, I.

E. Medical Disaster: In the event of a medical disaster, the Director of Medical Services/ designee shall coordinate medical services with the local emergency room, local Fire Department, local County Medical Emergency Services, and the facility. Refer to Policy XI.30 Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures

1. The Director of Medical Services/designee shall immediately notify the Facility Administrator.
2. The Facility Administrator/designee shall notify the Division Director.
3. The Facility Administrator/ designee shall make available to the Director of Medical Services any staff, as necessary.

F. Medical emergency drills shall be performed at a minimum, annually and shall encompass at least one medical injury (not self inflicted) and one suicide or self harming incident

1. The drills shall not be announced to medical staff before the beginning of said drill.
2. Documentation of the drill results shall be given to the Director of Medical Services so that any changes in procedure or training regarding handling of the emergency procedure may be addressed.
3. Drills shall be administered by personnel as outlined in Policy VIII.2- Emergency and Disaster Drills and Planning

G. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services

YOUTH INJURY AND ASSESSMENT FORM

Youth Name: _____ **DOB:** _____ **Living Unit:** _____

Medical Assessment and Action Taken: Date of Assessment: _____ Time: _____

Reason for Assessment:

☐ Accident ☐ Fight ☐ Physical Response ☐ Restraints ☐ Other: _____

Vital Signs: T _____ P _____ R _____ BP _____/_____ (As Indicated)

Youth Complaint: _____

_____

_____

Exam/Assessment: _____

_____

_____

Treatment: _____

_____

Youth sent off site for care: Yes ☐ No ☐ **ABUSE HOTLINE NOTIFIED :** Yes ☐ No ☐

Location: _____ Time Sent: _____ Emergency Transport: Yes ☐ No ☐

Health Services Supervisor Notified: Yes ☐ No ☐ Physician Notified: Yes ☐ No ☐

Photo Taken: Yes ☐ No ☐ (Number of photos taken and attach to form: _____)

Restraints Reviewed: Yes ☐ No ☐ N/A ☐ (If yes, Type and any Modifications): _____

_____

Documented on IPN: : Yes ☐ No ☐ **Incident Report available:** : Yes ☐ No ☐

Copy for Program Integrity: : Yes ☐ No ☐ (For any alleged staff on student event)

Anatomical Front	Anatomical Back	Anatomical Notation
		Note: Place an "X" in the area(s) of injury

Nurse's Signature: _____ **Date:** _____ **Facility:** _____

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Emergency Medical Referral**	**Policy Number:** 27
Number of Pages: 2	**Section:** X I
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-12, 4-JCF-4C-13, 4-JCF-4C-14, 4-JCF-4C-15
Effective Date: 06/09/06 **Revised Date: 04/25/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that guidelines shall be established for youth access to emergency medical services, and emergency transport. In the event that detoxification from alcohol, opiates, hypnotics or other drug is needed, the youth will be transported under appropriate security conditions to a facility where specialized care is available. (4-JCF-4C-12, 4-JCF-4C-13, 4-JCF-4C-14)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. If a youth requires emergency medical or dental care, the medical staff shall ensure that necessary medical and dental services are provided. A nearby emergency medical facility shall be utilized. (4-JCF-4C-12, 4-JCF-4C-13, 4-JCF-4C-14, 4-JCF-4C-15)

1. The Director of Medical Services/designee shall develop a list of nearby emergency medical and dental facilities. This listing shall be posted within the clinical setting and is reviewed and updated annually.

2. The Director of Medical Services/designee shall approve all emergency medical referrals.

   a. The facility Physician/Dentist shall be notified, when possible, prior to youth transfer.

   b. Off campus emergency referrals shall be recorded by the nurse on the Medical Department Off-Campus Log Form XI.25A.

3. A written order on the Doctor's Order Form XI.14.A for all out-side referrals shall be required. Refer to MDYS Policy XI.14, Administration of Medical Treatment.

   After the order has been written, the designated nurse shall complete the Consultation Form XI.25.B, which contains sufficient health information to allow for a complete evaluation by the Physician/Dentist. If time does not permit completion of the Consultation Form, the nurse shall call the emergency medical facility to provide appropriate medical information. The Consultation Form shall then be faxed to the facility. The nurse shall document all events in the youth's health record, Interdisciplinary Progress Notes XI.8.A.

   a. When a youth returns from an outside emergency medical referral, the nurse shall review the Consultation Form XI.25.B; sign their name, the date and the time received.
   b. Recommendations by consultants for youth seen for emergency care shall be initiated per the consultant's orders, however, the facility Physician in consultation with the consultant may choose an alternative treatment.
   c. The facility Physician shall review, sign and date the Consultation Form XI.25.B on their next facility visit.

B. If a youth requires emergency transport, the facility shall use "911" services. Refer to policy XI.26, Emergency Medical Response and Services. The Director of Medical Services/designee shall approve a youth being transported by an emergency squad. If time does not permit prior notification and approval for emergency squad transport, the nurse shall notify the Director of Medical Services/designee as soon as reasonably possible. (4-JCF-4C-14)

C. When a youth is in need of emergency medical services outside the facility, a JCW shall accompany and supervise the youth at all times. Refer to Policy on Transportation of Youth and related procedures. (4-JCF-4C-14)

   1. Medically sensitive conditions are addressed prior to transport with the JCW by nursing personnel. The nurse shall complete the Medical Transportation Instruction Form XI.25.C. This form shall be provided to operations prior to any youth transport.
   2. A medical escort to accompany security staff if indicated shall be provided by clinic staff. The Director of Medical Services/designee or Facility Administrator approves medical escort.

D. The parent, guardian, or the legal custodian of the youth shall be notified of all hospitalizations and urgent hospital related services. Refer to policy XI.12, Medical Notification of Designated Individuals.

E. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Infirmary Care**	**Policy Number: 28**
Number of Pages: 3	**Section:** XI
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-21
Effective Date: 06/09/06 **Revised Date: 04/25/08. 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established for admission to, and care within the facility's Infirmary. (4-JCF-4C-21)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

None

III. PROCEDURE

A. The Infirmary, is located in the medical clinic, provides twenty-four (24) hour nursing care services and a Physician/Dentist on call. All youth shall be within sight or sound of a JCW. All nursing care procedures and/or treatment plans are derived from standard of care guidelines. Refer to policy XI.20, Special Health Care Needs Program and Health Care Treatment Plans.

B. Admission to the Infirmary shall be for illness or medical conditions, as diagnosed by a Physician/Dentist, which require observation and management in a facility other than an accredited hospital. Admissions to the Infirmary are generally categorized as:

- Post-operative Admission
- Trauma Admission
- Medical Observation and/or youth requiring frequent therapeutic modality or interventions
- Complicated pregnancy and/or complicated post partum recovery
- Medical isolation i.e. Active pulmonary TB, Acute Hepatitis and/or other infectious diseases

- Frequent lab and/or medication monitoring
- Special Physical Needs
- Other conditions not listed, but approved for admission by the facility Physician/Dentist, Director of Medical Services.

1. Youth admitted shall have a diagnosis and treatment plan in place. Diagnostic tests, lab work, and X-Rays shall be completed prior to admission if possible.

2. If the diagnostic work-up is found to be incomplete or inadequate, the Director of Medical Services/designee shall refer the youth to an appropriate medical facility.

3. Youth admitted to the Infirmary shall be able to perform self-care with assistance and/or supervision provided by the medical personnel, JCW and/or security officer. The Infirmary is not designed for long-term custodial care.

4. Youth admitted to Infirmary with a contagious disease shall be managed in accordance with standards in the Mississippi Department of Health Epidemiology standards.

C. Infirmary Procedures

1. The Director of Medical Services/designee shall notify the Shift Supervisor of the admission and the need for JCW assignment to the clinic for the duration of the youth's stay in the medical clinic (Infirmary).

2. The Director of Medical Services/designee shall notify food service of admission details so that youth's meals can be delivered to the medical clinic for the youth in the infirmary. The following information shall be given:

   - The Youth's name
   - DOB
   - Living Unit to which youth is assigned
   - Length of expected Infirmary confinement
   - Therapeutic diet orders
   - Food allergies

3. The lights shall remain on in the infirmary room during the daytime hours so that the nursing staff can observe youth at all times.

4. The designated JCW assigned to the youth in infirmary shall remain in the room with the youth at all times.

5. Every shift shall document youth's status in the youth's health care record, Interdisciplinary Progress Notes, XI.8A and on the Medical Department Shift Report XI.10.A in addition to verbal shift reports.

D. The Director of Medical Services/designee and the responsible Physician/Dentist shall be consulted prior to taking action regarding chronically ill, physically disabled, or technology dependent youth in the following areas: housing assignments, program assignments, disciplinary measures, and transfers to other facilities. When immediate action is required, consultation to review the appropriateness of the action occurs as soon as possible, but no later than seventy-two hours.

E. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Pharmaceutical Management**	**Policy Number: 29**
Number of Pages: 3	**Section: XI**
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-28, 4-JCF-4C-29, 4-JCF-4C-30
Effective Date: 06/09/06 **Revised Date: 03/01/07, 04/25/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to provide pharmacy services as needed or appropriate to the youth population. These services shall be provided in compliance with all applicable state and federal regulations regarding the procurement, management, and security of all pharmaceuticals and the regulations regarding the prescribing and administering of all pharmaceuticals. (4-JCF-4C-28)

Under no circumstances shall stimulants, tranquilizers or psychotropic drugs be administered for purposes of discipline, security control or for purposes of experimental research. (4-JCF-4C-30)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Automatic Stop Order - a practice that predetermines when a prescribed drug order is discontinued unless reordered by the physician.

Controlled Substance – is any drug that falls in the schedule of I, II, III, IV or V medications of the Federal Food and Drug Act.

Open Formulary – The prescriber shall determine which medication is best suited to the youth's condition. There are no restrictions placed on the prescriber when choosing a medication.

Prescriber - Any health care professional that is authorized by his/her respective licensure to prescribe medications.

Terminal Distributor's License - The license, issued by the Mississippi State Board of Pharmacy to the responsible pharmacist which mandates compliance with all State and Federal laws regulating pharmacy practices and the distribution of medications.

III. PROCEDURE

A. A contracted pharmacy provider shall serve as the primary supply source for pharmaceuticals and related medical supplies.

B. Refer to the following policies:

- Medical and Dental Instruments and Sharps Management, XI.7
- Pharmaceutical Prescribing, Procurement, Administration and Documentation, XI.30
- Pharmaceutical Receipt, Storage, Inventory, and Disposal Management, XI.31
- Use and Management of Psychotropic Medication, XI.32

These policies are established by the Director of Medical Services to minimally address the following: (4-JCF-4C-28, 4-JCF-4C-29, 4-JCF-4C-30)

1. An open formulary, as provided by the contract with the outside pharmaceutical company, will be the practice for the facility prescription practices:

   a. The clinician will choose the best drug for the youth, substitution for

   b. Therapeutic or generic equivalent will be with the practitioner's permission.

   c. Medications are prescribed only when clinically indicated as one facet

   of a program of therapy,

   Medications are prescribed only by a health care practitioner licensed pursuant to federal and state law,

   d. Automatic "stop order" time periods for all medications,

   e. Psychotropic drugs, such as antipsychotic or antidepressants and other drugs used for psychiatric purposes, requiring parenteral administration are prescribed only by a physician and then only following a treatment plan. Such drugs are administered by the responsible Physician/Psychiatrist or licensed Nurse.

   h. The prescribing Physician/Dentist/Psychiatrist reevaluates a prescription before its renewal.

2. Procedures for medication procurement, receipt, storage, dispensing, administration or distribution, and disposal. Refer to the following policies:

   - Pharmaceutical Prescribing, Procurement, Administration and Documentation, XI.30
   - Pharmaceutical Receipt, Storage, Inventory, and Disposal Management, XI.31

3. Maximum security for storage of all medications, pharmaceuticals, and medical sharps, and periodic inventory of all controlled substances and syringes, needles, and other sharps. (4-JCF-4C-28)

4. Administration of medication by persons licensed, properly trained and

under the supervision of the Director of Medical Services. Administration of medications shall be documented in a manner and on a form approved by the Director of Medical Services.

5. Accountability for administering medications in a timely manner and according to practitioner's orders.

C. Licensing: the facility is responsible for maintaining the required Pharmacy Licenses. The facility must maintain a permit for the storage of controlled pharmaceuticals and a permit for the storage and security of controlled substances. The Director of Medical Services/designee shall maintain a current copy of all applicable licenses noting expiration dates.

D. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures**	**Policy Number: 30**
Number of Pages: 11	**Section: XI**
Attachments Medication Administration Record XI.30.A Medication Error Report Form XI.30.B Medication/Treatment Refusal Form XI.30.C	**Related Standards & References** ACA Juvenile Health Care Performance based Standards 2009: 4-JCF-4C-28
Effective Date: 06/09/06 **Revised Date: 0701/07, 04/25/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established to outline documentation requirements for prescribing of prescription, nonprescription pharmaceuticals and for pharmaceutical procurement and medication administration. Medication administration time shall be scheduled as necessary to ensure timely administration according to pre-scriber's orders. (4-JCF-4C-28)

The facility shall adhere to the current Contract Pharmacy Services, Pharmacy Policy and Procedure Manual's instructions delineating specific medication prescribing, documentation and procurement guidelines. Procedural guidelines to cover medication administration involving a facility emergency or medical disaster, these guidelines will include evacuation of the facility.

From admission through discharge, every effort will be made to avoid discontinuity of medications.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Automatic Stop Order – A practice that predetermines when a prescribed drug order is discontinued unless reordered by the physician.

Contingency (stock) medications – A predetermined stock of dispensed prescription medications that are accessible to medical staff. A written or telephone physician order is necessary to initiate therapy with these medications.

Disaster- Can be man made such as bomb threat or explosion or natural such as severe weather, or a fire that causes students to have to be contained or evacuated

Facility Emergency- Any situation that causes the facility to enter into a period in which facility control is in question and the students have to be contained or evacuated. Examples would be attempted or successful escape, riot or hostage situation

Medical disaster- Can be a communicable disease process that puts the facility at risk for an epidemic, or injuries suffered by youth that due to the sheer quantity of students involved or quality of injuries sustained the medical staff are not equipped or manned adequately to give timely care.

Health care personnel- an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

Prescriber – Any health care personnel who is authorized by his/her respective licensure to prescribe medications.

Telephone Orders - A verbally communicated order received from the physician via telephone, which is given to the facility Nurse for initiation of a prescribed medication and/or treatment.

B.I.D. (Twice Daily): two daily medication pass times that usually coincide with the facility's a.m. (breakfast) and afternoon (supper) meal time frames.

Q.D. (Once Daily): a morning-only medication pass that usually coincides with the facility's a.m. (breakfast) meal time frame.

Q.H.S. (At bedtime): an evening-only medication pass that usually coincides with the facility's scheduled medication pass prior to bedtime.

Q.I.D. (Four Times Daily): four daily medication pass times that usually coincide with the facility's three meal (breakfast, lunch, and dinner) time frames and a later evening time frame prior to bedtime.

T.I.D. (Three Times Daily): three daily medication pass times that usually coincide with the facility's three meals (breakfast, lunch, and dinner) time frames.

II. PROCEDURE

A. Only health care personnel licensed pursuant to federal and state law shall prescribe medications. Medications shall be prescribed only when clinically indicated as one facet of a program of therapy and a prescribing provider reevaluates a prescription prior to its renewal. (4-JCF-4C-28)

1. Prescription pharmaceuticals shall be written on the Doctor's Order Form XI.14.A, within the youth's health record. All doctors' orders shall contain the following information and shall be signed by the prescriber:

   - Youth's name, living unit, date of birth, facility name, and allergies

- Date and time the order is written
- Name, strength, and dosage of the medication and/or treatment
- Dosage regimen (directions to include frequency and times, and route of administration)
- Duration of the order
- Pre-scriber signature

2. The prescriber shall renew all long-term pharmaceuticals at least every 30 days.

   a. The nursing staff shall ensure that printed orders are forwarded to the appropriate contract pre-scriber for review and signature.

   b. The nursing staff shall ensure that the original signed order is maintained in the youth's health record and follow the procedure to procure the medication.

   c. Any change from the original doctor's order shall be rewritten on the Doctor's Order Form.

3. Telephone Orders: the Nurse may accept telephone orders from a Physician, Dentist, and Psychiatrist or within their scope of practice.

   a. The Nurse receiving the telephone order shall write the order on the Doctor's order form XI.14.A, within the health record. The order shall be read back to for confirmation. The telephone order shall be written legibly and include the following:

      - Youth's name, identification number, date of birth, facility name, and allergies;
      - Date and time the order is received;
      - Name, strength, and dosage of the medication and/or treatment;
      - Dosage regimen (directions to include frequency and times, and route of administration);
      - Duration of the order;
      - Name of the pre-scriber with co-signature of the Nurse receiving the order.

   b. All telephone orders shall be counter-signed by the prescriber on his/her next visit to the facility.

4. Automatic Stop Orders: should be included within the Pharmacy Services Inpatient Policy and Procedure Manual and shall be posted in the clinical setting in clear view for all health care personnel. The following automatic stop orders for medication shall be adhered to:

Medications	**Duration**
Schedule II drugs except those for ADHD	7days
Schedule III analgesics	5days
Anti-emetics	2 days
Cough and cold preparations	7 days
Antihistamines	7 days

Hypnotic agents	7 days
Medications	**Duration**
Non-steroidal anti-inflammatory agents	7 days
Anti-infective agents	30 days
Anti-Tubercular agents (Preventative)	9 months
Active anti-Tubercular agents	Physician Order
All other medications	30 days

Life-sustaining medications shall not be automatically stopped. The prescriber shall be contacted for such medications as cardiovascular, hypertensive, insulin, anti-convulsants or any other medication in question.

B. During the intake nursing assessment if a youth states that he/she is currently on medication, and does not have the properly labeled bottle or a paper prescription, the nursing staff will call the parent/guardian and verify the medication, dosage and pre-scriber. Then the Nurse shall:

1. Call the Physician, Dentist or Psychiatrist to obtain continuation or stop order,
2. If appropriate follow the procedure to procure the medication.

C. Transcription (noting) of medical orders (4-JCF-4C-28).

1. The Nurse transcribing an order from the Doctor's Order Form XI.14.A shall bracket the entire order to the left side and enter "noted." The Nurse shall also enter their signature, title, and the date /time the order was noted.

2. Each youth receiving medication shall have a Medication Administration Record (MAR) XI.30.A.

3. The Nurse shall initiate or utilize the current Medication Administration Record (MAR) XI.30.A when a youth is prescribed a new medication regimen. The Nurse shall transcribe the doctor's order on to the MAR and include the following information:
   - Medication name (legible);
   - Medication dosage;
   - Route of medication administration;
   - Medication administration times;
   - Nurse's signature and the date the order is written;
   - If the medication ordered is on hand, or readily available, enter the start and stop dates in the appropriate MAR blocks. If the ordered medication is not readily available, the start and stop dates shall be completed upon receipt of the medication.

D. Prescription medication recommendations by consulting Physicians/Dentists:

1. If the youth returns from the consultant with medication or treatment recommendations, the Nurse shall contact the facility's contract Physician/Dentist for approval, prior to initiation of the recommendations.

2. The contract Physician/Dentist may contact the consulting Physician directly if there is significant variance in medication and/or treatment orders.

3. All sample pharmaceuticals received from a consultant shall be destroyed appropriately as defined in Policy XI.31, Pharmaceutical Receipt, Storage, Inventory, and Disposal Management.

E. Pharmaceutical Procurement (4-JCF-4C-28).

1. When a prescriber's order has been reviewed/verified by the Nurse, any prescribed medication shall be obtained from the contract pharmacy or an outside pharmacy if appropriate.

2. No pharmaceutical may be purchased from a retail pharmacy without first contacting the contract pharmacy. Exceptions would include: when a youth is ordered a medication STAT and/or on a weekend, evening, or holiday and the ordered medication is not available in the contingency (backup) supply or when notice is received from contract pharmacy that the pharmaceutical(s) is/are not available.

   When notice is received from the contract pharmacy of the non-availability of an ordered pharmaceutical the Nurse shall order the pharmaceutical through the local retail pharmacy.

   a. The Nurse shall obtain no more than a three (3) to seven (7) day supply from the retail pharmacy on stat orders or for those emergent pharmaceutical orders to allow the contract pharmacy time for delivery.

   b. Additional medication may be ordered from the retail pharmacy when the contract pharmacy has indicated a delay in dispensing the ordered pharmaceutical due to their procurement unavailability.

F. Accepted medication administration times:

1. Per professionally accepted practice medication times will be set by the facility medical staff and will be completed within +/- (plus or minus) one (1) hour;

   a. Morning, or AM medication pass is at 7:00 AM and shall be started no earlier than 6:00AM and end no later than 8:00AM.

   b. Noon, or mid-day medication pass is a 12:00 and shall be started no earlier than11:00 AM and end no later than 1:00 PM.

   c. Evening medication pass is at 7:00PM and shall be started no earlier than 6:00PM and end no later than 8:00PM.

d. The exception to the above is if the physician/dentist writes and order that dictates the time that the mediation shall be given or due to extenuating circumstances the Nurse phones the prescriber for approval to give a medication at a time it was not originally prescribed.

G. All medication shall be administered to youth in accordance with accepted nursing practice. This procedure shall not be a substitute for professional nursing judgment. (4-JCF-4C-28) Nursing staff administering medications shall adhere to the following guidelines:

1. Medication times are set and shall not vary day to day.

2. Nurses shall not start a medication administration until the youths are orderly, preferably in alphabetical order by unit.

3. Nurses shall verify the identification, by photo and DOB, of the youth as needed. Youth photos adjacent to the MAR's are encouraged for positive identification.

4. Nurses shall always check the following prior to administering medication:

   - Correct Medication
   - Correct Date
   - Correct Time
   - Correct Medication
   - Correct Route of Administration
   - Correct Youth, as verified by student stating name and birth date (Nurse will verify with picture on MAR

5. Nurses shall ensure the youth remains directly in front of them while receiving medication. The youth's hands shall be kept visible above the waist at all times.

6. Nurses shall place oral medication in a paper soufflé cup, plastic medicine cup, envelope, or oral syringe. The Nurse shall provide water or other appropriate liquid to the youth and shall also watch the youth swallow the oral medication.

7. Nurses shall perform a standard "mouth check" and check the youth's hands prior to the youth leaving the designated facility medication area.

8. If the Nurse is not satisfied that a youth has swallowed the medication, the youth shall not be permitted to leave that area and the JCW shall perform a search of the youth.

9. All medication shall be documented at the time of administration.

a. The Nurse shall utilize the current monthly Medication Administration Record (MAR) Form XI.30.B.

b. The Nurse shall initial the record for the specific date and time the medication and/or treatment was given. The Nurse's signature shall also be in the designated signature area of the record.

c. The Nurse shall chart the medication administration using the following:

- "H" - Medication held
- "R" – Refuses the medication
- Nurse initials – When medication given

When charting "H" or "R" the Nurse must document the reason and any contacts made on the MAR, narrative and/or the Interdisciplinary Progress Notes Form XI.8.A.

d. The Nurse shall notify the pre-scriber during the course of treatment if the youth does not respond to the treatment and/or symptoms worsen. Document justification in the youth's health record, Interdisciplinary Progress Notes Form XI.8.A.

H. If there is an emergency or disaster or at any time the Nurse/s on duty have reason to suspect that control of the facility is in question. The Nurse/s on duty shall:

1. Suspend medication administration.

2. Have any students in the clinical area removed and lock the outer clinic doors.

3. Ensure that the medication cart is locked and secure.

4. Ensure that the medication room is locked and secure,

5. Ensure that all rooms, cabinets or drawers that contain items that could be used as weapons are locked and secure,

6. Document these occurrences, exactly as they happened with a time line given on the Medical Department Shift Report Form (XI.10.A) and finally;

7. Notify the Director of Medical Services.

8. During this time, the Nurse/s shall prepare a list of students who did not receive their medications before the medication administration had to be suspended.

   a. This list will not only contain the students name but also the list of medications, the dosages and the diagnosis/es.

      i. The Facility Administrator/designee shall be notified verbally

and shall be given a list of students that are receiving life sustaining or critical medications.

ii. The Administrator/designee shall be informed that these students must receive their medications on time since their omission could result in untoward side effects or sequelae.

b. The Nurse/s shall break this list down to include which prescriber ordered the medication in question.

c. When the Nurse is given the "all clear" from the Facility Administrator/ designee, the following actions will occur;

i. First, the Nurse shall attempt to phone each clinician regarding any students under their care that did not receive life sustaining or critical medications in a timely manner. The Nurse shall request orders regarding the administering of these medications outside of normal medication time and the possible need for evaluation outside of the facility or transport to a local hospital for monitoring then;

ii. The Nurse shall attempt to phone each clinician to receive orders regarding the administering of any other medication outside of normal medication time.

- If the Psychiatrist cannot be reached the contract Physician will be contacted and asked to make a decision as to whether one dose of the medications can be held with out causing untoward effects or sequelae to the students.
- If the Dentist can not be reached the contract Physician will be contacted and asked to make a decision as to whether the medications can be held with out causing untoward effects or sequelae to the students.

iii. The Nurse shall document on each student's health record the new order received from the physician/dentist/psychiatrist regarding each individual student on the Doctor's Order Form (Form XI.14.A), the Interdisciplinary Progress Note (Form XI.8.A) and the MAR (Form XI.30.A).

- The Nurse/s shall then notify the Facility Administrator/designee and provide a list of the students that need their medications.
- The facility Administrator/designee shall advise the Nurse of where each of the students on the list is located.

I. If there is reason to evacuate all students from OYDC. The Nurse/s on duty shall:

1. Suspend medication administration;
2. Have any students in the clinical area removed and lock the outer clinic doors.
3. Ensure that the medication cart is locked and secure.

4. Ensure that the medication room is locked and secure, then;
5. Ensure that all room, cabinets or drawers that contain items that could be used as weapons are locked and secure, then;
6. Notify by telephone the Director of Medical Services, who shall then notify the Facility Administrator.
7. Gather all active health records in an appropriate transporting conveyance.
8. Ensure that medication carts are stocked with an appropriate supply of all over-the-counter and contingency medications and medical supplies (i.e. bandage scissors, syringes and needles, medication cups).
9. Ensure that all students' prescribed medications are contained within the appropriate medication cart and ensure that the medications carts are locked and secure. Perform an accounting of controlled substances and medical instruments and sharps count.
10. Ensure that the emergency (first responder) bags are appropriately stocked and secure for transport.
11. Prepare the AED for transport;
12. Ensure that medical records, equipment, medication carts and contents are always under line of sight by the Nurse/s during transport and delivery.
13. When the Nurses have arrived at the evacuation destination. The Nurse/s shall secure the medication cart and perform an accounting of controlled substances and medical instruments and sharps count.
14. The Nurses shall prepare a list of students who did not receive their medications before the medication administration had to be suspended.
    a. This list will not only contain the students name but also the list of medications, the dosages and the diagnosis/es.
    b. The Facility Administrator/designee shall be notified verbally as an emergency and shall be given a list of students that are receiving life sustaining or critical medications.
15. Medication administration post evacuation. The Facility Administrator/ designee shall inform the Nurse/s on duty when the students are secure;
    a. First, the Nurse shall attempt to phone each clinician regarding any students under their care that did not receive life sustaining or critical medications in a timely manner. The Nurse shall request orders regarding the administering of these medications outside of normal medication time and the possible need for evaluation outside of the facility or transport to a local hospital for monitoring then;
    b. The Nurse shall attempt to phone each clinician to receive orders regarding the administering of any other medication outside of normal medication time.
        i. If the Psychiatrist cannot be reached the Physician will be contacted and asked to make a decision as to whether one dose of the medications can be held with out causing untoward effects or sequelae to the students.

ii. If the Dentist can not be reached the Physician will be contacted and asked to make a decision as to whether the medications can be held with out causing untoward effects or sequelae to the students.

iii. The Nurse shall document on each student's health record the new order received from the Physician/Dentist/Psychiatrist regarding each individual student on the Physician Order Form (Form XI.14.A), the Interdisciplinary Progress Note (Form XI.8.A) and the MAR (Form XI.30.A).

- The Nurse/s shall then notify the Facility Administrator/designee and provide a list of the students that need their medications
- The Facility Administrator/designee shall advise the Nurse of where each of the students on the list are located.

iv. The Nurse shall document on each student's health record the new order received from the Physician/Dentist/Psychiatrist regarding each individual student on the physician order form (Form XI.14.A), the Interdisciplinary Progress Note (Form XI.8.A) and the MAR (Form XI.30.A.).

J. The living units shall receive a written notice of youth's medication times on a daily basis.

1. Medication administration times shall not be used as a substitute for health call.

2. Youth missing "medication time" shall be called back at the end of that particular unit's line. The Nurse shall have the JCW call the youth back to the medication line.

3. A youth refusing a call back shall be document as a refusal. The youth must refuse to the Nurse.

4. Any time a youth refuses medication a Medication/Treatment Refusal Form (XI.30.C) shall be completed and signed by the Nurse and the youth.

   a. The youth must refuse to the Nurse.

   b. If the youth refuses to sign the Medication/Treatment Refusal Form, the Nurse and the JCW shall sign noting the youth's refusal.

K. Medication refusal

1. If a youth's refusal of a medication reflects a health risk, the Nurse shall notify the prescribing physician, Dentist or Psychiatrist, as well as the Director of Medical Services. Documentation of the notification shall be written in the youth's health record, Interdisciplinary Progress Notes Form XI.8.A.

2. If a youth exhibits a pattern of refusal with any prescribed medication, the Nurse shall notify the prescribing Physician, Dentist or Psychiatrist, as well as the Director of Medical Services. The Nurse shall document the notification in the youth's health record, Interdisciplinary Progress Notes.

L. Medication Errors

1. A Nurse shall accurately and timely report to the appropriate pre-scriber errors in or deviation from the prescribed regimen of care.
2. Medication errors shall be reported immediately to the Director of Medical Services
3. The Nurse discovering a medication error shall complete the Medication Error Report Form XI.30.B.
   a. The Medication Error Report shall be reviewed and signed by the facility Physician, Dentist or Psychiatrist who shall note any adverse reactions that may have resulted.
   b. Following review by the facility Physician, Dentist or Psychiatrist the Director of Medical Services shall discuss the incident with the respective Nurse(s).
   c. The Director of Medical Services shall maintain the original copy in the Medical Department files.

M. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services

Medication Administration Record (MAR)

Name _____ *DOB*: _____ *Month/Year*: _____

☐ NKA ☐ Allergies: _____ **Living Unit:** _____

Medications		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Ⓡ = Med refusal **H** = Hold; must document in narrative on back

Medication Administration Record (MAR)

Date	Time	Narrative Notes	Effective	Not Effective	Time	Initials

Initials	Signature/Title	Initials	Signature/Title	Initials	Signature/Title

Mississippi Department of Human Services
Division of Youth Services

---------- MEDICATION ERROR REPORT ----------

Youth Name:	DYS No.	Living Unit

Signature and Title of Person Completing This Section	Date	Time AM PM

Physician's Findings and Actions, following your assessment of the youth.

Signature and Title of Person Completing This Section	Date	Time AM PM

Supervisor's Evaluation of Error Incident - Include cause and action taken; indicate corrective measures to prevent further errors of similar nature.

Signature and Title of Person Completing This Section	Date	Time AM PM

Conclusive Findings/Recommendations - What processes were identified that need analysis or improvement.

Signature and Title of Person Completing This Section	Date	Time AM

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Name:_____ **DOB:**_____

Date: **Time:**

Check Item/s Refused:

☐ **Medication** _____
Medication Name Dose Time

☐ **Medical Treatment** _____
Name of Treatment Refused

☐ **Medical Assessment**_____
Type of Service Refused (i.e. pelvic exam, Gynecological)

☐ **Dental Treatment** _____
Type of Service Refused (i.e. exam, root canal, ALL)

I, _____, am refusing the above checked items.

I understand that by refusing the above services, treatments, medications I may continue to have Pain, Discomfort, Infection, Behavioral Difficulties, sleep difficulties and/or sleep deprivation.

_____
Signature

_____
Witness (JCO or Security)

_____
Nurse Signature

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Pharmaceutical Receipt, Storage, Inventory and Disposal Management**	**Policy Number: 31**
Number of Pages: 6	**Section: XI**
Attachments Non-Prescription Pharmaceuticals Control Form XI.31.A Contingency Medication and Controlled Substance Daily Count Sheet XI.31.B Non-Prescription Pharmaceuticals Supply Monitoring Form XI.31.C	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-28, 4-JCF-4C-61
Effective Date: 06/09/06 **Revision Date: 05/01/07, 04/25/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established to ensure management of pharmaceuticals. Instructions delineating specific pharmacy inventory management, as well as, the applicable drug laws of Mississippi. Medical and dental supplies are securely stored, controlled and perpetually inventoried. (4-JCF-4C-28; 4-JCF-4C-61)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Controlled Substances: are any "dangerous drugs" that fall in the schedule of I, II, III, IV, or V medication of the Federal Food and Drug Act.

Schedule I Controlled Substance: any medication that requires the highest degree of control. Most drugs in this schedule are illegal for use in the United States, e.g. Phencyclidine, Mescaline, and Marijuana.

Schedule II Controlled Substance: any medication that can be used routinely, but legal controls are extensive, e.g. *narcotics*: Morphine, Methadone, Percodan/Percocet, Levomethorphan, Demerol; *stimulants:* Dexedrine, Ritalin, Adderall; and *depressants:* Seconal, Nembutal, Amytal.

Schedule III & IV: any medication that is a stimulant, depressant, or narcotic, but do not require as much control as Schedule II medications, e.g. Valium, Phenobarbital, Klonopin, Tylenol with Codeine #3, and Cylert.

Schedule V: any medication that has the least control of the scheduled medications, e.g. Terpin Hydrate with Codeine, Novahistine DH.

III. PROCEDURE

In accordance with the Drug Laws of Mississippi, the policies and procedures of the Contract Pharmacy Services shall govern the responsibility for accountability of all prescription pharmaceuticals. The Facility Medical, Dental, and Nursing Staff shall adhere to accountability policies and procedures as specified in the following procedure.

A. Prescription pharmaceuticals received from the Contract Pharmacy shall be delivered to the Medical Department and shall be labeled in accordance with the Mississippi State Board of Pharmacy guidelines. (4-JCF-4C-28)

1. These prescription medications shall be verified by a nurse with the packing list. The nurse shall sign (first initial, last name), title and date the bottom section of the packing list indicating that the ordered medications are labeled and inventoried. The nurse shall also inspect the packaging of drugs to ensure their integrity.

2. The Contract Pharmacy shall provide the Director of Medical Services with a list and cost of the monthly prescription medications that have been issued.

B. Prescription pharmaceuticals received from sources other than the Contract Pharmacy Services shall be labeled in accordance with the Mississippi State Board of Pharmacy guidelines. (4-JCF-4C-28)

1. These medications may be delivered to the facility clinic by a variety of facility staff that has been designated by the Facility Administrator/designee to pick up and transport the medication.

2. Upon receipt the nurse shall cross-reference the medication with the package label or invoice and physician order. The nurse shall sign and date the package label or invoice to verify the correct medication and count was received. A copy shall be maintained in the Medical Department files.

3. The medication shall be then placed in the appropriate area for storage and the receipt noted on the Medical Department Shift Report Form XI.10.A.

C. Non-prescription pharmaceuticals may be received through the facility's Receiving Department or directly to the clinic. (4-JCF-4C-28)

1. A perpetual inventory shall be maintained for all non-prescription pharmaceuticals. These pharmaceuticals shall be listed on the Non-Prescription Pharmaceuticals Control Form XI.31.A.

2. Each time a new bottle/package non-prescription pharmaceutical is removed from inventory by the nurse, the nurse shall timely complete the Non-Prescription Pharmaceuticals Control Form XI.31.A to document usage.

3. Any discrepancies in inventory shall be reported immediately to the Director of Medical Services for review and investigation as necessary.

D. Pharmaceuticals shall be stored in accordance with both the Drug Laws of Mississippi, and manufacturer's recommendations of temperature control. (4-JCF-4C-28)

1. Medication storage carts shall be locked at all times, other than during scheduled medication administration times.
2. Pharmaceutical storage areas shall be key-locked to keys only specific to the medical department and shall be strictly controlled in accordance with the policy Key Control, and related procedures. Only health care professionals may have keys to the pharmaceutical storage areas that are within the physical confines of the medication storage room.
3. Refrigerators for medication storage shall be equipped with a thermometer. The temperature of the medication storage refrigerator shall be checked and recorded daily by clinic personnel. Refer to policy XI.4, Medical Facilities and Equipment and Environmental Monitoring.
4. Annually, the Director of Medical Services or designated health care professional shall complete an inventory of all non-prescription pharmaceuticals.
5. When a patient specific medication is discontinued the nurse shall complete all necessary paperwork (i.e. sign off doctor's orders, make changes on the MAR add the medication to the list of discontinued medications)

   a. For patient specific, but not a controlled substance, the nurse shall take the patient specific medication card (blister pack) make a notation that the medication has been changed or discontinued on the Discontinued Medication Form and place the card in the locked bottom drawer of the locked specified medication cart.

   b. For patient specific, controlled substances, the nurse shall take the patient specific medication card (blister pack) make a notation that the medication has been changed or discontinued complete the discontinued controlled substance form and place the card appropriate location

      i. There is a bag used specifically to keep the controlled substance (medication) that has been discontinued there is a breakaway lock holding the zippers together so that access to the medications can only be had by breaking the lock.

         - The nurse shall obtain the log used specifically to note the opening of the bag for either the purpose of adding discontinued medications, or

         - Removing medications from the bag to be destroyed.

- The nurse shall complete the log form noting the date , the student's name, the name of the controlled substance, and the number of pills left unused (and sealed) in the blister pack.

- The nurse shall then place the blister pack in the bag; obtain a new breakaway lock, note the lock number and lock the bag with the new breakaway lock.

- The nurse shall then place the locked bag back in the locked cabinet behind a locked door. The storage location for controlled substances shall be in a locked room with limited access to the key.

E. At every shift change, both the off-going and on-coming nurse shall conduct a reconciliation count of contingency (back-up) medications, controlled substances, syringes, needles, and medical sharps. (4-JCF-4C-28)

1. Contingency (or back-up) medications shall be maintained in a locked cabinet located in the facility' pharmaceutical storage area and inventoried at every shift change.

2. The nurse shall utilize the Contingency Medication and Controlled Substance Daily Count Sheets XI.31.B for reconciliation of contingency (back-up) medications.

   a. After verifying count, the nurse shall sign (first initial, last name) this form.

   b. Immediate notification of unaccounted loss of any Contingency (or back-up) medications shall be reported to the Health Services Supervisor for review and investigation as necessary.

3. Controlled Substances that are currently being administered to youth shall be placed in a double locked medication cart and inventoried at every shift or medication nurse change.

   a. The nurse shall utilize the Contingency Medication and Controlled Substance Daily Count Sheets XI.31.B for reconciliation of Controlled Substances, and the patient specific narcotic sign out sheet After verifying count, the nurse shall sign (first initial, last name) to this form.

4. When a controlled substance discrepancy is noted, the nurse will notify the Juvenile Care Worker in the clinic to stop all movement of students. The Shift Supervisor or Security Administrator shall be notified so that a search of all students and staff in the clinic can be conducted. The discrepancy shall be immediately reported to the Director of Medical Services who shall notify the Facility Administrator/designee. The nurses shall be conducting a thorough search of the clinical area. A facility Incident Report and an Agency Serious Incident Report (SIR) shall be completed.

a. If the controlled substance is not found the State board of Pharmacy shall be notified as per Article XXV Inventory Requirements for controlled substances;

b. If a facility has a loss of controlled substances, a complete inventory of all remaining controlled substances shall be made within forty-eight (48) hours of discovery of the loss of controlled substances. This inventory shall be dated and signed by the pharmacist conducting the inventory. Any loss or suspected loss of controlled substances shall be reported directly to the Mississippi Board of Pharmacy immediately upon discovery and a written report made to the Mississippi Board of Pharmacy within fifteen (15) days. This written report shall include a copy of the inventory required by this ARTICLE.

c. Notification of unaccounted loss of any federally controlled substances shall be immediately reported to the Director of Medical Services and Facility Administrator/designee. Theft or unaccounted loss of controlled substances shall be reported whether or not the controlled substances is subsequently recovered and/or the responsible parties are identified and action taken against them.

d. When the Board of Pharmacy is contacted regarding the loss of a controlled substance, a Board of Pharmacy representative will give instructions to call the regional office of the Drug Enforcement Agency (DEA) in New Orleans, LA (phone number 504-840-1100),DEA Form 106

e. The Mississippi Bureau of Narcotics will send you forms to complete. A copy of this form will suffice for the report that is required to be sent to the Board. Copies of the written report or form must be submitted to the following agencies: the Board of Pharmacy, The Mississippi Bureau of Narcotics, and the DEA office in New Orleans and Mississippi Department of Human Services.

5. Medical instruments, needles, syringes with needles, and sharps shall be placed in a locked cabinet located in the facility locked laboratory area and inventoried at every shift change. The nurse shall utilize the Medical Instrument, Needle and Sharps Inventory Daily Count Sheets for reconciliation of medical instruments, syringes, and syringes with needles. Refer to MDYS Policy XI.7, Medical and Dental Instruments Sharps Management. (4-JCF-4C-60)

F. Disposal of pharmaceutical shall be in accordance with the Mississippi Drug Laws and Drug Enforcement Administration (DEA). (4-JCF-4C-28)

1. Pharmaceuticals dispensed by Contract Pharmacy shall not be sent back to the Pharmacy for destruction.

a. The 2 licensed nurses destroying prescription shall fill out the pharmaceutical destruction form provided by the contract pharmacy. The nurse shall provide a copy of this form to the Director of Medical Services and maintained in the Medical Department files. A copy of this form shall be provided to the contract pharmacy as requested.

b. Disposal documentation shall be completed and maintained by the Contract Pharmacy and Director of Medical Services.

c. The methods of disposal are as follows:

i. Flushing small amounts up to 30 pills down the toilet. Flushing at least 5 times to make sure that pills are completely gone.

ii. Pour a sufficient amount of bleach into a sharps' container to cover the bottom of the container and up the side about one inch (1"). Drop all non narcotic medications to be destroyed in to the container. Pour enough bleach into the container to just cover the medications. This container must be kept in a locked secure location until transported off-site by the contract bio-hazardous waste handler.

A count of the medications destroyed should be done pre disposal and during disposal to ensure that all medications listed on the destruction form are correct.

2. Once a medication has been prepared for administration, the medication shall not be returned to the patient labeled blister package. This single dose may be destroyed at the facility regardless of source utilizing the Certificate of Drug Destruction Form provided by the Contract Pharmacy. Using one of the two methods described above.

G. The Director of Medical Services/designee shall complete the Non-Prescription Pharmaceuticals Supply Monitoring Form XI.31.C monthly. Any discrepancies shall reviewed and investigated.

H. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

NON-PRESCRIPTION PHARMACEUTICAL CONTROL FORM

Product Description: _____

Lot Number: _____ **Expiration Date:** _____ **Package Size:** _____

Health Care Personnel Completing Form: _____ **Date:** _____

Date	Balance	Amount Removed from Stock	Amount Added to Stock	Balance	Comments	Nurse's Signature

Reviewed by Health Services Supervisor: _____
Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services
Contingency Medication and Controlled Substance Daily Count Sheets

Date:																					
Shift:	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N
Medication																					
Signature &title																					

Code:	D = Day	E = Evening	N = Night

Mississippi Department of Human Services
Division of Youth Services
Medical Services

PRESCRIPTION PHARMACEUTICAL CONTROL MONITORING FORM

Medication Name	Actual # Present	Actual # Recorded	Discrepancy/Comments

Health Care Personnel Completing Monitoring Form: _____

Date: _____ **Time:** _____ **Accountability accurate:** ☐ **Yes** ☐ **No**

Reviewed by Director of Medical Services: _____

Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

NON-PRESCRIPTION PHARMACEUTICAL CONTROL MONITORING FORM

Supply Item Name	Actual # Present	Actual # Recorded	Discrepancy/Comments

Health Care Personnel Completing Monitoring Form: _____

Date: _____ **Time:** _____ **Accountability accurate:** ☐ **Yes** ☐ **No**

Reviewed by Director of Medical Services: _____

Signature Date

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Psychiatric Evaluations Content, Referrals for Psychiatric Evaluation and the Use and Management of Psychotropic Medications**	**Policy Number:** 32
Number of Pages: 7	**Section:** XI
Attachments Informed Consent for Psychotropic Medication Forms XI.32.A.1-25	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-28, 4-JCF-4C-29, 4-JCF-4C-30
Effective Date: 06/09/06 **Revision Date: 07/01/07, 04/25/08, 06/22/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that Standard procedural guidelines shall be established for the management of psychotropic medications. Psychotropic medication shall be prescribed to manage the symptoms of mental illness of the youth. Under no circumstances shall psychotropic drugs be administered for purposes of discipline, to chemically restrain a youth for program management or security control, or for the purposes of experimentation or research. (4-JCF-4C-28, 4-JCF-4C-29, 4-JCF-4C-30)
Timely evaluations by a Psychiatrist after referral this includes initial referral by either nursing staff or Qualified Mental Health Professional (QMHP) and referrals after initial admission assessment has occurred.
The use of medical restraints (also known as 4 point restraints) is strictly forbidden.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Psychotropic medication - are medications that affect; psychological, emotional and cognitive functioning. These medications are traditionally utilized to treat mental illness and/or neurological conditions. Classes of these medications include those with an antianxiety, antidepressant, and antipsychotic actions. psychostimulants, anticonvulsants, and mood-stabilizing medications are also considered psychotropic in nature.

Mental Disorder –Statistical Manual of Mental Disorders" (DSM)- "Clinically significant behavioral or psychological syndrome or pattern that occurs in an

individual and that is associated with present distress, disability, or with significantly increased risk of suffering, death, pain disability or an important loss of freedom, In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event for example the death of a love one period. What ever its original cause it must currently be considered a manifestation of a behavioral, psychological or biological dysfunction in the individual.

Mental Health Treatment Plan – the structured treatment documentation outlining intervention needs and goals for change for youth on the mental health caseload.

Medical (4-point) restraints – usually made of sturdy material, these restraints are to designed to restrain patients with the minimum of discomfort and pain and to prevent patients injuring themselves or others. As a medical restraint, limb restraints are soft, padded cuffs which are applied to a patient to prevent the patient from causing harm to him/herself or to others. The device consists of cuffs which are wrapped around the patient's wrists and/or ankles, and straps that are attached to the frame of their bed or chair.

Qualified Mental Health Professional (QMHP)-Qualified Mental Health Professional (QMHP) - include Psychologist, and licensed mental health professionals who by virtue of their education, credentials and experience are permitted by law to evaluate and care for the mental health needs of patients.

III. PROCEDURE

A. While the use of psychotropic medication can be valuable in enabling a youth to achieve and maintain successful adaptive functioning, such medication shall only be utilized when clinically indicated as a part of the comprehensive mental health treatment plan.

1. A psychiatric assessment shall be completed documenting the need for psychotropic medication prior to the administration of this medication, unless the youth arrives at the facility on psychotropic medication prescribed by a community provider.

2. Continuous and regular reassessments, to occur at least once every 30 (thirty) days, are required by the Psychiatrist to maintain the use of psychotropics with any youth.

3. Psychotropic drugs, such as antipsychotics or antidepressants and other drugs used for psychiatric purposes, requiring parenteral administration shall be prescribed only by a Psychiatrist and then only following an established treatment plan, or in emergency situations. (4-JCF-4C-28)

B. Qualified Providers and Medical Prescription

1. A Board Certified or Board Eligible Psychiatrist Licensed in the State of Mississippi shall prescribe psychotropic Medication after psychiatric evaluation.

2. If a Psychiatrist is not available, a non-psychiatric Physician, Licensed in the State of Mississippi, may prescribe psychotropic medication for a period of up to thirty days after psychiatric evaluation.

C. Prescription and Administration

1. A psychiatric diagnosis shall be documented in the medical record prior to initiating a psychotropic medication order unless a youth is admitted to the facility with prescribed psychotropic medication. If a youth is admitted to the facility on psychotropic medication, a psychiatric diagnosis will be documented in the medical record as soon as reasonably possible either from past medical record or after an initial psychiatric evaluation at the facility. Refer to section "F" for acceptable time guidelines.

2. A written psychiatric evaluation and treatment plan shall be completed and filed in the youth's health record. This treatment plan shall minimally indicate presenting problems, background information, mental status examination, diagnostic impressions using DSM or ICD nomenclature and clinical recommendations. This shall be accomplished within 14 (fourteen) days of admission to the facility

3. Psychotropic Medication, which has been ordered by an emergency room Physician, may be continued for up to thirty (30) days by a facility Physician/Psychiatrist. The youth shall be seen within seven (7) to ten (10) business days but not to exceed fourteen (14) business days following return from the emergency room by the Psychiatrist.

4. The prescribing Psychiatrist or Physician shall verbally explain to the youth the need, use, benefits, and possible side effects of the prescribed psychotropic medication.

   a. The prescribing Psychiatrist or Physician shall complete the appropriate Informed Consent for Psychotropic Medication Form XI.32.A, which includes possible medication side effects. The prescribing Psychiatrist or Physician will attempt to notify the patent/guardian of the youth.

   b. The appropriate Informed Consent for Psychotropic Medication form XI.32.A shall be filed in the youth's health record under the informed consent tab.

5. All required testing (Laboratory, EKG, etc) shall be completed and reviewed by the psychiatrist prior to beginning any medication.

6. All Psychotropic medication shall be administered by a Psychiatrist, Physician or Nurse. Administration of Medication shall be recorded in accordance with the record keeping procedures as defined by policy XI.30 Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures.

7. Medical staff and/or supervising Juvenile Care Workers (JCW's) shall verify that oral medication has been swallowed. To verify ingestion, staff may check the youth's hands and look into the youth's mouth as part of the process. Refer to Policy XI.30 Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures.

D. Youth Refusal of Medication

1. The facility Psychiatrist shall receive weekly notification of youth who are non-compliant with their prescribed psychotropic medication.

   a. The nurse shall document all medication refusals on the Medication Administration Record (MAR), Medication/Treatment Refusal Form XI.30.C and Interdisciplinary Progress Notes form XI.8.A. Refer to policy XI.30 Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures.

   b. The Medication/Treatment Refusal Form XI.30.C completed when youth refuse medication shall be filed under the MAR (Medication Administration Record) form XI.30.A

   c. If the Psychiatrist wants immediate feedback from the nursing staff regarding the youth's non-compliance, the psychiatrist shall note this request in the physician's orders. The Psychiatrist shall then be notified by phone of the noncompliance.

2. The Psychiatrist, QMHP, Director of Medical Services/designee shall counsel the youth on psychotropic medication compliance and discuss with him/her the alternate routes of administration.

3. The Psychiatrist shall determine the appropriateness of discontinuing medication if a pattern of non-compliance, which has not resulted in deterioration of the youth's mental status or resulted in the youth being a danger to self, or others or his/her physical environment, has been documented.

E. Emergency Medication shall be administered only by order of a Psychiatrist or Physician. Administration may be involuntary in the event the youth is a danger to himself/herself or others. The order shall indicate whether medication is given orally or intramuscularly.

1. A youth who is prescribed emergency medication due to becoming a danger to himself/herself or others by a non-psychiatric physician shall be referred

to the Psychiatrist for a follow-up evaluation no later than 72 hours after the administration of the prescribed medication. The QMHP/designee shall maintain daily contact with the youth and medical department staff from the time the medication incident arises until the time the youth is no longer in psychiatric crisis as determined by the Psychiatrist.

2. The nurse shall notify the Psychiatrist immediately for a phone order to transport the youth to an emergency room for an evaluation and intervention when:

   - A youth appears to be experiencing acute psychiatric symptomology and cannot be seen by the Psychiatrist or Physician and/or
   - The youth is in imminent danger to themselves or others (i.e. severe unmanageable head banging, eye-poking, biting, etc.).
   - The youth does not respond to acute interventions by staff.

   Due to the urgency of such situations, if the psychiatrist cannot be contacted in a timely manner, the administrator or designee may provide authorization for transport.

   a. Transportation in such emergency situations shall follow standard procedures for transport.

   b. If during the emergency room consultation it is deemed necessary to transport the youth to another medical facility, the Facility Administrator and/or the Division Director shall be contacted by the Director of Medical Services/designee to facilitate the transfer and select the appropriate placement.

   d. Youth returning from an emergency room psychiatric consultation shall be given a risk assessment per standard procedures. In the absence of the QMHP or psychiatric assessment, the youth shall be placed on the appropriate level of observation per policy.

   e. Youth returning from an emergency room psychiatric consultation shall be referred for psychiatric evaluation to be completed immediately but no later than five (5) days following return to the facility.

F. Psychiatric Assessment and Referral

1. Upon admission to the facility, all youth currently on psychotropic medication shall receive a physical examination by a licensed physician in addition to clinical assessments. (4- JCF-4C-03)

2. When a youth is admitted to the facility on a prescribed psychotropic medication, the Psychiatrist shall review the youth's medical record. He/she may authorize continued use of the currently prescribed psychiatric medications prior to a full evaluation for thirty (30) days from the date of admission to the facility. In all cases,

the Director of Medical Services/designee shall have the youth examined by the Psychiatrist.

3. The admitting Nurse shall make a referral for psychotropic medication consultation by the Psychiatrist. The evaluation shall be completed with in 15 (fifteen) business days of youth's admission to the facility.

4. Any youth not on the psychotropic medication but identified as requiring a psychiatric consultation shall be referred to the Psychiatrist by the QMHP or nursing staff.

   a. This shall include all youth who have been hospitalized in a mental facility within the two (2) previous years.

   b. This shall also include youth deemed as having a serious mental illness

      i. Those youth who have a current mental health diagnosis and are receiving treatment or therapy
      ii. Those who have a history of mental health diagnosis that is not currently being treated.

5. Any youth who is referred to the Psychiatrist for evaluation the following classification timelines shall be followed:

   a. Emergency- the nurse shall notify the Psychiatrist by phone for orders.

   b. Urgent- the youth shall be seen on the next psychiatry clinic day, but not later than 72 hours.

   c. Routine- the youth shall be seen by the Psychiatrist with in 14 (fourteen) business days.

G. The initial psychiatric evaluation shall include at a minimum the following elements:

- Identifying data
- History of present illness
- Past psychological and psychiatric history
- Medical history to include allergies
- Developmental history
- Family history
- Social history
- Mental status exam
- Diagnostic Formulation
- Five Axis Diagnostic
- Assessment and Plan

H. The psychiatric follow-up (or progress note) shall include at a minimum the following elements:

- Identifying data
- Interim history
- Mental status exam
- Assessment
- Diagnosis(es)
- Plan

I. Under no circumstances will medical restraints will be used.

J. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Anti-anxiety

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

POSSIBLE SIDE EFFECTS: Sleepiness; sometimes these medications cause the opposite effects than those expected: excitement, irritability, dizziness, anger, aggression, trouble sleeping, nightmares, uncontrollable behavior, memory loss, dry mouth, blurred vision, addiction

WARNING: Stopping this medication suddenly may cause cramps, seizures, depression, hearing and seeing things that are not there, restlessness, trouble sleeping or shakiness

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Antihistamines

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, unsteadiness, decreased attention or trouble concentrating, dry mouth, blurred vision, constipation, loss of appetite
LESS COMMON: Clumsiness or poor coordination, motor tics (fast repeated movements), unusual muscle movements, irritability, overactivity, shakiness, confusion
VERY RARE BUT SERIOUS: Worsening of asthma or trouble breathing, seizure, uncontrollable behavior, severe muscle stiffness

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

_____
Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Beta-Blockers

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Tiredness, numbing, cold, or pain in the fingers or toes: dizziness; slow heartbeat, low blood pressure
LESS COMMON: Sadness or irritability, nausea, trouble sleeping or nightmares, diarrhea, skin rash, muscle cramps
SERIOUS: Worsening of asthma or trouble breathing, wheezing, seeing or hearing things that are not there, heart failure
WARNING: Stopping this medication suddenly may cause a dangerous rise in blood pressure

Parent/Guardian contact - Telephone number: _____ Results of contact:

_____

_____
Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Buspar

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

POSSIBLE SIDE EFFECTS: Sleepiness, dizziness, nausea, headache, restlessness; sometimes these medications can cause the opposite effects than those expected, uncontrollable behavior, memory loss

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

_____
Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Clonidine [Catapres] and Guanfacine [Tenex]

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Slow heartbeat, temporary worsening of tics in Tourette's Disorder, trouble sleeping, ringing in the ears, skin redness and itching under the skin patch, constipation, dry mouth, dizziness
USUAL MILD SIDE EFFECTS: Sleepiness, fatigue, low pressure, agitation
LESS COMMON: Depression, confusion, bed-wetting, muscle cramps, itching, runny nose
VERY RARE BUT SERIOUS: Fainting, irregular heartbeat, trouble breathing, kidney failure; decreased frequency of urination, swelling of body, sudden headaches with nausea and vomiting
WARNING: Stopping this medication suddenly may cause a dangerous rise in blood pressure; temporary worsening of behavioral problems or tics; nervousness or anxiety; rapid or irregular heartbeat; chest pain; headache; stomach cramps (nausea, vomiting), trouble sleeping

Parent/Guardian- contact. Telephone number: _____ Results of contact:

_____

_____
Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Psychotropic Medication Consent Form
Cymbalta

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Nausea, sleepiness, headaches, dry mouth, dizziness, trouble sleeping, constipation, tiredness
LESS COMMON: Diarrhea, loss of appetite, sore throat, runny nose, weakness, sweating, vomiting, decreased sex drive, shakiness, blurred vision, anxiety, agitation, hot flashes, yawning, coughing, muscle spasms, taste changes
RARE: Anxiety attacks, restlessness, ear pain, acne, sensitivity to the sun, high blood pressure
RARE BUT SERIOUS: Extreme feelings of happiness or depression, seeing or hearing things that are not there, chest palpitations, aggressiveness, trouble urinating, heart failure, very fast heart rate

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Anticonvulsants: Depakote

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Upset stomach, increased appetite, weight gain, thinning hair, tremor (shakiness), drowsiness, sleepiness, increased facial or body hair, irregular menstrual periods, increased aggression, increased irritability or depression, shakiness, vision problems
VERY RARE BUT SERIOUS: Liver failure, inflammation of the pancreas (severe abdominal pain), enlargement of ovaries, severe acne, problems breathing, infection
POSSIBLY DANGEROUS: Feeling weak or unusually tired, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of legs, feet or face; greatly increased or decreased frequency of urination; unusual bruising and bleeding; sore throat; mouth ulcers; vomiting; persistent stomachache; skin rash, seizure, severe behavioral problems; mental confusion

WARNING: May cause birth defects if given to pregnant women

WARNING: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact - Telephone number: _____ Results of contact:

_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Effexor [venlafaxine]

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____(Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Anxiety/nervousness, nausea, sleepiness, insomnia, decreased appetite, weight loss, weakness
LESS FREQUENT: Yawning, blurred vision, dry mouth, dizziness, constipation, excessive sweating, lack of energy, trouble with sexual functioning
LESS COMMON BUT MORE SERIOUS: Increased blood pressure, seizures

WARNING: Do not give MAOI's, stopping suddenly may cause flu-like symptoms

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Klonopin [clonazepam]

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Difficulty with balance, drowsiness or sleepiness, irritation, excitement, increased anger or aggression, trouble sleeping or nightmares, memory loss
SERIOUS: Uncontrollable behavior, depression if combined with alcohol, may lead to severe sleepiness, unconsciousness or **DEATH**

WARNING: Stopping this medication suddenly may cause; Cramps, seizures, depression, seeing or hearing things that are not there, restlessness, trouble sleeping or shakiness

WARNING: May be habit forming

Parent/Guardian contact-Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Lamictal

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, headache, double vision, unsteadiness, blurred vision, nausea, anxiety or nervousness, agitation or mania, dry mouth, cough, tiredness
VERY RARE BUT SERIOUS: Vomiting, change in color of urine or frequency of urination, severe skin rash
POSSIBLY DANGEROUS: Feeling weak or sick or unusually tired, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of legs, feet, or face, greatly increased or decreased frequency of urination, unusual bruising or bleeding, sore throat, mouth ulcers, vomiting, persistent stomachache, seizure, severe behavioral problems, mental confusion

WARNING: Rarely, a serious, sometimes fatal skin rash may occur while using this medication. These rashes are more common in children under 16 (sixteen). Immediately notify your doctor if you develop any type of rash.

WARNING: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____
Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Lithium

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Weight gain, stomachache, diarrhea, nausea, vomiting, mild increased thirst, increased frequency of urination, mild shakiness of hands, tiredness, headache, dizziness
OCCASIONAL: Low thyroid function or goiter (enlarged thyroid) tiredness, feeling cold, weight gain, dry skin, coarser hair, decreased school performance, acne, skin rash, hair loss, bed-wetting, change in blood sugar, metallic taste in mouth, irritability
LESS COMMON BUT MORE SERIOUS—CALL THE DOCTOR IF: Persistent vomiting or diarrhea, weakness, lack of coordination, unsteadiness when standing or walking, severe shaking extreme sleepiness or tiredness, severe dizziness, trouble speaking or slurred speech, confusion
SEVERE TOXIC EFFECTS OF TOO MUCH LITHIUM: Irregular heartbeat, fainting, staggering, blurred vision, ringing or buzzing sound, inability to urinate, muscle twitches, high fever, seizure, unconsciousness **WARNING-** dehydration can lead to the symptoms stated above **AVOID** drinking large amounts of coffee, tea, cola, or excessive sweating, which can cause dehydration. Taking NSAIDs may cause an increase in Lithium levels.

Warning: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Neurontin

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, itchy runny nose, unsteadiness, rapid involuntary movements of eyes, feeling tired, double vision, tremor, fever in children, nausea, weight increase (in children)
BEHAVIORAL OR EMOTIONAL: Worsening of behavioral problems, temper tantrums, increased anger and/or aggression, irritability

WARNING: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Lithium

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Weight gain, stomachache, diarrhea, nausea, vomiting, mild increased thirst, increased frequency of urination, mild shakiness of hands, tiredness, headache, dizziness
OCCASIONAL: Low thyroid function or goiter (enlarged thyroid) tiredness, feeling cold, weight gain, dry skin, coarser hair, decreased school performance, acne, skin rash, hair loss, bed-wetting, change in blood sugar, metallic taste in mouth, irritability
LESS COMMON BUT MORE SERIOUS—CALL THE DOCTOR IF: Persistent vomiting or diarrhea, weakness, lack of coordination, unsteadiness when standing or walking, severe shaking extreme sleepiness or tiredness, severe dizziness, trouble speaking or slurred speech, confusion
SEVERE TOXIC EFFECTS OF TOO MUCH LITHIUM: Irregular heartbeat, fainting, staggering, blurred vision, ringing or buzzing sound, inability to urinate, muscle twitches, high fever, seizure, unconsciousness **WARNING-** dehydration can lead to the symptoms stated above **AVOID** drinking large amounts of coffee, tea, cola, or excessive sweating, which can cause dehydration. Taking NSAIDs may cause an increase in Lithium levels.

Warning: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Neurontin

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, itchy runny nose, unsteadiness, rapid involuntary movements of eyes, feeling tired, double vision, tremor, fever in children, nausea, weight increase (in children)
BEHAVIORAL OR EMOTIONAL: Worsening of behavioral problems, temper tantrums, increased anger and/or aggression, irritability

WARNING: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Remeron

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, weight gain, nausea, increased appetite, dry mouth
OCCASIONAL: Dizziness, constipation, lack of energy, tiredness, frequent urination
LESS COMMON: Vomiting or diarrhea, confusion, seizure, infection, yellowing of skin or eyes, dark urine or pale colored bowel movements, increased irritability , abnormal dreams
WARNING: Avoid taking with MAOI's

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decreased in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Antipsychotics

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON AND USUAL, BUT NOT USUALLY SERIOUS SIDE EFFECTS: Anxiety, dry mouth, sleepiness, constipation, mild trouble urinating, blurred vision, dizziness, weight gain, decreased sexual interest or ability, changes in menstrual cycle, increase in breast size or discharge from the breasts, drooling, sadness, irritability, nervousness, clinginess, increased risk of sunburn, itchy skin or skin rash, restlessness or inability to sit still, shaking of hands of fingers,
RARE: Not being able to control face, arm or leg movements
RARE BUT SERIOUS: Feeling hot but not sweating or excessive sweating, fainting, trouble breathing, trouble swallowing, seizures, pounding heart beat, high fever with rigid muscles, trouble breathing, diabetes or high blood sugar
WARNING: May worsen glaucoma; may cause rhythmic movements that may not stop when the medicine is stopped
WARNING: May cause agranulocytosis
WARNING: In light of ACOG guidelines you seriously consider the use of this medication. You should discuss the risks and benefits of continuing this medication with your OB/GYN physician if you are pregnant and/or breastfeeding

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
SSRIs

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Nausea, upset stomach, diarrhea, headache, anxiety or nervousness, insomnia, restlessness, dry mouth, dizziness, tremor or shakiness, excessive sweating, lack or interest, decreased sexual interest or trouble with sexual functioning, weight loss, weight gain, flu-like symptoms, yawning

LESS COMMON BUT MORE SERIOUS: Increased activity, rapid speech, feeling "speeded up", decreased need for sleep, being very excited or irritability (cranky), easy bruising, bleeding

SERIOUS: Seizure, heatstroke, stiffness, high fever, confusion, tremors (shaking), severe rash

Warning: Stopping this medication suddenly may cause; flu-like symptoms

Warning: Do not take with an MAOI, or take and MAOI within 5 (five) weeks of stopping Symbyax. Do not take with Pimozide or Thioridazine

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

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_____

Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Stimulants

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Lack of appetite and weight loss, nausea, insomnia, headaches, stomachaches, nervousness, crying, emotional sensitivity
LESS COMMON: Irritability (crankiness), rebound (hyperactivity as medicine wears off), slowing of growth, nervous habits, stuttering, motor or vocal tics (fast repeated movements or sounds), staring into space, fast heart beat, increased blood pressure
RARE BUT SERIOUS: Muscle cramps or twitches, sadness that lasts more than a few days, auditory, visual or tactile hallucinations (hearing, seeing or feeling things that are not there) any behavior that is very unusual for your child, yellowing of the skin or eyes, stroke, sudden death in children with heart problems, seizures, chest tightness or chest pain, pounding or irregular heart beat, sweating, trembling or shaking

Warning: Do not take within 14 (fourteen) days of an MAOI

Warning: Chronic abuse can lead to psychological dependence; do not increase your dose without a doctor's order

Warning: Some stimulants have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Strattera (Atomoxetine)

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness or trouble sleeping, nausea, loss of appetite, upper abdominal pain, dry mouth
LESS COMMON: Indigestion, headache, constipation, facial tics,
RARE: Growth problems, diarrhea, abnormal dreams, weight loss, crying, mood swings, sudden attack of low blood pressure, aggressive behavior
RARE BUT SERIOUS: Possible liver problems (yellowing of the skin or eyes) seeing or hearing things that are not there, chest pain, racing heart

Warning: Some stimulants have been associated with an increase in suicidal thoughts

Warning: Do not take with MAOI's, avoid if you have narrow angle glaucoma

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Symbyax

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON AND USUAL, BUT NOT USUALLY SERIOUS SIDE EFFECTS: Anxiety, dry mouth, sleepiness, constipation, mild trouble urinating, blurred vision, dizziness, weight gain, loss of appetite and weight loss, decreased sexual interest or ability, changes in menstrual cycle, increase in breast size or discharge from the breasts, drooling, sadness, irritability, nervousness, clinginess, increased of sunburn, itchy skin or skin rash, restlessness or inability to sit still, shaking of hands of fingers, trouble urinating, fast heart rate, feeling weak, trouble concentrating
LESS COMMON: Nightmares, stuttering, increased risk of sunburn, nervousness, shakiness, high cholesterol or triglycerides
LESS COMMON BUT MORE SERIOUS: Increased activity, rapid speech, feeling "speeded up", decreased need for sleep, being very excited or irritability (cranky), easy bruising, bleeding
RARE: Fainting, high or low blood pressure, not being able to control face, arm or leg movements
RARE BUT SERIOUS: Feeling hot but not sweating or excessive sweating, fainting, trouble breathing, trouble swallowing, seizures, pounding heart beat, high fever with rigid muscles, diabetes or high blood sugar, severe rash, abnormal bleeding, trouble thinking clearly, seizures

WARNING: Stopping this medication suddenly may cause flu-like symptoms

WARNING: In light of ACOG guidelines you should discuss the risks and benefits of continuing this medication if you are pregnant and/or breastfeeding

WARNING: May worsen glaucoma; may cause rhythmic movements that may not stop when the medicine is stopped; liver problems in extreme cases leading to coma or death

WARNING: Do not take with an MAOI, or take and MAOI within 5 (five) weeks of stopping Symbyax. Do not take with Pimozide or Thioridazine

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

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Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Tegretol

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, clumsiness or decreased coordination, nausea, mild decrease in white blood cells,
LESS COMMON: Aching joints or muscles, constipation, diarrhea, dry mouth, headache, increased sweating, irritation or soreness of tongue or mouth, loss of appetite, loss of hair, sexual problems in males, stomach pain, increased sensitivity to sunlight, motor or vocal tics, anxiety or nervousness, behavioral changes, skin rash or itching
VERY RARE BUT SERIOUS: Decrease in number of blood cells, worsening of seizures, severe skin rash , low sodium in the blood, congestive heart failure
POSSIBLY DANGEROUS: Feeling weak or unusually tired for no reason, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of ;legs, feet or face; greatly increased or decreased frequency of urination; unusual bruising and bleeding; sore throat/fever; mouth ulcers; vomiting; persistent stomachache; skin rash especially with fever, seizure, severe behavioral problems, depression, hearing voices or seeing things that are not there, blurred or double vision

Warning: May make birth control pills less effective

Warning: May cause birth defects when used in pregnant women

Warning: Some mood stabilizers have been associated with an increase risk of suicidal thoughts

Parent/Guardian contact-Telephone number: _____ Results of contact:

_____

_____

Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Anticonvulsants: Topamax

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, slowed movements, skin feeling like "pins and needles, fatigue, nausea, memory problems and trouble concentrating, tremors (shakiness), weight loss and decreased appetite
LESS COMMON: Back pain, chest pain, constipation, indigestion, hot flashes, increased sweating, leg pain, taste changes, irritability, nervousness, vomiting
POSSIBLY DANGEROUS: Clumsiness or poor coordination, bloody or cloudy urine, unexplained fever (chills and/or sore throat), sharp back pain, blurred or double vision or eye pain, trouble breathing or rapid breathing, blood clots, fainting, depression, high blood sugar, increased temperature with decreased sweating

Warning: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

_____
Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Desyrel (Trazadone)

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

OCCASIONAL SIDE EFFECTS: Drowsiness/sleepiness or trouble sleeping, dry mouth, dizziness, headache, blurred vision, nausea, decreased appetite, constipation, more frequent erections [boys], increased interest in sex {girls}
LESS COMMON BUT SERIOUS: Rapid heartbeat, fainting, vomiting, fever (sore throat, other signs of infections), prolonged erection of the penis, yellowing of skin or eyes, chest pain, rapid heart rate, shortness of breath, prolonged erection of the clitoris in women , easy bruising or bleeding

Warning: Do not take with an MAOI or take an MAOI with in 2 weeks of stopping Desyrel (trazadone

Warning: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Tricyclic Antidepressants

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____(Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Dry mouth, constipation, sleepiness, dizziness, weight gain, loss of appetite and weight loss, irritability, blurred vision, trouble urinating, fast heart rate
LESS COMMON: Nightmares, stuttering, increased risk of sunburn, increase in breast size in boys or girls, nipple discharge in girls, decreased sexual interest, nervousness, shakiness
RARE: High or low blood pressure, nausea, trouble urinating, blurred vision, motor tics (fast, repeated movements), increased activity, rapid speech, feeling "speeded up", decreased need for sleep, being very excited or irritable, rash , fainting
RARE BUT POTENTIALLY SERIOUS: Seizure, very fast or irregular heartbeat, fainting, hallucinations (hearing voices or seeing things that are not there), inability to concentrate, severe change in behavior, liver problems
WARNING: Do not take with MAOI's
WARNING: Do not take this medication if you are pregnant, are planning to become pregnant, or are breastfeeding
WARNING: Stopping this medication suddenly may cause flu-like symptoms

WARNING: May worsen glaucoma

Warning: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

_____

Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Anti-convulsants (Trileptal)

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Sleepiness, dizziness, clumsiness or decreased coordination, nausea, mild decrease in the number of white blood cells, skin rash, diarrhea, constipation, decreased appetite, headache, dry mouth
VERY RARE BUT SERIOUS: Lung irritation, worsening of seizures, severe skin rashes, loss of sodium from the blood
POSSIBLY DANGEROUS: An allergic reaction (trouble breathing, swelling of lips, tongue or face) , symptoms of low blood sodium (nausea, headache, extreme drowsiness or confusion), trouble concentrating, feeling sick or unusually tired for no reason, loss of appetite, yellowing of skin or eyes, dark urine or pale bowel movements, swelling of legs or feet, greatly increased or decreased frequency of urination, unusual bruising or bleeding, sore throat or fever, mouth ulcers, vomiting, skin rash (especially with fever), severe behavioral problems, loss of feeling, back and forth movements of the eyes, blurred or double vision or other problems with vision

WARNING: Some mood stabilizers have been associated with an increase in suicidal thoughts

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services
Psychotropic Medication Consent Form
Wellbutrin (Bupropion)

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON SIDE EFFECTS: Irritability, nervousness or restlessness, shakiness, trouble sleeping, dry mouth, constipation, headache, decreased appetite and weight loss, nausea, dizziness, excessive sweating
LESS COMMON: Motor tics or muscle twitching, rash, swelling around the mouth, ringing in the ears, increased blood pressure, fast heart beat, blurry vision,
RARE: Vomiting, seizures, unusual excitement, decreased need for sleep, rapid speech, mood swings, hair loss, memory loss, acne, ulcers, flushing, confusion

WARNING: Do not take within 14 (fourteen) days of an MAOI

WARNING: All antidepressants may carry the risk of increasing suicidal thoughts in children, adolescents and young adults. However, studies have found that increased use of antidepressants in these populations is associated with a decrease in suicides

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____
Review of Food and Drug Administration approval status for this medication.

_____ _____ _____
Youth's Signature Psychiatrist's Signature Date

Mississippi Department of Human Services
Division of Youth Services

Medical Services

Psychotropic Medication Consent Form
Antipsychotics

_____ _____
Youth's name Date of Birth

Psychiatrist: Dr._____ (Please Print)

_____ _____
Name of Medication Dosage Range

I understand that my psychiatrist will prescribe, and I will take this medication as a part of my mental health treatment program. If I take this medication as prescribed every day, it should help with these target symptoms:

I know the medication will be started at a low dose to make sure I have as few side effects as possible. I understand that laboratory examinations, including blood work and an Electrocardiogram, may be required. I have been provided an information sheet regarding the medication that has been prescribed. My psychiatrist has reviewed the information with me. I was given the opportunity to ask questions regarding the information. If I have the following or other side effects, I will report them to a doctor or nurse:

COMMON AND USUAL, BUT NOT USUALLY SERIOUS SIDE EFFECTS: Anxiety, dry mouth, sleepiness, constipation, mild trouble urinating, blurred vision, dizziness, weight gain, decreased sexual interest or ability, changes in menstrual cycle, increase in breast size or discharge from the breasts, drooling, sadness, irritability, nervousness, clinginess, increased risk of sunburn, itchy skin or skin rash, restlessness or inability to sit still, shaking of hands of fingers,

LESS COMMON, BUT POTENTIALLY SERIOUS: stiffness of tongue, jaw, neck, back, or legs; overheating or heatstroke, seizure; very irregular heartbeat; prolonged erection of penis

RARE, BUT SERIOUS: Decrease in number of blood cells or damage to the liver (manifested sometimes by fever, sore throat, illness, yellowing of eyes or skin, or skin rash or bruising); extreme stiffness or lack of movement, very high fever, mental confusion, irregular pulse rate, or eye pain (GO TO THE EMERGENCY ROOM IF THESE OCCUR); sudden stiffness and inability to breathe or swallow (GO TO THE EMERGENCY ROOM IF THESE OCCUR)Feeling hot but not sweating or excessive sweating, fainting, trouble breathing, trouble swallowing, seizures, pounding heart beat, high fever with rigid muscles, trouble breathing, diabetes or high blood sugar

WARNING: May worsen glaucoma; may cause rhythmic movements that may not stop when the medicine is stopped

WARNING: You should discuss the risks and benefits of continuing this medication with your OB/GYN physician if you are pregnant and/or breastfeeding

Parent/Guardian contact- Telephone number: _____ Results of contact:

_____

_____

Review of Food and Drug Administration approval status for this medication.

_____	_____	_____
Youth's Signature	Psychiatrist's Signature	Date

Oakley Training School

Psychotropic Medication Standing Orders

1) *Stimulants and Amoxetine (Strattera) Work-up:
   - EKG (baseline)
   - Hepatic Function Panel (baseline) and then every 6 (six) months.
   - Weight and height measurements
   - Blood Pressure and Pulse recorded at initiation

   *Stimulants and Amoxetine (Strattera) Monitor:
   - Blood Pressure and Pulse recorded every 2 (two) weeks
   - Monthly weight and height measurements
   - Hepatic Function Panel every 6 (six) months

2) Tricyclic Antidepressants Work-up:
   - EKG (baseline)
   - CBC
   - CMP

   Tricyclic Antidepressants Monitor:
   - CBC every 6 (six) months
   - CMP every 6 (six) months

   EKG with any significant increase in dosage

3) Lithium Work-up
   - CBC with Diff/Plts
   - TSH
   - CMP
   - Pregnancy Test (for females)
   - U/A
   - Baseline EKG

   Lithium Monitor
   - Lithium level weekly x 2 (two) weeks, then monthly
   - TSH every 3 (three) months
   - CMP every 3 (three) months
   - U/A every 3 (three) months
   - Annual EKG
   - Pregnancy Test (for females) every 3 (three) months

4) Depakote Work-up
   - CBC with Diff/Plts
   - CMP
   - Fasting Amylase and Lipase
   - Pregnancy Test (for females)
   - Hepatic Function Panel

Depakote Monitor

- Depakote level weekly x 2 (two), then monthly
- CBC w/Plts, Hepatic Function Panel, Fasting Amylase and Lipase every other month

5) Carbamazepine (Tegretol) Work-up

- CBC with Diff/Plts
- CMP
- EKG
- Pregnancy test (for females)
- Hepatic Function Panel

Carbamazepine (Tegretol) Monitor:

- Carbamazepine (Tegretol) level weekly x 2(two), then monthly
- CBC with Diff, Hepatic Function every other month

6) Alpha Antagonist: Clonidine and Guafacine (Tenex) Work-up:

- Baseline EKG
- Blood Pressure and pulse readings (sitting and standing) on initiation then once a day for 3 (three) days

Alpha Antagonist: Clonidine and Guafacine (Tenex) Monitor:

- Blood Pressure and pulse once every 2 (two) weeks
- Blood Pressure readings and pulse (sitting and standing) on any dosage increase or decrease then once a day for 3 (three) days

7) All Atypcials (SGA'S) including Clozaril Work-up:

- CMP (fasting)
- Lipid Profile (fasting)
- CBC with Diff/Plts
- Hepatic Function Panel
- Base line EKG
- Waist/Hip Ratio
- Weight
- Blood Pressure
- Pregnancy Test (for females)
- Potassium and Magnesium with Geodon only

Atypical (SGA'S)Monitor:

- Weight,Waist/Hip ratio monthly
- Fasting Plasma Glucose, CMP, Lipid Profile, Hepatic Function Panel, CBC with Diff/Plts after 1 (one) month then every 3 (three) months
- Potassium and Magnesium every 3 (three) months with Geodon only

Clozaril Monitor:

- All of the above
- Weekly CBC x 1 (one) month then every 3 (three) months
- Weekly White Blood Cell count

8) Effexor Work-up

- Blood pressure reading 3 (three) times per week x 2 (two) weeks. Notify MD if not within normal limits for age/size or Systolic >140

Effexor Monitor

- Blood pressure reading weekly. Notify MD if not with in normal limits for age/size or Systolic >140

9) Trileptal Work-up

- BMP
- CBC with Diff/ Plts

Trileptal Monitor

- Monthly Oxycarbazepine Level
- Monthly BMP

10) Lamictal

- Call MD immediately for any signs or symptoms of a rash

11) Obtain drug levels on admission if the student arrives on the following medications:

- Lithium
- Depakote
- Tegretol
- Nortriptyline
- Trileptal

Signatures:

_____

Dr. John Pruett Date

_____

Dr. Maude Wright Date

_____

Dr. Faiza Qureshi Date

_____

Dr. Dirk Dhossche Date

Mississippi Department of Human Services
Division of Youth Services
Medical Clinic

Initial Evaluation for students placed on Stimulants:

(Circle medication prescribed)

ADDERALL /XR

CONCERTA/METADATE/RITALIN /DAYTRANA
(methylphenidate)

FOCALIN/XR
(dexmethylphenidate)

DEXADRINE
(dextroanphetamine)

STRATTERA
(amoxetine)

Date stimulant was started:_____ Date of Admission:_____

The following baseline history was obtained during the student's admission:

PERSONAL/FAMILY HISTORY (Circle)			IF YES: WHO AND NATURE OF PROBLEM:
Hypertension	Yes	No	
Cardiovascular	Yes	No	

The following baseline information was obtained during the student's admission:

Weight (pounds):	**Fasting Labs:**_____ (Date completed) Hepatic Function Panel:
Height (inches):	Total Protein _____ Albumin_____ Alk Phos_____
Blood Pressure:	SGOT_____ SGPT_____ Total Bili_____ Direct Bili_____
Pulse:	**Baseline EKG:**_____

Mississippi Department of Human Services
Division of Youth Services
Medical Clinic

Initial Evaluation for students placed on SGA's:
(Second Generation Antipsychotics)

(Circle medication prescribed)

ABILIFY	CLOZARIL	GEODON	RISPERDAL	SEROQUEL	ZYPREXA
(Aripiprazole)	(Clozapine)	(Ziprasidone)	(Risperidone)	(Quetiapine)	(Olanzapine)

Date SGA was started:_____ Date of Admission:_____

The following baseline history was obtained during the student's admission:

PERSONAL/FAMILY HISTORY (Circle)	IF YES: WHO AND NATURE OF PROBLEM:
Obesity Yes No	
Diabetes Yes No	
Dyslipidemia Yes No (Elevated cholesterol or triglycerides)	
Hypertension Yes No	
Cardiovascular Yes No	

The following baseline information was obtained during the student's admission:

Weight (pounds):	**Fasting Labs:**_____ (Date completed)
Waist Circumference (inches):	Glucose:_____
Hip Circumference (inches):	Lipid Profile:
Waist/Hip Ratio:	Cholesterol:_____ Triglyceride:_____
Blood Pressure:	**Baseline EKG:**_____
AIMS Score of :	**on** (Date)

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Communicable Disease Management**	**Policy Number:** 33
Number of Pages: 7	**Section:** XI
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C22, 4-JCF-4C23, 4-JCF-4C24, 4-JCF-4C25, 4-JCF-4C-26
Effective Date: 06/09/06 **Revised Date:** 05/01/07, 04/25/08, 05/01/11, 11/01/13	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, to address the management of serious infectious and communicable diseases for the safety of staff and youth. The Health Authority shall establish procedures that address the following: (4-JCF-4C-22, 4-JCF-4C-23, 4-JCF-4C-24, 4-JCF-4C-25, 4-JCF-4C-26)

- Ongoing education programs for staff and youth
- Identification, Control, Treatment, Surveillance, Prevention strategies and for:
  - Screening and testing
  - Special supervision
  - Safeguards for staff and youth including immunizations, when applicable
  - Follow-up care, when applicable
  - Special housing arrangements, as appropriate
- Protection of individual confidentiality and media relations
- Reporting requirements to applicable local, state, and federal agencies
- Medical examination of any youth suspected of a communicable disease.
- Actions to be taken by employees concerning youths who have been diagnosed as HIV+.

The Director of Medical Services shall immediately notify the Facility Administrator/ designee of all suspected or confirmed cases of infectious and communicable diseases. Communicable disease and infection control activities shall be discussed and reviewed by a multidisciplinary team that includes clinical, security, and administrative representatives that meets at least quarterly. (4-JCF-4C-22)

The facility shall provide youth with prevention, education, identification, surveillance, immunization when applicable, treatment or isolation when indicated, follow-up care, and adhere to reporting requirement to applicable local, state, and federal agencies for chickenpox. Precautions shall also be taken to protect staff and visitors from harmful effects of this contagious disease. (4-JCF-4C-22)

Standard procedural guidelines shall be established to provide screening, examination, and treatment of youth who are suspected of an ectoparasite infestation. (4-JCF-4C-13, 22)

Please refer to medical policies XI.11.34-HIV Screening, Testing and Management, XI.11.35-Hepatitis Screening, Testing and Management and XI.11.36-TB Testing and Management XI.39 Pandemic Response Plan for Medical and Mental Health Services.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

AIDS – the illness caused by the Human Immunodeficiency Virus (HIV). Infection with this virus attacks the immune defenses of the body and leaves its victims vulnerable to opportunistic infection. AIDS and AIDS related conditions are regarded as disabilities, and are protected under disability laws.

Chicken Pox –an acute, contagious viral disease characterized by fever and the onset of a generalized papulo-vesicular rash without other apparent cause. Communicability is usually 5-6 days prior to rash onset.

Incubation Period – is the phase in the development of a disease between the infection and first appearance of symptoms. This is generally 14-21 days for chicken pox.

Isolation – the separation from others to prevent the spread of infection. Uncomplicated cases of chicken pox should be excluded from general population until all lesions are crusted over. This is usually one week.

Ectoparasite – a parasite that lives on the outer surface of the body, such as fleas, ticks and lice.

Direct Contact – transmission via person-to-person contact with an infected host.

Indirect Contact – transmission from other than the infected host; may be from inanimate objects such as combs, hats, clothing, etc.

Hepatitis B (HBV) – inflammation of the liver caused by the Hepatitis B virus.

Human Immunodeficiency Virus (HIV) – the viral agent responsible for causing AIDS.

Tuberculosis (TB) - An infectious disease caused by the Mycobacterium Tuberculare bacilli.

Methicillin-resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It may also be called multidrug-resistant Staphylococcus aureus or oxacillin-resistant Staphylococcus aureus (ORSA).MRSA is, by definition, any strain of Staphylococcus aureus bacteria that has developed resistance to beta-lactam antibiotics which include the penicillins (methicillin, dicloxacillin, nafcillin, oxacillin, etc.) and the cephalosporins.

Seasonal Flu: A respiratory illness that can be transmitted person to person. Most people have some immunity, and a vaccine is available. This is also known as the common flu or winter flu, which may cause mild illness and rarely requires hospitalization.

Standard Precautions – protective procedures that apply to blood and other body fluids containing visible blood, semen and vaginal secretions. They also apply to tissues and the flowing fluids:

- Cerebrospinal fluid – found in the brain and spinal cord
- Synovial fluid – found around the joints and tendons
- Pleural fluid – found around the lungs
- Pericardial fluid – found around the heart
- Amniotic fluid – found around the fetus of a pregnant woman

Although the risk of transmission of HIV and HBV from feces, nasal secretions, sputum, sweat, tears, urine, vomitus and saliva is extremely low, standard precautions also apply.

III. PROCEDURE

A. Education is the most effective tool for alleviating fear associated with contagious diseases, such as HIV, Tuberculosis, Hepatitis and seasonal Influenza.

1. The Director of Medical Services shall coordinate ongoing health education and prevention training to youth. Refer to MDYS Policy XI.22, Health Education and Prevention.
2. Personnel are informed of potential endemic and epidemic contagious disease, including transmission route, precautions and treatment of disease.

B. Any youth with an infectious or contagious disease shall be medically managed in accordance with the Mississippi Department of Health's Disease Control Policy. (4-JCF-4C-22, 4-JCF-4C-23, 4-JCF-4C-24, 4-JCF-4C-25, 4-JCF-4C-26)

1. Upon entering the facility, a Nurse shall screen all youth to determine if any contagious diseases are present. If any unusual or suspicious findings the facility Physician shall be consulted immediately. Refer to policy XI.15, Admission Health Screening and Assessment.

   a. A visual inspection shall be made and notation made of any rash, pustule, skin eruption/drainage, jaundice.

   b. A complete set of vital signs including BP, temperature, pulse , respirations and oxygen saturation via pulse oximeter shall be obtained on admission.

   c. Physical assessment including, but not limited to auscultation and palpation shall be completed.

   d. Any anomalies noted shall:

      i. Be recorded on the Interdisciplinary Progress Note form XI.8.A and
      ii. Any of that are indicative of communicable disease or illness shall be communicated with the Physician immediately. Any further notification of facility administration will proceed based on orders received from the Physician.

2. The Nurse reviews all health records that are received from the Court, parent or guardian.
   a. Significant health data is noted in the youth's health record, Interdisciplinary Progress Notes XI.8.A.
   b. If medical and immunization history is not received from the Court, parent or guardian on intake, the on site clinic staff shall be responsible for contacting the youth's parent or guardian and requesting this documentation. Documentation of this request is noted in the youth medical record, Interdisciplinary Progress Notes.
3. The following policies shall outline the requirements for the management of specific diseases not covered in this policy: (4-JCF-4C-23, 4-JCF-4C-24, 4-JCF-4C-25,)
   - HIV Screening, Testing and Management Policy XI.34
   - Hepatitis Screening, Testing and Management Policy XI.35
   - Tuberculosis (TB) Testing and Management Policy XI.36

C. When an employee is suspected of being infected with a contagious disease, he/she shall be referred to their family physician for examination and/or treatment. The employee shall obtain written approval from their family physician to return to work.

D. Since vaccinations help eradicate disease MDYS shall provide an immunization program for all youth in our facility (4-JCF-4C-22, 4-JCF-4C-24)
   - Youth Immunization Program Policy XI.37

E. The gravity, methods of transmission and public sensitivity to contagious diseases require special attention for the safety of youth and staff. Communicable disease and infection control activities shall be discussed and reviewed by a multidisciplinary team that includes clinical, security, and administrative representatives that meets at least quarterly. (4-JCF-4C-22)

   Reduction of employee exposure to blood borne pathogens shall require utilization of prevention measures. Refer to the following standing operating procedures:

   - Exposure Control and Standard Precautions policy XI.38

F. The clinic staff shall manage any youth with a suspected or confirmed case of Chickenpox.
   1. All suspected cases of Chickenpox shall be assessed immediately.
      a. The youth shall be placed in medical isolation and shall remain in isolation pending a confirmation of the diagnosis. The youth shall not have contact with youth from the general population at any time until released by the medical department.
         i. If Chicken Pox is confirmed, the youth shall remain in medical isolation until the vesicles have crusted over. This shall normally take about one week.
         ii. If the youth is determined not to have Chickenpox, the Physician shall write an order to release him/her back to the general population.

b. When a youth is in medical isolation, a Nurse shall assess the youth each shift and document their visit in the youth's medical record, Form XI.8 Interdisciplinary Progress Notes.

2. After the Chicken Pox diagnosis has been confirmed. The Director of Medical Services/designee shall contact the Facility Administrator. Those staff and students who have been exposed the following things shall take place:

a. Determining who is susceptible and who is immune. The facility contract Physician will decide the best approach. Whether it be blood IgG Varicella titers, by history or simply offering the Varicella vaccination to all.

b. Cohorting the exposed susceptibles together for entire incubation period twenty-one (21) days. This way any secondary cases no new susceptibles will be exposed.

c. Providing the first dose of Varicella vaccine to all susceptibles after exposure.

3. Any youth experiencing complicated chickenpox symptoms shall be monitored closely.

4. Chickenpox warning notice shall be posted at the door of the of the isolation room notifying staff of a diagnosed Chickenpox case within the clinic.

5. In the event of an epidemic within the facility, the facility physician may authorize the youth with confirmed previous cases of chickenpox to be housed in the same living unit with the active chickenpox case. The Director of Medical Services/designee shall notify the Facility Administrator and unit staff that the Physician has authorized these housing arrangements.

G. After the diagnosis of Influenza has been confirmed The Director of Medical Services/designee shall contact the Facility Administrator.

1. The single best way to prevent the seasonal flu is vaccination. Therefore both the seasonal and any other variation of flu vaccination will be offered to the youth every year from October thru March. Refer to policy XI.37 Immunization Program.

2. To lower the risk of contracting the influenza virus experts recommend people do the following:

- Cover mouth and nose when coughing or sneezing and when using tissues dispose of them in receptacles
- Clean hands often
- Avoid touching eyes, nose, or mouth
- Social distancing
- Avoid close contact with people who are sick
- If possible, stay home from work, school or errands when sick

H. Decontamination process on admission

1. Prior to placement in general population, all youth shall shower and receive a delousing treatment upon intake.
2. After showering, each youth shall be provided clean facility issue clothing.
3. The youth's personal clothing shall be stored per policy.

I. Treatment of active infestations: Youth with an Ectoparasite infestation shall be treated as prescribed by the facility physician and reevaluated in 7-10 after initial treatment for possible follow up treatment.

1. Staff members handling youth clothing shall utilize Standard Precautions. Refer to policy XI.38, Exposure Control and Standard Precautions.
2. Any youth determined to have an active ectoparasite infestation shall have all clothing and linens placed in a water-soluble bag, then placed in a red biohazard bag and washed according to the manufacturer's recommendations in a normal wash cycle. The youth's room shall be vacuumed and cleaned prior to replacing the linens.
3. Those youth with signs and symptoms of an infestation requiring isolation shall be handled as follows;
   a. Following assessment and identification of continued infestation, re-treatment may be necessary if the youth continues to complain after the initial treatment. A physician order shall be required prior to re-treatment.
   b. Youth may resume normal activities upon completion of the prescribed treatment regimen and when medically cleared by the facility physician.
4. Patient teaching shall be documented in the youth health record. Youth shall be advised to avoid sharing clothing, bedding, combs, hats, etc.

J. MRSA may progress substantially within 24–48 hours of initial topical symptoms. After 72 hours MRSA can take hold in human tissues and eventually become resistant to treatment. The initial presentation of MRSA is small red bumps that resemble pimples, spider bites, or boils that may be accompanied by fever and occasionally rashes. Within a few days the bumps become larger, more painful, and eventually open into deep, pus-filled boils

1. Any student with wound suspicious of infection shall be referred to the facility clinical practitioner on an urgent basis. If the student cannot be seen within 24 hours the Director of Medical Services/designee will place a phone to the Physician for further instructions.
   a. The Physician shall evaluate the condition and decide if further actions are warranted; such as
      i. A wound culture,
      ii. Treatment with antibiotics,

iii. Referral to appropriate facility for more intensive treatment

K. Confidentiality: Medical diagnosis and treatment of youth shall be kept in strictest confidence by health care personnel and released on a need to know basis to the Facility Administrator by the Director of Medical Services. The youth's confidentiality in accordance with state and federal law shall be maintained at all times. The Health Services Coordinator may share data in written or electronic form with the Centers for Disease Control (CDC), the Mississippi Department of Health (MDH), and local Health Departments. The Director of Medical Services shall approve any other requests for medical information or statistical data prior to release.

L. Media: All requests for information on any issue received from radio, press, television or electronic media personalities shall be referred to the Division Director.

M. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **HIV Screening, Testing and Management**	**Policy Number: 34**
Number of Pages: 4	**Section: XI**
Attachments HIV Informed Consent and Confidentiality of Test Results Form XI.34.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-22, 4-JCF-4C-25
Effective Date: 06/09/06 **Revised Date: 05/01/07, 04/25/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established to ensure that HIV screening, identification, testing, education, surveillance, immunization when applicable, treatment, counseling, follow-up care, and isolation when indicated is provided to youth. This procedure identifies actions to be taken by employees concerning youths who are in need of HIV screening and/or have been diagnosed as HIV positive; when and under what condition youths shall be separated from the general population; and confidentiality. (4-JCF-4C-22, 4-JCF-4C-25)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Acquired Immune Deficiency Syndrome (AIDS) – an illness caused by the Human Immunodeficiency Virus. Infection with the virus attacks the immune defenses of the body and leaves its victims vulnerable to opportunistic infections.

Human Immunodeficiency Virus (HIV) – the viral agent responsible for causing AIDS.

High risk exposure for blood and body fluids- when body fluids contact non-intact skin or mucus membranes.

Low risk exposure for blood and body fluids – when body fluids contact intact skin or clothing.

Standard Precautions -protective procedures recommended to reduce the risk of the spread of infections in health care facilities. This applies to blood, other body fluids containing visible blood, semen, and vaginal secretions. They also apply to tissues and the following fluids:

- Cerebrospinal fluids – found in the brain and spinal cord
- Synovial fluid – found around the joints and tendons
- Pleural fluid – found around the lungs
- Pericardial fluid – found around the heart
- Amniotic fluid – found around the fetus of a pregnant woman
- Although the risk of transmission of HIV and HBV from feces, nasal secretions, sputum, sweat, tears, urine, vomitus, and saliva is extremely low, standard precautions shall also apply.

III. PROCEDURE

A. Upon admission the nursing staff assess the youth's general health condition, HIV status, establish a baseline for future comparisons, identify any medical problems or conditions that might affect placement or treatment, and identify any active communicable diseases. (4-JCF-4C-25)

1. Upon admission, a nurse shall complete a health history assessment on all youth. Refer to policy XI.15, Admission Health Screening and Assessment.

2. The HIV Informed Consent and Confidentiality of Test Results Form XI.34.A shall be reviewed with the youth for their signature.

   a. When reviewing the consent form with the youth, the nurse should ask if he/she understands the consent for testing.

   b. If the youth refuses testing, have him/her sign the bottom of the consent form as "refusing testing" and forward it to the Director of Medical Services.

   c. The Nurse shall also document the youth's reason for refusal in the youth's health record, Interdisciplinary Progress Notes Form XI.8.A.

3. If the youth refuses to have an HIV test performed, the Physician shall be notified so that the youth can be counseled at the time of the physical examination.

4. Youth who meet the following criteria are considered to be at high-risk:

   - Any youth stating a history of exposure to someone with known or suspected HIV infection
   - Any youth with active Tuberculosis (current or past history)
   - Any youth with a sexually transmitted disease, a history of recent or frequent STD's or diagnosis of Hepatitis
   - Youth who engage in unprotected sex
   - Youth that have been victims of sexual abuse
   - Youth known to be IV drug users
   - Youth who have shared needles either for IV drug use, tattooing, piercing, or steroid use
   - Youth who engage in sex with multiple partners (male or female)
   - Bite wounds, when the skin is broken it constitutes a high risk

exposure for both parties
- Presence of an opportunistic infection if determined to be medically necessary by the Physician
- Adjudicated sex offender

B. After a youth consents to have an HIV test performed, the Physician order shall be required prior to testing. Refer to policy XI.16, Health Care Appraisal and Examination, and policy XI.17, Laboratory Services, for guidelines and requirements for drawing laboratory specimens. (4-JCF-4C-25)

C All results of HIV testing shall be held in strictest confidence.

1. If the results are negative, the Nurse shall inform the youth who has been tested of the negative HIV results. The youth shall be instructed in safe sex practices.

2. If the results are positive the Director of Medical Services/designee and/or the Physician shall communicate the status to the youth. The Director of Medical Services/designee shall forward the results to the Mississippi Health Department's (MDH) Sexually Transmitted Diseases Unit for further counseling direction.

3. HIV laboratory results shall be maintained confidentially in the youth's health record, each result document shall be stamped as confidential.

4. Only those persons with a medical need to know may be informed. Facility and Division staff that falls under "medical need to know" shall be:

   - Division Director
   - Facility Administrator
   - Director of Medical Services
   - Health Care Professionals who provide direct care to youth

5. If a staff person request results of a youth HIV test as a result of a high risk exposure refer to policy XI.38, Exposure Control and Standard Precautions. Bite wounds in which the skin is broken, both people involved in the incident are to be considered as a high risk exposure. The results of said test will be given to the Facility Administrator for further disposition.

D. All counseling shall be documented in the youth's medical record, Interdisciplinary Progress Notes Form XI.8.A.

E. A youth who is HIV positive shall remain in general population unless his or her medical condition requires more intensive care, the individual is expressing threatening behaviors that might infect others, or the individual is threatened with violence and/or intimidation. (4-JCF-4C-25)

F. Court Ordered Testing

1. The Facility Administrator and Director of Medical Services shall be notified of any court ordered testing.

2. Youth refusing court ordered testing shall be referred to the Facility Administrator for further directions.

3. The Director of Medical Services shall send testing results directly to the ordering Judge.

4. A copy of the court order shall be maintained in the youth's health record.

G. Hospitalized youths, who in the opinion of the attending physician require a HIV test for diagnostic purposes, shall receive necessary pre-test and post-test counseling by the hospital physician/designee. If the youth is no longer hospitalized when the results became available, the facility shall provide and document the post-test counseling.

H. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Hunan Services
Division of Youth Service
Medical Services

HIV INFORMED CONSENT and CONFIDENTIALITY OF TEST RESULTS FORM

HUMAN IMMUNODEFICIENCY VIRUS DIAGNOSTIC TESTING

Name: _____

DOB: _____ **Admit Date:** _____

Allergies: _____

INFORMED CONSENT TO HIV ANTIBODY TEST (TESTING FOR THE AIDS VIRUS)

Before an HIV antibody test can be given in Mississippi, consent is needed. If your have any questions, please ask your doctor or counselor.

1. WHAT IS THE HIV ANTIBODY TEST?

The HIV antibody test is a blood test. The test shows if you have antibodies to the virus that causes AIDS. A sample of your blood will be taken from your arm with a needle. If the first test shows that you have antibodies, a series of tests, including a different test, will then be done on the same blood sample to make sure the first test was right. A positive test result means that you have been exposed to the virus and are infected. It does not mean that you have AIDS, or that you will necessarily become sick with AIDS in the future. A negative test means that you are probably not infected with the virus. It takes the body time to produce HIV antibodies. If you have been exposed to HIV recently, you need to be retested in several months to make sure you are not infected. Your doctor or counselor will explain this to you.

2. VOLUNTARY TESTING

Taking an HIV antibody test is voluntary. You do not have to take the test. Consent may be withdrawn at any time before you leave the premises where your blood is drawn for the test. If you are under age 16, you may consent to be given an HIV test. If you do not wish anyone to know your test results, or even that you have been tested, you can go to an anonymous test site. This is a place where you can receive counseling and the HIV test without giving your name or address. You can find the nearest anonymous test site by calling the AIDS Hotline – number is available from the nurse.

3. BEHAVIORS THAT POSE RISKS

Most AIDS infections are spread through certain sexual activities or sharing of intravenous needles. Oral, anal, or vaginal intercourse with an infected individual can transmit the virus. The virus can be passed from an infected mother to her child during pregnancy, the birth process and breastfeeding.

4. WHAT IS THE VALUE OF AN HIV ANTIBODY TEST?

If you test negative, you can learn how to continue to avoid getting infected; ask your counselor for advice. Getting education through counseling is the key to preventing the spread of AIDS. If you test positive: (1) you can learn how to avoid giving the virus to others. (2) With this information, your doctor can take better care of you. (3) If you are a woman or a man thinking about having a baby, you can learn about the risk to your baby.

5. RISKS INVOLVED WITH DISCLOSURE AND SOURCES OF HELP

If you test positive, you should be careful about telling others what your test showed. Employers, landlords and others have discriminated against some HIV positive people. If you have experienced discrimination because of release of HIV-related information, you may contact the Mississippi AIDS Hotline 1-800-232-4363.

6. FOR MORE INFORMATION

For a list of resources for further counseling or support, ask your doctor or counselor. If you have any further questions about HIV antibody testing, you may contact the AIDS Hotline – number is available from the nurse.

7. CONFIDENTIALITY OF TEST RESULTS

If you take the HIV antibody test, your test results are confidential. Under Mississippi law, confidential HIV related information can only be given to people you allow to have it by signing a release form, or to those persons listed below:

A. Yourself
B. Your legal guardian
C. Your spouse or sexual partner
D. A person authorized by you or your guardian in a written release
E. Your physician
F. The Department of Health or a health commissioner
G. Agencies involved in screening your donated body parts
H. Health care facility groups conducting program reviews
I. Law enforcement authorities with a search warrant or a subpoena
J. Health care providers who are treating or caring for youth
K. MDYS Staff member(s) authorized by signor to receive test results (Youth Initials and Date Required)

_____	_____	_____
Print Name of Staff Member	Youth Initials	Date
_____	_____	_____
Print Name of Staff Member	Youth Initials	Date

You have the right to ask the person who tested you if HIV related information has been or shall be released to anyone listed above.

INFORMED CONSENT TO HIV ANTIBODY TEST

I have reviewed the information in the INFORMED CONSENT TO HIV ANTIBODY TEST. My questions about the HIV test have been answered. I agree to take the HIV antibody test.

Comment: _____

_____

_____	_____
Signature of the person who will be tested	**Date**
_____	_____
Nurses Signature	**Date**

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Hepatitis Screening, Testing and Management**	**Policy Number: 35**
Number of Pages: 3	**Section: XI**
Attachments None	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards: 4-JCF-4C-22, 4-JCF-4C-24
Effective Date: 06/09/06 **Revision Date: 05/01/07, 05/01/11, 11/01/13**	**Approved:** James V. Maccarone, Director

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established to ensure that Hepatitis screening, identification, testing, education, surveillance, immunization when applicable, treatment, counseling, follow-up care, and isolation when indicated shall be provided to all youth. This procedure identifies actions to be taken by staff concerning youth who are in need of Hepatitis screening and/or have been diagnosed as active or chronic Hepatitis; when and under what condition youth shall be separated from the general population; and confidentiality. (4-JCF-4C-22, 4-JCF-4C-24)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Hepatitis A (HAV) - HAV is a virus that causes inflammation of the liver but does not lead to chronic disease.

Hepatitis B (HBV) - HBV is a virus that causes inflammation of the liver, but can cause liver cell damage, leading to cirrhosis and cancer.

Hepatitis C (HCV) - HCV is a virus that causes inflammation of the liver, which can also lead to cirrhosis and cancer.

Hepatitis D (HDV) - HDV is a virus that causes inflammation of the liver, but it only infects those persons with HBV.

Hepatitis E (HEV) - HEV is a virus that causes inflammation of the liver, but there is no chronic state. It is rare in the United States.

Standard Precautions -protective procedures recommended to reduce the risk of the

spread of infections in health care facilities. This applies to blood, other body fluids containing visible blood, semen, and vaginal secretions. They also apply to tissues and the following fluids:

- Cerebrospinal fluids – found in the brain and spinal cord
- Synovial fluid – found around the joints and tendons
- Pleural fluid – found around the lungs
- Pericardial fluid – found around the heart
- Amniotic fluid – found around the fetus of a pregnant woman
- Although the risk of transmission of HIV and HBV from feces, nasal secretions, sputum, sweat, tears, urine, vomitus, and saliva is extremely low, standard precautions shall also apply.

III. PROCEDURE

A. Upon admission evaluation the nursing staff assess the youth's general health condition including hepatic function, establish a baseline for future comparisons, identify any medical problems or conditions that might affect placement, or treatment, and identify any active communicable diseases. (4-JCF-4C-22, 4-JCF-4C-24)

1. Upon admission, a nurse shall complete a health history on all youth. Youth are screened to determine their risk for having contracted Hepatitis. Refer to policy XI.15, Admission Health Screening and Assessment.

2. Health care personnel shall determine if the youth meets the criteria to be screened for Hepatitis A, B, and C. The criteria for testing shall be based on a youth's history and may include, but not be limited to:
   - Any youth stating a history of exposure to someone with known or suspected Hepatitis.
   - Any youth with a sexually transmitted disease, a history of recent or frequent STD's or diagnosis of Hepatitis, Jaundice or Scleral Icterus.
   - Youth that have been victims of sexual abuse
   - Youth known to be IV drug users
   - Youth who have shared needles either for IV drug use, tattooing, piercing, or steroid use
   - Youth who have engaged in high risk sexual habits, either male or female (prostitutes)
   - Youth who have sustained bite wounds, especially where skin is broken and there is transference of blood
   - Recipients of blood transfusion

B. When a youth requests or meets any of the above noted criteria for potential exposure Hepatitis the physician order shall be required prior to testing. Refer to policy XI.16, Health Care Appraisal and Examination, and policy XI.17, Laboratory Services for guidelines and requirements for drawing laboratory specimens. (4-JCF-4C-24)

1. Each youth must receive education regarding the method of transmission of Hepatitis by the Director of Medical Services/designee, or facility contract physician prior to Hepatitis testing.

   a. If the testing results are negative, the nurse shall inform the youth he/she is negative for Hepatitis. The youth shall be instructed in safe sex practices and be retested only if indicated.

   b. If positive, the results shall be communicated to the youth by the Physician and the positive results shall be forwarded to the Facility Administrator and Director of Medical Services/designee.

   c. Only those persons with a medical need to know may be informed. Staff who fall under "medical need to know" shall be:

      - Facility Administrator
      - Division Director
      - Health Care Professionals who provide direct patient care

2. All counseling shall be documented in the youth's medical record, Form XI.8 Interdisciplinary Progress Notes.

C. A juvenile who has Hepatitis shall remain in general population unless his or her medical condition requires more intensive care, the individual is expressing threatening behaviors that might infect others, or the individual is threatened with violence and/or intimidation. (4-JCF-4C-24)

D. Court Ordered Testing

1. The Facility Administrator and Director of Medical Services/designee shall be notified of any court ordered testing.

2. Youth refusing court ordered testing shall be referred to the Facility Administrator for further directions.

3. The Facility Administrator shall send testing results directly to the ordering Judge.

4. A copy of the court order shall be maintained in the youth's health record.

E. The Director of Medical Services shall revise this policy as necessary.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **TB Screening, Testing and Management**	**Policy Number: 36**
Number of Pages: 3	**Section: XI**
Attachments TB Skin Testing Record Form XI.36.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards2009: 4-JCF-4C-22, 4-JCF-4C-23
Effective Date: 06/09/06 **Revision Date: 05/01/07, 05/07/08, 05/13/09, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established to ensure Tuberculosis (TB) testing, education, surveillance, monitoring, treatment, isolation when indicated, and follow-up care for all youth including arrangement with applicable Department of Health for continuity of care if a youth shall be released prior to completing treatment. (4-JCF-4C-22, 4-JCF-4C-23)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Tuberculosis (TB) – An infectious disease caused by the Mycobacterium Tuberculosis bacteria.

Tuberculosis Infection – the bacteria that is breathed in becomes inactive, but remains live in the body and may become active later. This is called TB infection. Most people who have breathed in the bacteria are able to fight the bacteria to stop them from growing.

Tuberculosis Disease – TB bacteria becomes active if the immune system can't stop the bacteria from growing. The active bacterium begins to multiply in the body and cause TB disease. Some people develop TB disease soon after becoming infected, before their immune system can fight the TB bacteria. Other people may become sick later, if their immune system becomes weakened.

Tuberculin Skin Test – an intra-dermal screening test, which within 48 to 72 hours becomes indurated if the individual has either an active Tuberculosis infection or Tuberculosis infection without active disease.

Induration – is a local area that is slightly raised and firm that results from a cell mediated response to the injected antigen.

III. PROCEDURE

A. All youth admitted to the facility shall receive a Mantoux type TB skin test during the initial assessment screening. Youth who have previously tested positive shall receive a chest X-Ray. (4-JCF-4C-23)

1. Upon the youth's arrival at the facility a Nurse shall perform TB skin testing. A Physician order shall be required.

   a. Results shall be read and documented by a nurse between forty-eight (48) and seventy-two (72) hours after test administration. Results shall be documented in millimeters within the youth's health record, TB Testing Record XI.36.A and noted in the Interdisciplinary Progress Note XI.8.A

   b. Youth who have previously tested positive shall not receive a TB skin test. They shall instead, have a chest X-Ray performed.

2. Youth with a positive TB skin test shall be referred to the Physician for evaluation

   a. Per current CDC recommendations a positive skin reaction shall be rated on the following criteria.

      i. 5 (five) mm shall be considered positive if the youth has had exposure to a known active TB case, or if the youth is immune compromised.
      ii. 10 (ten) mm for people from higher risk populations, like the youth in the juvenile justice system.

   b. Youth with a positive reaction shall receive a chest X-Ray and preventative medication regimen as prescribed by the Physician and within the Mississippi Department of Health guidelines.

3. Active TB shall be confirmed by a chest X-Ray and acid-fast sputum test. The Physician in conjunction with the Mississippi Department of Health shall determine the need for hospitalization or the immediate transfer to the appropriate medical facility for placement in respiratory isolation.

4. The Director of Medical Services/designee shall notify the parents or guardian and the appropriate Health Department when a youth's PPD skin test is positive or the youth is diagnosed with pulmonary tuberculosis.

   a. Notifications may be provided orally, but shall be documented in writing on the Interdisciplinary Progress Note XI.8.A.

   b. Refer to Mississippi Department of Health Disease Control Manual for reporting.

B. The Health Services Supervisor or designee shall report all cases of positive TB skin testing and active Pulmonary Tuberculosis to their local Health Department, as is the requirement of the Mississippi Department of Health TB control office reporting procedure. Refer to the Mississippi Department of Health Disease's

Control Website for reporting requirements. (4-JCF-4C-23)

1. The Mississippi Department of Health, Bureau of Tuberculosis Control will be in complete control should an investigation or mass testing is necessary. Complete cooperation will be given and recommendations will be strictly adhered to. Access to youth, records and personnel will be complete and unimpeded, to the Mississippi Department of Health.

2. Additionally, all facility personnel, including the living unit where the youth is housed, shall be informed when active tuberculosis is diagnosed.

3. Information shall be provided regarding the route of transmission, precautions to be observed, and the treatment of the disease.

4. The youth's name shall not be shared except on a "need to know basis." Confidentiality shall be strictly adhered to.

C. When a youth is released, the nurse shall report the name of each youth who tested positive and/or received treatment at the facility to the health department in which the youth shall reside. Refer to the Mississippi Department of Health's Disease Control Manual for reporting requirements. (4-JCF-4C-23)

   a. Notifications may be provided orally, but shall be documented in writing on the Interdisciplinary Progress Note XI.8.A.

2. Youth requiring continued treatment or follow up care on discharge from the facility shall be instructed to report to their local health department. The youth's parent, guardian or legal custodian shall also be notified in writing on the discharge summary form XI.9.A The nurse shall document the instructions given and the notification in the youth's health record, Interdisciplinary Progress Notes form XI.8.A.

3. A copy of the youth's medical release summary shall be sent to the Community Counselor to ensure that follow-up care and/or treatment is provided. Refer to policy XI.8, Health Record: Structure, Documentation and Confidentiality, and policy XI.9, Medical Release Summarizes.

D. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services

T B Skin Testing Record

Name:_____

DOB:_____

ALLERGIES:_____

Student ☐ **Employee**☐

Tuberculin Testing: (inject 0.1cc,Intradermal
Single dose administration inner aspect left forearm)

Past Positive **PPD** Date:_____ ☐unknown

CXR Date:_____ Results:_____

	Date Given	MFR.	Lot#	Exp Date	Nurse Initials	Facility	Result Date	Reaction	Nurse Initials	CXR Date	CXR Result	Physician Review
PPD Test												
PPD Test												

Positive Test: (current or past- nurses complete the following assessment)

Signs/Symptoms of **TB**	Check Box	Nursing Comments
Fatigue (weakness,tiredness)	**Y** ☐ **N**☐	
Anorexia (nausea)	**Y** ☐ **N**☐	
Weight loss	**Y** ☐ **N**☐	
Night Sweats	**Y** ☐ **N**☐	
Productive Cough	**Y** ☐ **N**☐	
Hemoptysis	**Y** ☐ **N**☐	
Chest Pain	**Y** ☐ **N**☐	
Contact w/ **TB** case	**Y** ☐ **N**☐	

Health Department notified of Positive: Date:_____ Time:_____ Initials_____

INH Treatment of Latent TB Infection

Start Date	End Date	Transition Date (back to home Health Dept)	Comments:
Physician Signature:			

Initials	Signature/Title	Initials	Signature/ Title

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Immunization Program**	**Policy Number:** 37
Number of Pages: 4	**Section:** XI
Attachments Immunization Administration Record (MDH) Protocols: Hepatitis A Vaccination; Hepatitis B; Human Papillomavirus(HPV); Meningococcal; Measles, Mumps and Rubella #2 (MMR#2), Tdap, Varicella Vaccination CDC Tetanus Toxoids, Diphtheria and Acellular Pertussis (DPT) VIS; CDC Measles, Mumps, and Rubella (MMR) VIS; CDC Hepatitis A VIS; CDC Hepatitis B VIS; CDC VIS Varicella; CDC Human Papillomavirus (HPV); CDC VIS Meningococcal Temperature Log for Vaccines (Fahrenheit)- Distributed by the Immunization Action Coalition –Days 1-15, 16-31	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards: 4-JCF-4C-22, 4-JCF-4C-24, 4-JCF-4C-25
Effective Date: 06/09/06 **Revision Date: 05/01/07, 05/07/08, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established for the implementation of a youth immunization program. (4-JCF-4C-22, 4-JCF-4C-24, 4-JCF-4C-25)
This program shall apply to only the following vaccines unless otherwise noted:

- Hepatitis A Vaccine (HAV)
- Hepatitis B Vaccine (HBV)
- Human Papillomavirus (HPV)
- Meningococcal
- Measles/Mumps/Rubella Vaccine (MMR)
- Tetanus Toxoids, Diphtheria and Acellular Pertussis (Tdap)
- Varicella

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Contraindication - a condition in which giving the immunization to the would-be recipient greatly increases the chance of serious or adverse side effects.

One Month - defined as twenty-eight (28) to thirty-one (31) days for purposes relating to immunizations. Twenty-eight (28) days as one (1) month may be utilized for short

time intervals of three (3) months or less. Timeframes greater than three months should be from calendar date to calendar date, for example, four (4) months equals January 8th to May 8th.

Precaution - a condition in which a recipient may have increased the chance of an adverse event. It may also compromise the ability of a vaccine to produce immunity

III. PROCEDURE

A. Upon admission nursing staff shall ensure that all new youth shall be screened for and receive appropriate immunizations.

1. The Nurse shall review the immunization history of all youth on intake. If immunization records are inadequate or incomplete, the nurse shall contact the parent or guardian, and/or review school records in order to complete the youth's immunization record. The nurse may also review the computerized Health Department Vaccination Record page (via internet connection).

   a. Youth requiring an immunization administration shall have a written order on the Doctor's Order Form XI.14.A. Refer to the following vaccination protocols for immunization order guidelines:

      - Hepatitis A Vaccination Protocol
      - Hepatitis B Vaccination Protocol
      - MMR Vaccination Protocol
      - Tdap Vaccination Protocol
      - Varicella
      - HPV
      - Meningococcal

   b. Nurses shall ensure that youth are informed of each vaccine prior to administration. The nurse on the Immunization Administration Record (MDH) notes documentation. Nurses shall refer to the following Center for Disease Control and Prevention's "What you need to know before you or your child gets the vaccine" Vaccine Information Statements (VIS): (Refer to www.cdc.gov)

      - Tetanus Toxoids, Diphtheria and Acellular Pertussis (Tdap) VIS
      - CDC Measles, Mumps, and Rubella (MMR) VIS
      - CDC Hepatitis A VIS
      - CDC Hepatitis B VIS
      - CDC Varicella VIS
      - CDC Human Papillomavirus VIS
      - CDC Meningococcal VIS

   c. The Varicella vaccination is the only vaccine that can be deferred if the youth and/or parent document that the youth has a history of Varicella (chicken pox). If however the history can not be verified or the parent is unsure then the Varicella vaccine should be given.

i. If the youth is 13 years of age or older the he/she will require a series of 2 vaccinations 4 – 8 (four – eight) weeks apart.
ii. Varicella vaccine may be given at the same time as other vaccines.

d. The nurse shall document administration of all immunizations on the Immunization Administration Record (MDH). This form shall be maintained in the youth's medical record.

e. The nurse shall also be responsible for entering the youth's immunization history and all administered immunizations in the computerized Department of Health Vaccination Record page.

2. If allergies, contraindications, or precautions exist, the vaccine shall not be administered and the youth shall be referred to the facility physician for assessment.

   a. If the Physician deems the vaccine shall not be administered, the Physician shall clearly document the reason in the health record, Interdisciplinary Progress Notes form XI.8.A.

   b. If the Physician deems the vaccine shall be safe for administration, the Nurse shall administer the vaccine while the Physician is on site.

3. Youth refusing vaccines shall be referred to the Director of Medical Services/designee.

   a. The Director of Medical Services shall notify the Physician for direction if youth still refuses after Director of Medical Services' consultation.

   b. The Director of Medical Services/designee shall notify the Facility Administrator/designee if youth still refuses after the physician's consultation.

B. Procurement of Vaccines

1. Vaccines shall be obtained from the Mississippi Department of Health (MDH), through the Mississippi Vaccines for Children (MVFC) via completion of a vaccine request form. A copy of the order form shall be sent to the MVFC's program.

2. The Mississippi Department of Health issues the ordered vaccines with a packing list (invoice). The packing list shall indicate the following information:

   - Name of vaccine
   - Number of units sent

C. Receipt and Storage of Vaccines

1. Upon receipt in the clinic, medical staff shall inventory the vaccine and cross-reference with the packing list for accuracy. The Nurse who receives and inventories the vaccine shall then sign and date the packing list. Any discrepancies shall be documented on the packing list and the MDH MVFC's

program shall be immediately notified.

2. Following inventory, vaccines are stored in a secure refrigerator designated for medication storage. Vaccines shall be checked on a monthly basis for expiration dates. See Expired Vaccine (Section E) form for processing of outdated medication.
3. The original signed packing list shall be maintained in the medical department.

D. Vaccine Storage and accountability

1. Vaccines shall be stored per MVFC and CDC recommendations, they are as follows;
   a. Vaccines stored in the freezer are as follows:
      - Proquad (combination of MMR and Varicella)
      - Varicella
      - MMR

   b. Vaccines stored in the refrigerator are as follows:
      - Tdap
      - Hepatitis A & B
      - HPV

2. An accountability record (perpetual inventory form) and the vaccine vials/pre-filled syringes shall be placed in a zip lock bag;

   a. The accountability records shall be completed as each dose is administered. The original completed accountability form shall be maintained in the medical department.

   b. Tetanus Toxoids, Diphtheria and Acellular Pertussis (Tdap) and the Varicella vaccine are issued in a multi-dose vial; only one vial should be open at a time from which to administer doses. Keeping the corresponding accountability record with the open vial prevents incorrect documentation of the accountability sheet.

E. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

HEPATITIS A VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each Hepatitis A vaccine and the administration by an MDYS nurse. All vaccines require a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications or precautions.

If it is determined that the youth (up to 18 years old) is to receive this vaccine, the dosage shall be written as follows:

Hepatitis A Series (Single dose administration in the deltoid muscle)

Primary Course:	1st dose 0.5 ml IM	Elected Time
	2nd dose0.5 ml IM	Give at least six (6) month thereafter

Physician Signature Date

Printed Name of Physician

HEPATITIS A VACCINE

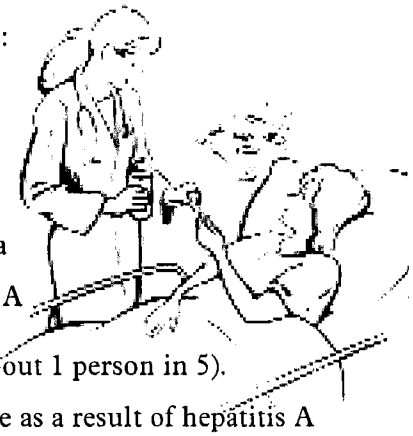
WHAT YOU NEED TO KNOW

1 What is hepatitis A?

Hepatitis A is a serious liver disease caused by the hepatitis A virus (HAV). HAV is found in the stool of persons with hepatitis A. It is usually spread by close personal contact and sometimes by eating food or drinking water containing HAV.

Hepatitis A can cause:

- mild "flu-like" illness
- jaundice (yellow skin or eyes)
- severe stomach pains and diarrhea



People with hepatitis A often have to be hospitalized (up to about 1 person in 5).

Sometimes, people die as a result of hepatitis A (about 3-5 deaths per 1,000 cases).

A person who has hepatitis A can easily pass the disease to others within the same household.

Hepatitis A vaccine can prevent hepatitis A.

2 Who should get hepatitis A vaccine and when?

WHO?

Some people should be routinely vaccinated with hepatitis A vaccine:

- All children 1 year (12 through 23 months) of age.
- Persons 1 year of age and older traveling to or working in countries with high or intermediate prevalence of hepatitis A, such as those located in Central or South America, Mexico, Asia (except Japan), Africa, and eastern Europe. For more information see **www.cdc.gov/travel**.
- Children and adolescents through 18 years of age who live in states or communities where routine vaccination has been implemented because of high disease incidence.
- Men who have sex with men.
- Persons who use street drugs.
- Persons with chronic liver disease.
- Persons who are treated with clotting factor concentrates.
- Persons who work with HAV-infected primates or who work with HAV in research laboratories.

Other people might get hepatitis A vaccine in special situations:

- Hepatitis A vaccine might be recommended for children or adolescents in communities where outbreaks of hepatitis A are occurring.

Hepatitis A vaccine is not licensed for children younger than 1 year of age.

WHEN?

For children, the first dose should be given at 12-23 months of age. Children who are not vaccinated by 2 years of age can be vaccinated at later visits.

For travelers, the vaccine series should be started at least one month before traveling to provide the best protection.

> Persons who get the vaccine less than one month before traveling can also get a shot called immune globulin (IG). IG gives immediate, temporary protection.

For others, the hepatitis A vaccine series may be started whenever a person is at risk of infection.

Two doses of the vaccine are needed for lasting protection. These doses should be given at least 6 months apart.

Hepatitis A vaccine may be given at the same time as other vaccines.

3 Some people should not get hepatitis A vaccine or should wait

- Anyone who has ever had a severe (life-threatening) **allergic reaction to a previous dose** of hepatitis A vaccine should not get another dose.
- Anyone who has a severe (life threatening) **allergy to any vaccine component** should not get the vaccine. Tell your doctor if you have any severe allergies. All hepatitis A vaccines contain alum and some hepatitis A vaccines contain 2-phenoxyethanol.
- Anyone who is **moderately or severely ill** at the time the shot is scheduled should probably wait until they recover. Ask your doctor or nurse. People with a **mild illness** can usually get the vaccine.
- Tell your doctor if you are **pregnant**. The safety of hepatitis A vaccine for pregnant women has not been determined. But there is no evidence that it is harmful to either pregnant women or their unborn babies. The risk, if any, is thought to be very low.

4 What are the risks from hepatitis A vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of hepatitis A vaccine causing serious harm, or death, is extremely small.

Getting hepatitis A vaccine is much safer than getting the disease.

Mild problems

- soreness where the shot was given *(about 1 out of 2 adults, and up to 1 out of 6 children)*
- headache *(about 1 out of 6 adults and 1 out of 25 children)*
- loss of appetite *(about 1 out of 12 children)*
- tiredness *(about 1 out of 14 adults)*

If these problems occur, they usually last 1 or 2 days.

Severe problems

- serious allergic reaction, within a few minutes to a few hours of the shot *(very rare)*

5 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

6 The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit their website at www.hrsa.gov/vaccinecompensation.

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC websites at: **www.cdc.gov/hepatitis** or **www.cdc.gov/nip**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL IMMUNIZATION PROGRAM

Mississippi Department of Human Services
Division of Youth Services
Medical Services

HEPATITIS B VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each Hepatitis B vaccine and the administration by an MDYS nurse. All vaccines require a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications or precautions.

If it is determined that the youth is to receive this vaccine, the dosage shall be written as follows:

Hepatitis B Series (Single dose administration in the deltoid muscle)

1st dose	0.5 ml IM	Give now
2nd dose	0.5 ml IM	Give no sooner than one (1) month after the first dose
3rd dose	0.5 ml IM	Give four (4) to six (6) months after the first dose with at least 2 (two) months from second dose given

Physician Signature Date

Printed Name of Physician

HEPATITIS B VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Hepatitis B is a serious disease.
The hepatitis B virus (HBV) can cause short-term (acute) illness that leads to:

- loss of appetite
- diarrhea and vomiting
- tiredness
- jaundice (yellow skin or eyes)
- pain in muscles, joints, and stomach

It can also cause long-term (chronic) illness that leads to:

- liver damage (cirrhosis)
- liver cancer
- death

About 1.25 million people in the U.S. have chronic HBV infection.

Each year it is estimated that:

- 80,000 people, mostly young adults, get infected with HBV
- More than 11,000 people have to stay in the hospital because of hepatitis B
- 4,000 to 5,000 people die from chronic hepatitis B

Hepatitis B vaccine can prevent hepatitis B. It is the first anti-cancer vaccine because it can prevent a form of liver cancer.

2 How is hepatitis B virus spread?

Hepatitis B virus is spread through contact with the blood and body fluids of an infected person. A person can get infected in several ways, such as:

- by having unprotected sex with an infected person
- by sharing needles when injecting illegal drugs
- by being stuck with a used needle on the job
- during birth when the virus passes from an infected mother to her baby

About 1/3 of people who are infected with hepatitis B in the United States don't know how they got it.

3 Who should get hepatitis B vaccine and when?

1) Everyone 18 years of age and younger
2) Adults over 18 who are at risk

Adults at risk for HBV infection include:

- people who have more than one sex partner in 6 months
- men who have sex with other men
- sex contacts of infected people
- people who inject illegal drugs
- health care and public safety workers who might be exposed to infected blood or body fluids
- household contacts of persons with chronic HBV infection
- hemodialysis patients

If you are not sure whether you are at risk, ask your doctor or nurse.

✓ **People should get 3 doses of hepatitis B vaccine according to the following schedule.** *If you miss a dose or get behind schedule, get the next dose as soon as you can. There is no need to start over.*

Hepatitis B Vaccination Schedule		WHO?		
		Infant whose mother is infected with HBV	Infant whose mother is *not* infected with HBV	Older child, adolescent, or adult
WHEN?	First Dose	Within 12 hours of birth	Birth - 2 months of age	Any time
	Second Dose	1 -2 months of age	1 - 4 months of age (at least 1 month after first dose)	1 - 2 months after first dose
	Third Dose	6 months of age	6 - 18 months of age	4 - 6 months after first dose

- The second dose must be given at least 1 month after the first dose.
- The third dose must be given at least 2 months after the second dose and at least 4 months after the first.
- The third dose should *not* be given to infants under 6 months of age, because this could reduce long-term protection.

Adolescents 11 to 15 years of age may need only two doses of hepatitis B vaccine, separated by 4-6 months. Ask your health care provider for details.

Hepatitis B vaccine may be given at the same time as other vaccines.

4 Some people should not get hepatitis B vaccine or should wait

People should not get hepatitis B vaccine if they have ever had a life-threatening allergic reaction to **baker's yeast** (the kind used for making bread) or to **a previous dose of hepatitis B vaccine**.

People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting hepatitis B vaccine.

Ask your doctor or nurse for more information.

5 What are the risks from hepatitis B vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of hepatitis B vaccine causing serious harm, or death, is extremely small.

Getting hepatitis B vaccine is much safer than getting hepatitis B disease.

Most people who get hepatitis B vaccine do not have any problems with it.

Mild problems

- soreness where the shot was given, lasting a day or two (up to 1 out of 11 children and adolescents, and about 1 out of 4 adults)
- mild to moderate fever (up to 1 out of 14 children and adolescents and 1 out of 100 adults)

Severe problems

- serious allergic reaction (very rare)

6 What if there is a moderate or severe reaction?

What should I look for?

Any unusual condition, such as a serious allergic reaction, high fever or unusual behavior. Serious allergic reactions are extremely rare with any vaccine. If one were to occur, it would be within a few minutes to a few hours after the shot. Signs can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

  VAERS does not provide medical advice

7 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help you pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit the program's website at **www.hrsa.gov/osp/vicp**

8 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (1-800-CDC-INFO) or **1-888-443-7232**
  - Visit the National Immunization Program's website at **www.cdc.gov/nip** or CDC's Division of Viral Hepatitis website at **www.cdc.gov/hepatitis**

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Centers for Disease Control and Prevention
National Immunization Program

Mississippi Department of Human Services
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Medical Services

MMR VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each MMR #2 vaccine and the administration by an MDYS nurse. All vaccines required a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications, or precautions.

If it is determined that the youth is to receive this vaccine, the dosage shall be written as follows:

MMR Immunization Series

If not previously vaccinated, administer 2 doses of MMR during any visit, with 4 or more weeks between the doses

MMR #2 Immunization

Inject 0.5 ml, Subcutaneous, Single dose administration in the outer aspect of upper arm.

Note: Use only diluents supplied with the vaccine to reconstitute. Use as soon as possible after reconstitution and discard unused vaccine 8 hours after reconstitution.

_____

Physician Signature Date

_____

Printed name of Physician

MEASLES MUMPS & RUBELLA VACCINES

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Measles, mumps, and rubella are serious diseases.

Measles

- Measles virus causes rash, cough, runny nose, eye irritation, and fever.
- It can lead to ear infection, pneumonia, seizures (jerking and staring), brain damage, and death.

Mumps

- Mumps virus causes fever, headache, and swollen glands.
- It can lead to deafness, meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, and, rarely, death.

Rubella (German Measles)

- Rubella virus causes rash, mild fever, and arthritis (mostly in women).
- If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

You or your child could catch these diseases by being around someone who has them. They spread from person to person through the air.

Measles, mumps, and rubella (MMR) vaccine can prevent these diseases.

Most children who get their MMR shots will not get these diseases. Many more children would get them if we stopped vaccinating.

2 Who should get MMR vaccine and when?

Children should get 2 doses of MMR vaccine:

✓ The first at **12-15 months of age**
✓ and the second at **4-6 years of age.**

These are the recommended ages. But children can get the second dose at any age, as long as it is at least 28 days after the first dose.

Some **adults** should also get MMR vaccine: Generally, anyone 18 years of age or older, who was born after 1956, should get at least one dose of MMR vaccine, unless they can show that they have had either the vaccines or the diseases.

Ask your doctor or nurse for more information.

MMR vaccine may be given at the same time as other vaccines.

3 Some people should not get MMR vaccine or should wait

- People should not get MMR vaccine who have ever had a life-threatening allergic reaction to **gelatin**, the antibiotic **neomycin**, or to **a previous dose of MMR vaccine.**

- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting MMR vaccine.

- Pregnant women should wait to get MMR vaccine until after they have given birth. Women should avoid getting pregnant for 4 weeks after getting MMR vaccine.

- Some people should check with their doctor about whether they should get MMR vaccine, including anyone who:
  - Has HIV/AIDS, or another disease that affects the immune system
  - Is being treated with drugs that affect the immune system, such as steroids, for 2 weeks or longer.
  - Has any kind of cancer
  - Is taking cancer treatment with x-rays or drugs
  - Has ever had a low platelet count (a blood disorder)

Over . . .

- People who recently had a transfusion or were given other blood products should ask their doctor when they may get MMR vaccine

Ask your doctor or nurse for more information.

4 What are the risks from MMR vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of MMR vaccine causing serious harm, or death, is extremely small.

Getting MMR vaccine is much safer than getting any of these three diseases.

Most people who get MMR vaccine do not have any problems with it.

Mild Problems

- Fever (up to 1 person out of 6)
- Mild rash (about 1 person out of 20)
- Swelling of glands in the cheeks or neck (rare)

If these problems occur, it is usually within 7-12 days after the shot. They occur less often after the second dose.

Moderate Problems

- Seizure (jerking or staring) caused by fever (about 1 out of 3,000 doses)
- Temporary pain and stiffness in the joints, mostly in teenage or adult women (up to 1 out of 4)
- Temporary low platelet count, which can cause a bleeding disorder (about 1 out of 30,000 doses)

Severe Problems (Very Rare)

- Serious allergic reaction (less than 1 out of a million doses)
- Several other severe problems have been known to occur after a child gets MMR vaccine. But this happens so rarely, experts cannot be sure whether they are caused by the vaccine or not. These include:
  - Deafness
  - Long-term seizures, coma, or lowered consciousness
  - Permanent brain damage

5 What if there is a moderate or severe reaction?

What should I look for?

Any unusual conditions, such as a serious allergic reaction, high fever or behavior changes. Signs of a serious allergic reaction include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness within a few minutes to a few hours after the shot. A high fever or seizure, if it occurs, would happen 1 or 2 weeks after the shot.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.
  VAERS does not provide medical advice.

6 The National Vaccine Injury Compensation Program

In the rare event that you or your child has a serious reaction to a vaccine, a federal program has been created to help you pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit the program's website at www.hrsa.gov/osp/vicp

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department's immunization program.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit the National Immunization Program's website at www.cdc.gov/nip

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TETANUS TOXOIDS, DIPHTHERIA AND ACELLULAR PERTUSSIS VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each Tdap vaccine and the administration by an MDYS nurse. All vaccines required a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications, or precautions.

If it is determined that the youth is to receive this vaccine, the dosage shall be written as follows:

Tdap Immunization

Inject 0.5 ml, IM, Single dose administration in the deltoid muscle in an individual age 10 through 18 years old

_____

Physician Signature Date

_____

Printed name of Physician

TETANUS, DIPHTHERIA PERTUSSIS (Tdap) VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Tdap (**T**etanus, **D**iphtheria, **P**ertussis) vaccine can protect adolescents and adults against three serious diseases.

Tetanus, diphtheria, and pertussis are all caused by bacteria. Diphtheria and pertussis are spread from person to person. Tetanus enters the body through cuts, scratches, or wounds.

TETANUS (Lockjaw) causes painful tightening of the muscles, usually all over the body.

- **It can lead to** "locking" of the jaw so the victim cannot open his mouth or swallow. Tetanus leads to death in up to 2 cases out of 10.

DIPHTHERIA causes a thick covering in the back of the throat.

- **It can lead to** breathing problems, paralysis, heart failure, and even death.

PERTUSSIS (Whooping Cough) causes severe coughing spells, vomiting, and disturbed sleep.

- **It can lead to** weight loss, incontinence, rib fractures and passing out from violent coughing, pneumonia, and hospitalization due to complications.

  In 2004 there were more than 25,000 cases of pertussis in the U.S. More than 8,000 of these cases were among adolescents and more than 7,000 were among adults. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications.

2 Tdap and related vaccines

Vaccines for Adolescents and Adults

- **Tdap** was licensed in 2005. It is the first vaccine for adolescents and adults that protects against all three diseases.
- **Td** (tetanus and diphtheria) vaccine has been used for many years as booster doses for adolescents and adults. It does not contain pertussis vaccine.

Vaccines for Children Younger than 7 Years

- **DTaP** vaccine is given to children to protect them from these three diseases. Immunity can fade over time, and periodic "booster" doses are needed by adolescents and adults to keep immunity strong. (**DTP** is an older version of DTaP. It is no longer used in the United States.)
- **DT** contains diphtheria and tetanus vaccines. It is used for children younger than 7 who should not get pertussis vaccine.

3 Who should get Tdap vaccine and when?

Adolescents 11 through 18 years of age should get one booster dose of Tdap.

- A dose of Tdap is recommended for **adolescents who got DTaP or DTP as children** but have not yet gotten a dose of Td. The preferred age is 11-12.
- **Adolescents who have already gotten a booster dose of Td** are encouraged to get a dose of Tdap as well, for protection against pertussis. Waiting at least 5 years between Td and Tdap is encouraged, but not required.
- **Adolescents who did not get all their scheduled doses of DTaP or DTP** as children should complete the series using a combination of Td and Tdap.

Adults 19 through 64 years of age should substitute Tdap for **one** booster dose of Td. Td should be used for later booster doses.

- **Adults who expect to have close contact with an infant** younger than 12 months of age should get a dose of Tdap. Waiting at least 2 years since the last dose of Td is suggested, but not required.
- **Healthcare workers who have direct patient contact** in hospitals or clinics should get a dose of Tdap. A 2-year interval since the last Td is suggested, but not required.

An adolescent or adult who gets a severe cut or burn might need protection against tetanus infection. Tdap may be used if the person has not had a previous dose.

> **Td should be used rather than Tdap** if Tdap is not available, and for:
> - Anybody who has already gotten Tdap,
> - Adults 65 years of age and older,
> - Children 7 through 9 years of age.

If vaccination is needed during **pregnancy,** Td usually is preferred over Tdap. Ask your doctor. **New mothers** who have never received a dose of Tdap should get a dose as soon as possible after delivery.

Tdap may be given at the same time as other vaccines.

4 Some people should not get Tdap vaccine or should wait.

- Anyone who has had a **life-threatening allergic reaction** after a dose of DTP, DTaP, DT, or Td vaccine should not get Tdap.
- Anyone who has a **severe allergy to any component of the vaccine** should not get Tdap. Tell your health care provider if the person getting the vaccine has any known severe allergies.

continued . . .

Talk with your doctor if the person getting the vaccine has a **severe allergy to latex**. Some Tdap vaccines should not be given to people with a severe latex allergy.

- Anyone who went into a **coma** or had a **long seizure** within 7 days after a dose of DTP or DTaP should not get Tdap, unless a cause other than the vaccine was found.
- Talk to your doctor if the person getting the vaccine:
  - has **epilepsy** or another **nervous system problem,**
  - had **severe swelling or severe pain** after a previous dose of any vaccine containing tetanus, diphtheria or pertussis,
  - has had **Guillain Barré Syndrome** (GBS).

Anyone who has a **moderate or severe illness** on the day the shot is scheduled should usually wait until they recover before getting the vaccine. Those with a mild illness or low fever can usually be vaccinated.

5 What are the risks from Tdap vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. However, the risk of a vaccine causing serious harm, or death, is extremely small.

If rare reactions occur with any new product, they may not be identified until many thousands, or even millions, of people have used the product. Like all vaccines, Tdap is being closely monitored for unusual or severe problems.

Clinical trials (testing before the vaccine was licensed) involved about 4,200 adolescents and about 1,800 adults. The following problems were reported. These are similar to problems reported after Td vaccine.

Mild Problems

(Noticeable, but did not interfere with activities)

- Pain (about 3 in 4 adolescents and 2 in 3 adults)
- Redness or swelling (about 1 in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents and 1 in 100 adults)
- Headache (about 4 in 10 adolescents and 3 in 10 adults)
- Tiredness (about 1 in 3 adolescents and 1 in 4 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents and 1 in 10 adults)
- Other mild problems reported include chills, body aches, sore joints, rash, and swollen lymph glands.

Moderate Problems

(Interfered with activities, but did not require medical attention)

- Pain at the injection site (about 1 in 20 adolescents and 1 in 100 adults)
- Redness or swelling (up to about 1 in 16 adolescents and 1 in 25 adults)
- Fever over 102°F (about 1 in 100 adolescents and 1 in 250 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 3 in 100 adolescents and 1 in 100 adults)
- Headache (1 in 300)

Severe Problems

(Unable to perform usual activities; required medical attention)

- None were seen among adolescents.
- In the adult clinical trial, two adults had nervous system problems after getting the vaccine. These may or may not have been caused by the vaccine. They went away on their own and did not cause any permanent harm.
- A severe allergic reaction could occur after any vaccine. They are estimated to occur less than once in a million doses.

A person who gets these diseases is much more likely to have severe complications than a person who gets Tdap vaccine.

6 What if there is a severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

In the event that you or your child has a serious reaction to a vaccine, a federal program has been created to help pay for the care of those who have been harmed.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation.**

8 How can I learn more?

- Ask your immunization provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's National Immunization Program website at **www.cdc.gov/nip**

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VARICELLA (CHICKENPOX) VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each Varicella (chickenpox) vaccine and the administration by an MDYS nurse. All vaccines require a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications or precautions.

If it is determined that the youth (up to 18 years old) is to receive this vaccine, the dosage shall be written as follows:

Varicella Vaccination (Single dose administration in the deltoid muscle)

Primary Course:	1st dose 0.5 ml IM	Elected Time
2nd dose	0.5 ml IM	Give no sooner than 28 days after the first dose

Physician Signature Date

Printed Name of Physician

CHICKENPOX VACCINE

WHAT YOU NEED TO KNOW

1 Why get vaccinated?

Chickenpox (also called varicella) is a common childhood disease. It is usually mild, but it can be serious, especially in young infants and adults.

- It causes a rash, itching, fever, and tiredness.
- It can lead to severe skin infection, scars, pneumonia, brain damage, or death.
- The chickenpox virus can be spread from person to person through the air, or by contact with fluid from chickenpox blisters.
- A person who has had chickenpox can get a painful rash called shingles years later.
- Before the vaccine, about 11,000 people were hospitalized for chickenpox each year in the United States.
- Before the vaccine, about 100 people died each year as a result of chickenpox in the United States.

Chickenpox vaccine can prevent chickenpox.

Most people who get chickenpox vaccine will not get chickenpox. But if someone who has been vaccinated does get chickenpox, it is usually very mild. They will have fewer blisters, are less likely to have a fever, and will recover faster.

2 Who should get chickenpox vaccine and when?

Routine

Children who have never had chickenpox should get 2 doses of chickenpox vaccine at these ages:

1st Dose: 12-15 months of age

2nd Dose: 4-6 years of age (may be given earlier, if at least 3 months after the 1st dose)

People 13 years of age and older (who have never had chickenpox or received chickenpox vaccine) should get two doses at least 28 days apart.

Catch-Up

Children or adolescents who are not fully vaccinated should receive one or two doses of chickenpox vaccine. The timing of these doses depends on the person's age. Ask your provider.

Chickenpox vaccine may be given at the same time as other vaccines.

> Note: Chickenpox vaccine may be given along with measles-mumps-rubella (MMR) vaccine in a combination vaccine called MMRV.

3 Some people should not get chickenpox vaccine or should wait

- People should not get chickenpox vaccine if they have ever had a life-threatening allergic reaction to gelatin, the antibiotic neomycin, or a previous dose of chickenpox vaccine.
- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting chickenpox vaccine.
- Pregnant women should wait to get chickenpox vaccine until after they have given birth. Women should not get pregnant for 1 month after getting chickenpox vaccine.
- Some people should check with their doctor about whether they should get chickenpox vaccine, including anyone who:
  - Has HIV/AIDS or another disease that affects the immune system
  - Is being treated with drugs that affect the immune system, such as steroids, for 2 weeks or longer
  - Has any kind of cancer
  - Is getting cancer treatment with radiation or drugs
- People who recently had a transfusion or were given other blood products should ask their doctor when they may get chickenpox vaccine.

Ask your doctor or nurse for more information.

4 What are the risks from chickenpox vaccine?

Getting chickenpox vaccine is much safer than getting chickenpox disease. Most people who get chickenpox vaccine do not have any problems with it.

However, a vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of chickenpox vaccine causing serious harm, or death, is extremely small.

Mild Problems

- Soreness or swelling where the shot was given (about 1 out of 5 children and up to 1 out of 3 adolescents and adults)
- Fever (1 person out of 10, or less)
- Mild rash, up to a month after vaccination (1 person out of 20, or less). It is possible for these people to infect other members of their household, but this is extremely rare.

> Note: MMRV vaccine has been associated with higher rates of fever (up to about 1 person in 5) and measles-like rash (about 1 person in 20) than MMR and varicella vaccines given separately.

Moderate Problems

- Seizure (jerking or staring) caused by fever (less than 1 person out of 1,000).

Severe Problems

- Pneumonia (very rare)

Other serious problems, including severe brain reactions and low blood count, have been reported after chickenpox vaccination. These happen so rarely experts cannot tell whether they are caused by the vaccine or not. If they are, it is extremely rare.

5 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarse ness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.
  Or you can file this report through the VAERS website at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

  VAERS does not provide medical advice.

6 The National Vaccine Injury Compensation Program

A federal program has been created to help people who may have been harmed by a vaccine.

For details about the National Vaccine Injury Compensation Program, call **1-800-338-2382** or visit their website at **www.hrsa.gov/vaccinecompensation.**

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC website at: **www.cdc.gov/nip**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Vaccine Information Statement (Interim)
Varicella Vaccine (1/10/07) 42 U.S.C. §300aa-26

Mississippi Department of Human Services
Division of Youth Services
Medical Services

MENINGOCOCCAL VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each Meningococcal vaccine and the administration by an MDYS nurse. All vaccines require a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications or precautions.

If it is determined that the youth (up to 18 years old) is to receive this vaccine, the dosage shall be written as follows:

Meningococcal Vaccination (Single dose administration in the deltoid muscle)

Primary Course: 1st dose 0.5 ml IM Elected Time

_____

Physician Signature Date

_____

Printed Name of Physician

MENINGOCOCCAL VACCINES

WHAT YOU NEED TO KNOW

1 What is meningococcal disease?

Meningococcal disease is a serious illness, caused by a bacteria. It is a leading cause of bacterial meningitis in children 2-18 years old in the United States.

Meningitis is an infection of fluid surrounding the brain and the spinal cord. Meningococcal disease also causes blood infections.

About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics. Of those who live, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people with certain medical conditions, such as lack of a spleen. College freshmen who live in dormitories have an increased risk of getting meningococcal disease.

Meningococcal infections can be treated with drugs such as penicillin. Still, about 1 out of every ten people who get the disease dies from it, and many others are affected for life. This is why *preventing* the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

Two meningococcal vaccines are available in the U.S.:

- **Meningococcal polysaccharide vaccine (MPSV4)** has been available since the 1970s.
- **Meningococcal conjugate vaccine (MCV4)** was licensed in 2005.

Both vaccines can prevent **4 types** of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. Meningococcal vaccines cannot prevent all types of the disease. But they do protect many people who might become sick if they didn't get the vaccine.

Both vaccines work well, and protect about 90% of those who get it. MCV4 is expected to give better, longer-lasting protection.

MCV4 should also be better at preventing the disease from spreading from person to person.

3 Who should get meningococcal vaccine and when?

MCV4 is recommended for all children at their routine preadolescent visit (11-12 years of age). For those who have never gotten MCV4 previously, a dose is recommended at high school entry.

Other adolescents who want to decrease their risk of meningococcal disease can also get the vaccine.

Meningococcal vaccine is also recommended for other people at increased risk for meningococcal disease:

- College freshmen living in dormitories.
- Microbiologists who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

MCV4 is the preferred vaccine for people 11-55 years of age in these risk groups, but MPSV4 can be used if MCV4 is not available. MPSV4 should be used for children 2-10 years old, and adults over 55, who are at risk.

How Many Doses?

People 2 years of age and older should get 1 dose. (Sometimes an additional dose is recommended for people who remain at high risk. Ask your provider.)

MPSV4 may be recommended for children 3 months to 2 years of age under special circumstances. These children should get 2 doses, 3 months apart.

4 Some people should not get meningococcal vaccine or should wait

- Anyone who has ever had a severe (life-threatening) **allergic reaction to a previous dose** of either meningococcal vaccine should not get another dose.
- Anyone who has a severe (life threatening) **allergy to any vaccine component** should not get the vaccine. Tell your doctor if you have any severe allergies.
- Anyone who is **moderately or severely ill** at the time the shot is scheduled should probably wait until they recover. Ask your doctor or nurse. People with a **mild illness** can usually get the vaccine.
- Anyone who has ever had **Guillain-Barré Syndrome** should talk with their doctor before getting MCV4.
- Meningococcal vaccines may be given to pregnant women. However, MCV4 is a new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed.
- Meningococcal vaccines may be given at the same time as other vaccines.

5 What are the risks from meningococcal vaccines?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Mild problems

Up to about half of people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a fever.

Severe problems

- Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.
- A serious nervous system disorder called **Guillain-Barré Syndrome** (or GBS) has been reported among some people who received MCV4. This happens so rarely that it is currently not possible to tell if the vaccine might be a factor. Even if it is, the risk is very small.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's National Immunization Program website at **www.cdc.gov/nip**
  - Visit CDC's meningococcal disease website at **www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm**
  - Visit CDC's Travelers' Health website at **www.cdc.gov/travel**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Mississippi Department of Human Services
Division of Youth Services
Medical Services

HUMAN PAPILLOMAVIRUS (HPV) VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each Human Papillomavirus (HPV) vaccine and the administration by an MDYS nurse. All vaccines require a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications or precautions.

If it is determined that the youth (up to 18 years old) is to receive this vaccine, the dosage shall be written as follows:

Human Papillomavirus (HPV) Series (Single dose administration in the deltoid muscle)

Primary Course:	1st dose 0.5 ml IM	Elected Time
	2nd dose 0.5 ml IM	Give one (2) months thereafter
Booster:	3rd dose 0.5 ml IM	Give six (6) months after Dose 1

_____

Physician Signature Date

_____

Printed Name of Physician

HPV (HUMAN PAPILLOMAVIRUS) VACCINE

WHAT YOU NEED TO KNOW

1 What is HPV?

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States.

There are about 40 types of HPV. About 20 million people in the U.S. are infected, and about 6.2 million more get infected each year. HPV is spread through sexual contact.

Most HPV infections don't cause any symptoms, and go away on their own. But HPV is important mainly because it can cause **cervical cancer** in women. Every year in the U.S. about 10,000 women get cervical cancer and 3,700 die from it. It is the 2nd leading cause of cancer deaths among women around the world.

HPV is also associated with several less common types of cancer in both men and women. It can also cause genital warts and warts in the upper respiratory tract.

More than 50% of sexually active men and women are infected with HPV at sometime in their lives.

There is no treatment for HPV infection, but the conditions it causes can be treated.

2 HPV Vaccine - Why get vaccinated?

HPV vaccine is an inactivated (not live) vaccine which protects against 4 major types of HPV.

These include 2 types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. ***HPV vaccine can prevent most genital warts and most cases of cervical cancer.***

Protection from HPV vaccine is expected to be long-lasting. But vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

3 Who should get HPV vaccine and when?

Routine Vaccination

- HPV vaccine is routinely recommended for girls **11-12 years of age**. Doctors may give it to girls as young as 9 years.

  Why is HPV vaccine given to girls at this age? It is important for girls to get HPV vaccine **before** their first sexual contact – because they have not been exposed to HPV. For these girls, the vaccine can prevent almost 100% of disease caused by the 4 types of HPV targeted by the vaccine.

  However, if a girl or woman is already infected with a type of HPV, the vaccine will not prevent disease from that type.

Catch-Up Vaccination

- The vaccine is also recommended for girls and women **13-26 years of age** who did not receive it when they were younger.

HPV vaccine is given as a 3-dose series:

1st Dose:	Now
2nd Dose:	2 months after Dose 1
3rd Dose:	6 months after Dose 1

Additional (booster) doses are not recommended.

HPV vaccine may be given at the same time as other vaccines.

4 Some girls or women should not get HPV vaccine or should wait

- Anyone who has ever had a life-threatening **allergic reaction** to **yeast**, to **any other component of HPV vaccine**, or to a **previous dose of HPV vaccine** should not get the vaccine. Tell your doctor if the person getting the vaccine has any severe allergies.

- **Pregnant women** should not get the vaccine. The vaccine appears to be safe for both the mother and the unborn baby, but it is still being studied. Receiving HPV vaccine when pregnant is **not** a reason to consider terminating the pregnancy. Women who are breast feeding may safely get the vaccine.

> Any woman who learns that she was pregnant when she got HPV vaccine is encouraged to call the **HPV vaccine in pregnancy registry** at 800-986-8999.
>
> Information from this registry will help us learn how pregnant women respond to the vaccine.

- People who are mildly ill when the shot is scheduled can still get HPV vaccine. People with **moderate or severe illnesses** should wait until they recover.

5 What are the risks from HPV vaccine?

HPV vaccine does not appear to cause any serious side effects.

However, a vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of **any** vaccine causing serious harm, or death, is extremely small.

Several **mild problems** may occur with HPV vaccine:

- Pain at the injection site (about 8 people in 10)
- Redness or swelling at the injection site (about 1 person in 4)
- Mild fever (100°F) (about 1 person in 10)
- Itching at the injection site (about 1 person in 30)
- Moderate fever (102°F) (about 1 person in 65)

These symptoms do not last long and go away on their own.

Life-threatening allergic reactions from vaccines are very rare. If they do occur, it would be within a few minutes to a few hours after the vaccination.

Like all vaccines, HPV vaccine will continue to be monitored for unusual or severe problems.

6 What if there is a severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

  Or you can file this report through the VAERS website at www.vaers.hhs.gov, or by calling 1-800-822-7967.

  VAERS does not provide medical advice.

7 How can I learn more?

- Ask your doctor or nurse. They can show you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)**
  - Visit CDC's website at **www.cdc.gov/std/hpv** and **www.cdc.gov/nip.**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

Mississippi Department of Human Services
Division of Youth Services
Medical Services

SEASONAL INFLUENZA VACCINATION PROTOCOL

This protocol shall serve as a prescription guideline for the ordering of each Seasonal Influenza vaccine and the administration by an MDYS nurse. All vaccines require a physician order on the Doctor's Order Form prior to administration.

Information, contraindications, precautions, and side effects are provided in the attached vaccine information statement from the Mississippi Department of Health. Follow the procedure within this protocol for reviewing the medical record for allergies, contraindications or precautions.

If it is determined that the youth (up to 18 years old) is to receive this vaccine, the dosage shall be written as follows:

Seasonal Influenza (Single dose administration in the deltoid muscle)

Primary Course: 1st dose 0.5 ml IM Elected Time

Physician Signature Date

Printed Name of Physician

Temperature Log for Vaccines (Fahrenheit)

Month/Year:_____ **Days 1–15**

***Instructions:** Place an "X" in the box that corresponds with the temperature. The hatched zones represent unacceptable temperature ranges. If the temperature recorded is in the hatched zone: 1. **Store the vaccine** under proper conditions as quickly as possible, 2. **Call the vaccine manufacturer(s)** to determine whether the potency of the vaccine(s) has been affected, 3. **Call the immunization program at your local health department** for further assistance: (_____) _____, and 4. **Document the action taken** on the reverse side of this log.

Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Exact Time															
°F Temp	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm
≥49°															
48°															
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32°															
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30°															
29°															
≤28°															
≥8°															
7°															
6°															
5°															
4°															
≤3°															
Room temp															
Staff Initials															

Refrigerator temperature

Freezer temp

Take immediate action if temperature is in shaded section*

Take immediate action if temperature is in shaded section*

Adapted by the Immunization Action Coalition courtesy of the Michigan Department of Community Health

www.immunize.org/catg.d/p3039.pdf • Item #P3039 (11/05)

Vaccine Storage Troubleshooting Record

Date	Time	Storage Unit Temp	Room Temp	Problem	Action Taken	Results	Initials

Temperature Log for Vaccines (Fahrenheit)

Month/Year:_____ **Days 16–31**

***Instructions:** Place an "X" in the box that corresponds with the temperature. The hatched zones represent unacceptable temperature ranges. If the temperature recorded is in the hatched zone: 1. **Store the vaccine** under proper conditions as quickly as possible, 2. **Call the vaccine manufacturer(s)** to determine whether the potency of the vaccine(s) has been affected, 3. **Call the immunization program at your local health department** for further assistance: (_____) _____, and 4. **Document the action taken** on the reverse side of this log.

Day of Month	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Exact Time																
°F Temp	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm	am pm
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4°																
≤3°																
Room temp																
Staff Initials																

Refrigerator temperature

Freezer temp

Take immediate action if temperature is in shaded section*

Take immediate action if temperature is in shaded section*

Vaccine Storage Troubleshooting Record

Date	Time	Storage Unit Temp	Room Temp	Problem	Action Taken	Results	Initials

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Exposure Control and Standard Precautions**	**Policy Number: 38**
Number of Pages: 7	**Section: XI**
Attachments Standard Precautions Form XI.38.A	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-22; 4-JCF-4C-36; 4-JCF4C-62
Effective Date: 06/09/06 **Revised Date: 05/07/08, 05/01/11, 11/01/13**	**Approved:** James V. Maccarone **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that standard procedural guidelines shall be established to reduce employee exposure to blood borne pathogens. Specific precautions shall be taken when exposure is possible. (4-JCF-4C-22; 4-JCF-4C-61)

Job classifications in which an employee may be expected to incur occupational exposure to blood or body fluids regardless of frequency for the Department are:

- Administrators
- Nurses, medical and dental Staff
- Psychology/Psychiatry Staff
- Juvenile Care Workers and Security Officers
- Maintenance Workers
- Warehouse Personnel
- Teachers and related Staff
- Laundry Personnel
- Recreational Staff
- Counselors
- Food Service Workers
- Any other MDYS Staff, including contractors and volunteers, having direct youth contact

The management of biohazardous waste and decontamination of medical and dental equipment shall comply with applicable local, state and federal regulations. (4-JCF-4C-62)

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Blood-Borne Pathogens – are Pathogenic microorganisms that are present in human blood and have the ability to cause disease in humans.

Standard Precautions – are protective procedures that apply to blood, other body fluids containing blood, semen, and vaginal secretions. They also apply to tissues and the following fluids:

- Cerebrospinal fluids – found in the brain and spinal cord
- Synovial fluid – found around the joints and tendons
- Pleural fluid – found around the lungs
- Pericardial fluid – found around the heart
- Amniotic fluid – found around the fetus of a pregnant woman

Although the risk of transmission of HIV and HBV from feces, nasal secretions, sputum, sweat, tears, urine, vomitus, and saliva is extremely low, standard precautions shall apply.

High-risk exposure for blood and body fluids- when body fluids come in contact with non-intact skin or mucus membranes.

Low-risk exposure for blood and body fluids – when body fluids come in contact intact skin or clothing.

III. PROCEDURE

A. Personal Protection Equipment and Clothing

All medical staff shall use personal protection equipment as a physical barrier to eliminate or minimize exposure to blood borne pathogens or other potentially infectious materials. Personal protective equipment shall be readily accessible and available at the employee's workstation or work site.

1. Equipment shall be considered appropriate only if it does not permit blood or other potentially infectious material to pass through or reach the employee's work clothes, street clothes, under garments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time for which equipment shall be used. This equipment shall be provided at no cost to the employee. Appropriate equipment shall include, but not be limited to the use of:

   - Gloves (Latex or Vinyl)
   - Masks
   - Eye protection
   - Face shields
   - Gowns
   - Lab Coats (Moisture Resistant)
   - Aprons and other protective body clothing
   - Shoe covers
   - Resuscitation bags, pocket masks, and other ventilation devices

2. Disposable gloves shall be worn when it can reasonably be anticipated that the staff may have direct contact with blood or other potentially infectious material, mucous membranes, and non-intact skin. Gloves shall be worn when

handling or touching contaminated surfaces.

3. Personal protective equipment manufactured and intended for re-use shall be cleaned or laundered by the department at no cost to the employee. The department shall repair or replace any personal protective equipment as needed to maintain its effectiveness.

4. One-way valve masks shall be available in the Personal Protection Pouches and first aid kits located throughout the facility to avoid direct mouth-to-mouth contact when administering CPR.

B. Exposure Control Guidelines

All staff shall adhere to the following Exposure Control guidelines for the prevention of exposure to body fluids:

1. All staff for protection from infectious diseases shall utilize standard precautions. Standard Precautions Form XI.38.A shall be posted in all staff rest rooms and in common areas of the facility, under the supervision Health Services Coordinator.

2. It is the responsibility of all facility employees to wear latex or vinyl gloves when:

   a. There is contact with body fluids.

   b. When handling items/equipment that is soiled or contaminated with body fluids.

   c. When cleaning any area or equipment that is contaminated with body fluids.

3. It is the responsibility of all staff following removal of gloves to wash their hands with soap and water. When water is not available, the staff may use alcohol or hand cleaning germicide. Soap and water shall be used as soon as it is available.

4. It is the responsibility of all staff to cover all open cuts and abrasions on exposed parts of their body. Bandages shall be changed immediately if they become wet or soiled.

5. It is the responsibility of all staff to take necessary precautions during youth searches to prevent potentially hazardous needle sticks and cuts from hidden metal. The following precautionary measures shall help staff to reduce significant exposure risk:

   a. Use great caution in searching the clothing of a youth. Instruct the youth to empty their own pockets and turn all pockets inside out. (A gentle pat search of the rest of the clothing shall be used.)

   b. Wear protective gloves when exposure to blood is likely to be encountered.

   c. Use puncture-proof containers to store sharp instruments, and clearly marked plastic biohazard bags to store other possibly contaminated items.

   d. Wear facemasks and eye protection or face shields (required for nurses

who draw blood and other staff members whose job has the potential exposure to blood being splashed in the face, mouth, nose or eyes).

6. It is the responsibility of all facility employees to place contaminated personal protective equipment and/or any clothing immediately or as soon as feasible in an appropriately designated area or container for biohazard storage, washing, decontamination or disposal, which is the responsibility of the facility.

7. Potentially contaminated sharps shall not be picked up directly with the hands. Sharps removal shall be accomplished by using a mechanical device such as forceps, tongs, or brush and dustpan. All mechanical devices used to clean up a contaminated area shall be decontaminated after use.

C. Cleaning, Disinfecting, and Disposal (4-JCF-4C-61)

1. All environmental surfaces, working surfaces, and equipment shall be cleaned and decontaminated after contact with blood, body fluids, or any potentially infectious material. Refer to policy XI.4, Medical Facility, Equipment and Environmental Monitoring and policy XI.5, First Aid Kits, Spill Kits and Automated External Defibrillator (AED).

   a. Contaminated equipment shall display a readily observable label identifying which portions of the equipment are contaminated until cleaned and disinfected.

   b. Protective coverings used to cover equipment and environmental surfaces shall be removed and replaced as soon as feasible when they become contaminated or at the end of the work shift. Receptacles shall be cleaned and decontaminated immediately when visibly contaminated.

   c. Equipment that becomes contaminated and is unsuitable for adequate decontamination shall be discarded and replacement considered if feasible.

   d. Information identifying contaminated equipment shall be conveyed to all affected employees, servicing representatives, and/or manufacturers as deemed necessary prior to handling, servicing, or shipping. Appropriate precautions shall be implemented based on need.

2. The following cleaning and disinfecting guidelines shall be used for any area(s) and/or equipment and clothing contaminated with fluids: Refer to policy XI.4, Medical Facility, Equipment and Environmental Monitoring and policy XI.5, First Aid Kits, Spill Kits and Automated External Defibrillator (AED).

   a. An approved disinfectant or freshly made solution of one (1) part bleach to nine (9) parts water shall be used as a cleaner. The beach solution shall be changed every 24 hours, or mixed at the time of need. An approved disinfectant shall be used for areas not suitable for bleach.

b. Contaminated clothing shall be placed in a melt-a-way bag, then in a container labeled Biohazard Waste. Contaminated clothing shall be washed in normal laundry cycles according to the washer and detergent manufacturer's recommendations. Clothes that cannot be washed can be dry-cleaned. This shall be the responsibility of the facility.

3. Sterilization of Medical and Dental Instruments

a. Medical and dental instruments shall be packaged for sterilization in an autoclave pouch.

b. The package shall include the date sterilized.

c. Dental and health care personnel shall ensure that each medical/dental instrument is washed and either re-sterilized or cold sterilized after use. Instruments not in use are re-sterilized at least once every three months.

d. The Director of Medical Services or designated health care professional shall monitor proper sterilization of the autoclave on a monthly basis. Refer to policy XI.4, Medical Facility, Equipment and Environmental Monitoring

4. Disposal of contaminated materials (4-JCF-4C-61)

a. The State of Mississippi has specific regulation regarding the disposal of infectious waste. The detailed requirements can be found on the Mississippi Environmental Protection Council Website. Refer to policy XI.4, Medical Facility, Equipment and Environmental Monitoring.

b. It is the responsibility of all facility employees to dispose of contaminated materials in the following manner:

- Pour or flush body fluids into a sewer system. Be careful to avoid splashes.
- Bag non re-usable items in a "red" biohazard plastic bag to prevent leakage. If the outside bag becomes soiled, double bag it.
- Use puncture-proof containers to store sharp instruments, and clearly marked plastic biohazard bags to store other possibly contaminated items.
- Contaminated materials shall be maintained in a locked area until removed from the facility.

D. Exposure to Blood or Body Fluids: Staff experiencing a high risk exposure to blood or other body fluids through a needle stick, cut, and puncture wound, splash to the eyes or mouth shall always:

- Remove the body fluid from the mucus membranes (e.g. eyes or mouth) by flushing with water

- Clean the wound immediately with soap and water. If a human bite occurs, breaking the skin, milk the wound as you clean with soap and water
- Seek medical attention as with any injury
- Immediately report the incident to the appropriate supervisor
- Complete a Serious Incident Report (SIR)

E. Only staff with a history of High Risk exposure may request to have youth tested for any contagious or infectious disease.

1. A staff member exposed to the blood or body fluid of a youth may request notification of exposure to a contagious or infections disease.

2. The staff member with a high-risk exposure to the body fluid of a youth may request notification of the test results of the youth. This request for notification shall be in writing and sent the facility Director of Medical Services. The Director of Medical Services shall notify the Facility Administrator and any outside health care facilities or coroners where the youth may have been sent. The written request shall include:

   - The name, address, and telephone number of the staff member
   - The name of the staff member's supervisor
   - The date, time, location and manner of the exposure

3. This request for notification to the Director of Medical Services shall be valid for ten (10) days and is renewed if necessary by resubmitting a second completed request.

4. Notification of youth test results to a staff member is not guaranteed; notification procedures in section F (For HIV test results) and section G (For non-HIV test results) shall be followed.

F. Notification of HIV test results performed on youth

1. After receipt and processing of the request for notification, the Director of Medical Services shall notify the Facility Administrator of the following: test performed or test not performed.

2. The results of HIV test performed on a youth shall not be given to staff members who were exposed to blood or other bodily fluids of the youth unless the youth signs a written authorization for release that specifically identifies the staff member as an authorized recipient of the test results. The Director of Medical Services/designee shall ensure the HIV Informed Consent and Confidentiality of Test Results Form XI.34.A is utilized and is maintained in the youth's medical record. Documentation that this form has been signed by the youth and includes the staff member's name to whom the results can be released shall be noted in the youth's Interdisciplinary Progress Notes form XI.8.A.

   a. If the HIV Informed Consent and Confidentiality of Test Results Form XI.34.A specifically list the staff member as an authorized recipient of the test results, the Director of Medical Services may then give the results in writing

to the Facility Administrator; the staff member cannot be given the youth's name.

b. If the youth refuses to sign the HIV Informed Consent and Confidentiality of Test Results Form XI.34A, or the form does not specifically list the staff member as an authorized recipient of the test results, the court may order the test to be performed on the youth. The results are sent directly to the Judge signing the court order. It is then up to the court to release this information as the law allows. Staff shall be instructed to seek legal counsel.

G. Notification of non-HIV test results performed on youth

1. The facility's Facility Administrator shall notify the staff member requesting results of the following: tests not performed, no diagnosis made, or tests are negative.

2. If a contagious or infectious disease is diagnosed or confirmed by a positive test result, the Director of Medical Services shall give an oral notification to the Facility Administrator within two (2) days of such findings. A written notification shall follow the oral notification within three (3) days. Oral and written notification to staff shall not include the name of youth tested. The oral and written notification of a positive test result or diagnosis shall include:

   - The name of the disease and mode of transmission,
   - The diseases symptoms and inoculation period,
   - The medical precautions necessary to prevent transmission, to others, and
   - Appropriate prophylaxis treatment and counseling for the disease.

3. All positive results and diagnoses shall be reported to the Director of Medical Services.

H. The Director of Medical Services shall revise this policy as necessary.

Mississippi Department of Human Services
Division of Youth Services
Medical Services

Standard Precautions

1. It is the responsibility of all MDYS employees to wear latex or vinyl gloves when: (Gloves are available in all Personal Protection Pouches)

   - There is contact with body fluids
   - When handling items or equipment that is soiled or contaminated with body fluids
   - When cleaning any area, equipment or surface that is contaminated with body fluids.

2. Blood and body fluids must be cleaned-up immediately with a disposable towel (paper towels).

3. Place the contaminated disposable towels in a plastic red biohazard bag or a plastic trash bag with a sign on the bag: "BLOOD AND BODY FLUIDS" if a red plastic biohazard bag is not available. Tie the bag and place in a biohazard container.

4. Clean the environmental surfaces and/or equipment with a disinfectant or freshly made solution of one (1) part bleach to nine (9) parts water.

5. Place wet mop heads and any cloth items in a melt-a-way bag, and then place the melt-a-way bag in a red biohazardous plastic bag available with each Spill Kit. Tie the bag, and place a sign on the bag "BLOOD AND BODY FLUIDS" if a biohazard bag is not available. The melt-away bag tied within the biohazard bag shall be sent to the laundry.

6. After gloves have been disposed of appropriately, wash your hands.

7. Complete necessary paper work: First-Aid and Spill Kit usage form

Note: Spill Kits with instructions are located with each First Aid Kit.

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: Pandemic Response Plan for Medical Services	**Policy Number: 39**
Number of Pages: 12	**Section: XI**
Attachments XI.39.A Flu Screening Form XI.39 B.1 Ready Level Green XI.39 B.2 Ready Level Yellow XI.39 B.3 Ready Level Red VIS 2009 H1N1 Influenza Vaccine Inactivated "The Flu Shot" VIS 2009 Influenza Vaccine Live, Attenuated "The Nasal Spray Vaccine"	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-01, 4-JCF-4C-22
Effective Date: 2/15/10 **Revision Date: 05/01/11, 11/01/13**	**Approved:** James V. Maccarone **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services to address the management of a pandemic event. The Division of Youth Services shall establish a pandemic response plan so that medical, mental health, and correctional staff are prepared for such an occurrence and essential services are maintained to the degree possible. The pandemic influenza response plan shall include: (4-JCF-4C-01; 4-JCF-4C-22)

- Education and communication
- Prevention and infection control, including protections and precautions to be taken for staff and visitors from harmful effects of the influenza virus
- Identification
- Surveillance
- Immunization when applicable
- Treatment
- Medical isolation and/or quarantine, when indicated
- Follow-up medical and mental health care
- Adhering to reporting requirements of applicable local, state, and federal agencies
- An inventory of necessary medications and medical supplies, as well as prearranged means for obtaining additional supplies via emergency purchase order.
- Procedures for medical evacuation of sick and injured youth or staff to appropriate state, local or private medical facilities
- Morgue plans that address completion of death certificates, obtaining body bags and storage of deceased influenza victims.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Antiviral: drugs that are used to prevent or cure a disease caused by a virus, by interfering with the ability of the virus to multiply in number or spread from cell to cell.

Asymptomatic: presenting no symptoms of disease.

Contagious: A contagious disease is easily spread from one person to another by contact with the infectious agent that causes the disease. The agent may be in droplets of liquid particles made by coughing or sneezing, contaminated food utensils, water or food.

Epidemic: A disease occurring suddenly in a community, region or country in numbers clearly in excess of normal. Also see pandemic.

Epidemic Respiratory Infection (ERI): An acute respiratory tract illness that is caused by a pandemic influenzas virus transmitted from person to person.

Exposure: Coming in direct contact with an agent that might cause a disease or infectious process.

Incubation Period – is the phase in the development of a disease between the infection and first appearance of symptoms. This is generally 7-10 days for influenza.

Influenza: A serious disease caused by viruses that infect the respiratory tract.

Isolation (Medical): The separation from others to prevent the spread of infection.

Man-Made Disaster: An event caused by human action which results in destruction, environmental contamination, or other life threatening or unsafe conditions requiring the evacuation of the institution or area in whole or part or requiring other life safety response and/or recover actions.

Natural Disaster: An event produced by nature causing widespread destruction and distress. Examples of a natural disaster include, but are not limited to: floods, tornadoes, earthquakes, or pandemic events.

Outbreak: The sudden appearance of a disease in a specific geographic area (e.g. neighborhood or community) or population (e.g. adolescents). Influenza outbreak is the presence of 20 confirmed cases of highly pathogenic influenza in an institution or area over 14 calendar days.

Pandemic: The worldwide outbreak of a disease in numbers clearly in excess of normal. Also see epidemic.

Pandemic Phases: (As defined by World Health Organization (WHO) in the 1999 *Global influenza pandemic preparedness plan, The role of WHO and recommendations for national measures before and during pandemics*; updated in 2005)

WHO * Pandemic Phases	Overarching Goals
Inter-Pandemic Period	
Phase 1. No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk (a) of human infection or disease is considered to be low.	Strengthen influenza pandemic preparedness at the global, regional, national and sub-national levels.
Phase 2. No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk (a) of human disease.	Minimize the risk of transmission to humans; detect and report such transmission rapidly if it occurs.
Pandemic Alert Period	
Phase 3. Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact (b).	Ensure rapid characterization of the new virus subtype and early detection, notification and response to additional cases.
Phase 4. Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans (b).	Contain the new virus within limited foci or delay spread to gain time to implement preparedness measures, including vaccine development.
Phase 5. Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).	Maximize efforts to contain or delay spread, to possibly avert a pandemic, and to gain time to implement pandemic response measures.
Pandemic Period	
Phase 6. Pandemic: increased and sustained transmission in general population (b).	Minimize the impact of the pandemic.

(a) The distinction between ***phase 1*** and ***phase 2*** is based on the risk of human infection or disease resulting from circulating strains in animals. The distinction is based on various factors and their relative importance according to current scientific knowledge. Factors may include pathogenicity in animals and humans, occurrence in domesticated animals and livestock or only in wildlife, whether the virus is enzootic or epizootic, geographically localized or widespread, and/or other scientific parameters.

(b) The distinction between ***phase 3***, ***phase 4*** and ***phase 5*** is based on an assessment of the risk of a pandemic. Various factors and their relative importance according to current scientific knowledge may be considered. Factors may include rate of transmission, geographical location and spread, severity of illness, presence of genes from human strains (if derived from an animal strain), and/or other scientific parameters.

* WHO: World Health Organization, an agency of the United Nations established in 1948 to further international cooperation in improving health conditions.

United States Government (USG) Department of Human Services (DHS)Pandemic Stages	Response
O	New domestic animal outbreak in at-risk country
1	Suspected human outbreak overseas

2	Confirmed human outbreak overseas
3	Widespread human outbreaks in multiple locations overseas
4	First Human Case in North America
5	Spread throughout United States
5 W	Pandemic Wave in Progress- High levels of infection lasting 8-12 weeks 6-12 weeks in each community
6	Recovery and preparation for subsequent waves

Quarantine: To isolate an individual who has or is suspected of having a disease, in order to prevent spreading the disease to others; alternatively, to isolate a person who does not have a disease during a disease outbreak, in order to prevent that person from catching the disease (this is called reverse isolation). Quarantine can be voluntary or ordered by public health officials in times of emergency.

Personal Protective Equipment: Masks, gloves and etc. to avoid direct contact with a patient's blood, body fluids, secretions and non-intact skin.

Seasonal Flu: A respiratory illness that can be transmitted person to person. Most people have some immunity, and a vaccine is available. This is also known as the common flu or winter flu, which may cause mild illness and rarely requires hospitalization.

Sentinel Influenza Cases: The first cluster of 2-3 cases diagnosed as influenza and confirmed by influenza antigen testing.

Social Distancing: The promotion of spatial separation in common areas, by maintaining a minimum of 3 feet from potentially infectious persons and limiting contact between people.

Standard Precautions: Standard precautions are basic infection control precautions (hand washing) in health care and shall be applied routinely in all health care settings covering mouth when coughing/sneezing etc.

Direct Contact – transmission via person-to-person contact with an infected host.

Indirect Contact – transmission from other than the infected host; may be from Inanimate objects such as combs, hats, clothing, etc.

Surveillance: The systematic collection, analysis, interpretation, and dissemination of health data on an ongoing basis, to gain knowledge of the pattern of disease occurrence and potential in a community, in order to control and prevent disease in the community.

Vaccine: A preparation consisting of antigens of a disease-causing organism which, when introduced into the body, stimulates the production of specific antibodies or altered cells. This produces immunity to the disease-causing organism. The antigen in the preparation can be whole disease-causing organisms (killed or weakened) or parts of these organisms.

Virus: Any of various simple submicroscopic parasites of plants, animals, and bacteria that often cause disease and that consist essentially of a core RNA or DNA surrounded by a protein coat. Unable to replicate without a host cell, viruses are typically not considered living organisms.

III. PROCEDURE

A. Education is the most effective tool for alleviating fear associated with a pandemic event. Refer to policies XI.22 Health Education and Prevention, XI.33 Communicable Disease Management and XI.38 Standard Precautions.

1. The Health Services Nurse Educator/designee shall provide at least annual educational training for youth. *"Cover your Cough" with and without face mask, "Be A Germ Stopper" "Take 3" Steps to Fight the Flu", Hand Hygiene with Soap and Water and/or Hand Sanitizer.*

2. To lower the risk of contracting the influenza virus experts recommend people do the following:

   - Cover mouth and nose when coughing or sneezing and when using tissues dispose of them in receptacles
   - Clean hands often
   - Avoid touching eyes, nose, or mouth
   - Social distancing
   - Avoid close contact with people who are sick
   - If possible, stay home from work, school or errands when sick

B. The single best way to prevent the seasonal flu is vaccination. Therefore both the seasonal and any other variation of flu vaccination will be offered to the youth every year from October thru March. Refer to policy XI.37, Immunization Program.

C. Communication of Information, including public service announcements:

1. The Director of Medical Services/designee shall serve as the point of communication for the Facility Administrator and Division Director of Institutions for information regarding serious medical concerns. The Director of Medical Services shall immediately notify the Facility Administrator or designee of all confirmed cases.

2. The Director of Medical Services/designee shall provide a daily status update to the Facility Administrator for information dissemination to other executive staff as needed.

3. Public service announcement releases related to influenza pandemic shall be directed by the MDHS office of Communications.

   a. All information received from the facility shall be disseminated through the Division of Youth Services Director and designees shall be responsible for

disseminating information to the staff, families and visitors of Oakley youth as needed.

b. Subject matter experts; the medical physician, the Director of Medical Services shall collaborate on the development of appropriate messages and products (e.g., fact sheets, FAQs, PowerPoint presentation).

4. The MDHS office of Communications shall work in collaboration with the MDYS Director to be the point person in facilitating information relayed to the Communities.

   a. Counselors along with Community personnel shall be charged with contacting students' families to provide support and keep them updated on current information about the pandemic's effects on the facility

   b. The MDHS office of Communications shall work with external partners, including other entities of the media to distribute any updates.

D. Influenza viruses may cause epidemics as well as the rare pandemic because they have ability to change genetically. *Pandemic Influenza Phases* as defined by the World Health Organization (WHO): In the United States, pandemic phases shall be defined based on the global phase. The six (6) phase's listed below are sub-categorized in three (3) periods: Inter-Pandemic Period, Pandemic Alert Period, and Pandemic Period (refer to definition section):

1. *Phase 1 and 2* (Inter-Pandemic Period).
2. *Phase 3* (Pandemic Alert Period): during this phase the following shall occur:

   a. Health Education: The facility Director of Medical Services/designee nurse shall make available the following health education for youth and staff:

      - *Cover your Cough*
      - *Pandemic Influenza Fact Sheet*
      - *Hand Hygiene with Soap and Water and/or Hand Sanitizer*

      Education shall be provided by nursing personnel to all youth on intake. Nurses in the facility shall provide educational training as part of ongoing health education and prevention. Topics specific to lowering the risk of contracting the influenza virus include:

      - Cover mouth and nose when coughing or sneezing and when using tissues dispose of them in receptacles
      - Clean hands often
      - Avoid touching eyes, nose, or mouth
      - Social distancing
      - Avoid close contact with people who are sick

      Refer to policy XI.22 Health Education and Prevention. Documentation of said training shall be noted in the youth's medical record, Form XI.22.A- A Teaching Learning Flow sheet.

b. Early monitoring:

i. Nurses shall utilize the Influenza Screening Form on all youth presented for admission to the training school and

ii. If the Nurse conducting the screening determines that the screen is positive based on the criteria noted on the form, the nurse shall immediately notify the Director of Medical Services who shall notify the Facility Administrator or designee so that an admission decision can be made.

iii. If the nurse conducting the assessment notes the appropriate sentinel symptoms of influenza noted on the Influenza Screening Form, then the nurse shall copy the completed form and immediately forward the copy to the Director of Medical Services. A list shall be generated of the students who have a "flu-like illness"

iv. Additionally, the nurse conducting the screening or assessment shall clearly note the presence of influenza symptoms on the Medical Department Shift Report Form XI.10.A and notify the facility contract physician. Such suggestive symptoms may include: fever, fatigue, body aches, headache, dry cough, and runny or stuffy nose.

v. The Director of Medical Services/designee shall review the list of students with a "flu-like illness" daily to ensure that these students are evaluated and their condition is reported to the Facility Administrator/designee.

c. Case Reporting: The Director of Medical Services shall report sentinel cases of influenza to the Facility Administrator/ designee.

i. Additionally, the Director of Medical Services shall be responsible for reporting outbreaks of influenza, as defined in the definition section of this policy, to their local county health department, office of epidemiology and/or the office of emergency preparedness.

ii. The Director of Medical Services shall be responsible for reporting outbreaks of influenza to the Facility Administrator, as soon as the presence of an outbreak in the facility is confirmed.

3. *Phase 4* (Pandemic Alert Period):

a. One or more clusters involving a small number of human cases (e.g., a cluster of less than 25 cases lasting less than two weeks). Appearance of a small number of human cases in one or several geographically linked areas without a clear history of a non-human source of exposure, for which the most likely explanation is considered to be human-to-human transmission.

b. Refer to *Phase 3*, Sections: b. Health Education, Communication, and Public Service Announcements; c. Early Monitoring; and d. Case Reporting.

c. Prevention or Delay of Pandemic Influenza Virus entry into the facility shall include, but not be limited to:

- The Facility Administrator shall control entry of visitors by assigning personnel to verbally and visually screen visitors for respiratory symptoms at points of entry to the facility.

- All visitors to the facility shall sign the *Flu Acknowledgment Form.*

d. Limiting the Transmission of Influenza in a pandemic includes three categories of strategies:

i. Education, Communication, and Public Service Announcements: Refer to Phase 3, Section 2.b., Health Education, Communication, and Public Service Announcements.

ii. Limitation on Movement: Social distancing within the facility includes the following cancellations or suspension of elective or nonessential trips outside of the facility including elective clinic appointments, scheduled elective tests and surgical procedures, school, group activities, and family visits.

iii. Isolation and Quarantine: youth with confirmed influenza may be admitted to single cells in the facility as space allows. The Facility Administrator in consultation with the Director of Medical Services/designee shall designate an area in the facility that may be used for quarantine purposes when the number of infectious and exposed contact exceeds the number of single cell rooms. The facility Physician shall be responsible for ordering isolation when necessary. The facility Physician in consultation with The Mississippi Department of Health (Office of Epidemiology and or Emergency Preparedness) shall be responsible for declaring the necessity of quarantine.

e. Stockpiling of medications and medical supplies: The Director of Medical Services/designee shall stockpile at least a fourteen (14) day supply of the following: (All supplies shall be secured in a locked area)

- Personal protective equipment for medical staff to include: gloves face masks, eye-shields and gowns;
- Personal protective equipment for all staff having direct contact with youth to include: gloves and face masks; and
- Routinely used medical supplies, including tissues.

f. Management of Personal Protective Equipment (PPE): The classification of all employee positions into one of the following four risk categories;

i. Very high exposure risk- occupations are those with high potential exposure to high concentrations of known or suspected sources of pandemic influenza during specific medical or laboratory procedures.

ii. High exposure risk- occupations are those with high potential for exposure to known or suspected sources of pandemic influenza virus.

iii. Medium exposure risk- occupations include jobs that require frequent, close contact (with in six (6) feet) exposures to known or suspected sources of pandemic influenza virus such as direct care staff, counselors, educational staff

iv. Lower exposure risk (caution) - occupations are those that do not require contact with people known to be infected with the pandemic virus, nor frequent close contact (within six (6) feet) with the public such as human resources, Information technology, business office/ administration/ clerical support, food service workers, volunteers, contract workers.

Note: Neither facemasks nor respirators are recommended for employees at lower risk of exposure to pandemic influenza.

4. *Phase 5* (Pandemic Alert Period):

a. Larger cluster(s), human-to-human spread is still localized; suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk). Examples include, ongoing cluster-related transmission, but total number of cases is not rapidly increasing, e.g., a cluster of 25-50 cases lasting from two to four weeks. Ongoing transmission, but cases appear to be localized (remote village, university, military base, island). In a community known to have a cluster, appearance of a small number of cases whose source of exposure is not readily apparent (e.g., beginning of more extensive spread).

d. Refer to *Phase 3*, Sections: Health Education, Communication, and Public Service Announcements; Early Monitoring; and Case Reporting.

c. Refer to *Phase 4,* Sections: Prevention or Delay of Pandemic Influenza Virus and Limiting the Transmission of Influenza.

5. *Phase 6* (Pandemic Period): During the pandemic phase 6, additional subdivisions may be defined by WHO, based on the extent of disease.

a. Nurses and facility staff directly caring for sick youth shall adhere to basic infection control principles for preventing the spread of pandemic influenza. Details of how these principles may be applied in the facility setting include the follow:

- Standard Precautions: Pay careful attention to hand hygiene before and after all patient contact or contact with items potentially contaminated with respiratory secretions. Limit contact between infected and non-infected persons and perform hand hygiene after contact with infectious patients.

- Contact Precautions: Use gloves and gowns for all patient contact. Use dedicated equipment such as stethoscopes, disposable blood pressure cuffs, disposable thermometers, etc.
- Eye Protection (i.e., goggles or faces shields): Wear when within 3 feet of the patient.
- Airborne Precautions: Face Mask

b. To maintain infection control standards, facility staff, including health care personnel shall:

- Limit contact between non-essential personnel and other persons (e.g., social visitors) and patients who are ill with pandemic influenza.
- Instruct persons who have "flu-like" symptoms to use respiratory hygiene/cough etiquette and use mask as necessary.
- Patients with known or suspected pandemic influenza should be placed on droplet precautions for a minimum of 5 days from the onset of symptoms. Because immune compromised patients may shed virus for longer periods, they may be placed on droplet precautions for the duration of their illness. Healthcare personnel should wear appropriate Personal Protective Equipment (gloves, gown, and mask).
- Isolate infected youth with confirmed influenza. Youth may be admitted to single cells in the facility as space allows. The Facility Administrator in consultation with the Director of Medical Services shall designate an area in the facility that may be used for quarantine purposes when the number of infectious and exposed contacts exceeds the number of single cell rooms. The facility physician shall be responsible for ordering isolation when necessary. The facility physician in consultation with the MDH Department of Epidemiology and/or the Office of Emergency Preparedness shall be responsible for declaring the necessity of quarantine.
- Promote social distancing in common areas (i.e., sit or stand as far away as possible – at least 3 feet – from potentially infectious persons) to limit contact between symptomatic and non-symptomatic individuals.
- If the pandemic virus is associated with diarrhea, contact precautions (i.e., gowns and gloves for all patient contact) should be added.
- For youth requiring emergency medical services refer to policy XI.26 Medical Consultation and Hospitalization. Staff shall be referred to their local health care provider or emergency care facility.

c. These precautions should be continued for 14 days after onset of symptoms or until either an alternative diagnosis is established or diagnostic test results indicate that the patient is not infected with influenza A virus. The Center for Disease Control (CDC) shall update these recommendations if changes occur in the anticipated pattern of transmission (www.cdc.gov/flu).

E. Oakley shall use the following phases for pandemic flu alert as a guideline for necessary actions. The three (3) phases of pandemic alert shall indicate the seriousness

of the threat and the need to launch progressively more intense preparedness activities as noted below see also XI.39.B.1-3.

Oakley Alert Phase	World Health Organization (WHO) and United States Government (USG) Pandemic Response Stages	Case Location
Green	WHO Inter-Pandemic Period Phases 1-2; USG stage zero (0)	New domestic animal outbreak in at-risk country
Yellow	WHO Pandemic Alert Phases 3-5; USG Stages 1-2	Confirmed Human Outbreak Overseas First Human Case in the mainland United States
Red	WHO Pandemic Alert Period Phases 3-5; USG stages 3-6	Spread throughout Untied States First Human Case in Mississippi or neighboring states Recovery and Preparation for Subsequent Waves

F. Surveillance and Monitoring

1. Case Reporting: The Director of Medical Services/ designee shall submit a daily report to include the number of: new cases, emergency/hospital referrals, ill youth, ill staff, and deaths to the Facility Administrator. Refer to section C of this report, Surveillance and Monitoring.

   a. Additionally, the Director of Medical Services shall be responsible for reporting outbreaks of influenza, as defined in the definition section of this, to their local county health department and/or Department of Epidemiology.

   b. The Director of Medical Services shall be responsible for reporting outbreaks of influenza to the MDH, Facility Administrator as soon as the presence of an outbreak in an institution is confirmed.

2. The Director of Medical Services shall monitor the capacity and capability of their local hospitals to provide continuity of critical hospital services. Hospital or community health provider may establish a nonstandard approach to the use of hospital resources, possibly including the use of all space and equipment available; relaxation of qualifications and credentials; consideration of off-site placement of patients; and expanded mortuary services capacity.

G. The Director of Medical Services shall establish an emergency staffing plan, due to call-offs and/or increased numbers of ill youth. Assistance through contractual nursing services shall be utilized.

H. The Director of Medical Services/designee, Facility Administrator and Director of Operations (warehouse) shall review at least annually pharmaceutical and medical supplies procurement procedures during a pandemic event.

I. The Director of Medical Services shall revise this policy as necessary.

Mississippi Division of Youth Services Medical Services **Influenza Screen**	**Name:**_____ **DOB:**_____**Date:**_____

Allergies:

Allergies:			
Symptoms:			

Subjective Data:

Sore Throat: □ **Yes** □ **No** if yes, onset/duration _____ Hours Days (Circle)

Comments:

Cough: □ **Yes** □ **No** if yes, Dry Productive, onset/duration _____ Hours Days

Comments:

Dyspnea □ **Yes** □ **No** Comments: _____

Chest Pain □ **Yes** □ **No** Comments:

Muscle and/or body aches □ **Yes** □ **No** if yes, onset/duration _____ Hours Days (Circle)

Comments:

Lives in area of confirmed case or recent visit to area □ **Yes** □ **No**

Objective Data:

Vital Signs	**Temp:**	**Pulse:**	**Resp:**	**B/P:**	**Pulse Ox:**

If the patient has a temperature of 100.4 or greater and one of the subjective identifiers this screen will be noted as positive.

Screen: ☐ **Positive** ☐ **Negative**

Additional Notes:

Nurses Signature/date/time:

Facility Pandemic Influenza Preparedness & Response Checklist
Level Ready- Green ERI Alert
Interpandemic Period (WHO)

____ Form a Facility Incident Command Team

____Pre-Incident activity list completed

A. Access Control

____Develop a plan and a timeline for implementing a policy that enables controlling access to the facility

____ Develop a plan to close down or curtail facility transportation, including facility shuttles if necessary, when ordered by the Facility Incident Command Team

B. Surveillance, Screening and Triage

____Have the facility's medical personnel screen all individuals upon intake.

____Report possible clusters to the Director of Institutions.

____Post informative infection control signs at building entrances and common areas.

____Monitor national, regional and local data related to the pandemic influenza.

C. Infection Control/Precautions

____Maintain adequate supplies of Personal Protective Equipment (PPE), waterless hand sanitizers surface disinfectants and tissues throughout public areas and meeting rooms.

____Display hand-washing posters, biohazard bags and waste receptacles in high-traffic areas.

D. Communication/Education

____Implement a plan for communication and promotion of messages relating to Epidemic Respiratory Infection (ERI) to staff.

____ Implement a plan to orient and educate staff regarding basic readiness activities at the facility.

____Deploy translation services needs within facility population.

____Identify counseling personnel to incorporate into communication plans.

E. Additional Preparedness Activities

____Implement vaccination campaign (offer vaccine on-site or provide references to area clinics, as applicable.)

____Develop educational and promotional materials to promote availability and desirability of influenza vaccine

____If administering flu vaccine on-site, documents administration of vaccine, preferably in a computerized data base (like the health departments Mississippi Immunization Registry).

____Provide regular updates to staff and youth.

____Health Authority will monitor the Health Alert Network.

Facility Pandemic Influenza Preparedness & Response Checklist
Level Ready- Yellow ERI Alert
Interpandemic Period (WHO)

____ Continue applicable activities from level Green/Interpandemic Period.

____Implement incident checklist

A. Access Control

____Restrict vendors, visitors and group activities and facility group transportation and work activities.

B. Surveillance, Screening and Triage

____Provide patients who have a new cough with a facemask and/or tissues, and replace frequently if soiled or moist.
____Restrict individuals (staff and youth) who have fever and a new cough from school or any group activity.
____Send any staff member home that is suspected of having a communicable disease that puts others in the facility at risk.
____Consult with the Facility Incident Command Team when it is suspected, after initial clinical evaluation, that a patient may have an ERI.
____Register staff traveling to, or youth who recently traveled to, designated high risk areas and report any symptoms of fever or cough that occur.
____Register staff and youth who have had contact with suspected patients and screen daily for fever or respiratory symptoms for five consecutive days or a period determined by the health authority.

C. Infection Control/Precautions
____Expand precautions for staff with PPE based on their exposure risk.
____Institute infection control precautions with PPE and possible housing assignments for symptomatic youth.

D. Communication/Education
____Place staff at high-traffic areas to answer questions and direct persons to the medical department as needed.
____ Keep staff and youth informed and provide education about prevention and symptom surveillance

E. Additional Preparedness Activities
____The facility Incident Command Team shall meet daily to review the situation and strategies.

Facility Pandemic Influenza Preparedness & Response Checklist
Level Ready- Red ERI Alert
Pandemic Period (WHO)

_____ Continue applicable activities from level Green/Interpandemic Period and level Yellow/Pandemic Alert Period.

A. Access Control

_____Restrict access to the facility to identified staff.
_____Suspend school, vocational trades and other group activities, including sporting events as determined by the Facility Incident Command Team
_____Implement plan for delivering meals to youth.
_____Suspension of facility group transportation.

B. Surveillance, Screening and Triage

_____Screen those allowed into the facility for fever or cough and have their temperature taken.
_____Record the number of all persons seen with suspected ERI and report to the Director of Institutions daily.

C. Infection Control/Precautions

_____Continue practice of airborne precautions, including staff who conducts screenings at facility entrances.
_____Implement isolation and quarantine guidelines as they are made available by Mississippi State Health Department
_____If suspected cases do not require hospitalization; housing assignments will be assessed by the Facility Incident Command Team.
_____Assist Mississippi State Health Department with contact investigations.

D. Communication/Education

_____Provide daily or more frequent updates to staff and youth.

INACTIVATED INFLUENZA VACCINE

WHAT YOU NEED TO KNOW 2010-11

Many Vaccine Information Statements are available in Spanish and other languages. See http://www.immunize.org/vis
Hojas de Información Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite http://www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease.

It is caused by the influenza virus, which can be spread by coughing, sneezing, or nasal secretions.

Anyone can get influenza, but rates of infection are highest among children. For most people, symptoms last only a few days. They include:

- fever
- sore throat
- chills
- fatigue
- cough
- headache
- muscle aches

Other illnesses can have the same symptoms and are often mistaken for influenza.

Infants, the elderly, pregnant women, and people with certain health conditions – such as heart, lung or kidney disease or a weakened immune system – can get much sicker. Flu can cause high fever and pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children. Each year thousands of people die from seasonal influenza and even more require hospitalization.

By getting vaccinated you can protect yourself from influenza and may also avoid spreading influenza to others.

2 Inactivated influenza vaccine

There are two types of influenza vaccine:

1. **Inactivated** (killed) vaccine, or the "flu shot" is given by injection into the muscle.

2. **Live, attenuated** (weakened) influenza vaccine is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

A "high-dose" inactivated influenza vaccine is available for people 65 years of age and older. Ask your healthcare provider for more information.

Influenza viruses are always changing, so annual vaccination is recommended. Each year scientists try to match the viruses in the vaccine to those most likely to cause flu that year.

The 2010-2011 vaccine provides protection against A/H1N1 (pandemic) influenza and two other influenza viruses – influenza A/H3N2 and influenza B. It will not prevent illness caused by other viruses.

It takes up to 2 weeks for protection to develop after the shot. Protection lasts about a year.

Some inactivated influenza vaccine contains a preservative called thimerosal. Thimerosal-free influenza vaccine is available. Ask your healthcare provider for more information.

3 Who should get inactivated influenza vaccine and when?

WHO

All people **6 months of age and older** should get flu vaccine.

Vaccination is especially important for people at higher risk of severe influenza and their close contacts, including healthcare personnel and close contacts of children younger than 6 months.

People who got the 2009 H1N1 (pandemic) influenza vaccine, or had pandemic flu in 2009, should still get the 2010-2011 seasonal influenza vaccine.

WHEN

Getting the vaccine as soon as it is available will provide protection if the flu season comes early. You can get the vaccine as long as illness is occurring in your community.

Influenza can occur at any time, but most influenza occurs from November through May. In recent seasons, most infections have occurred in January and February. Getting vaccinated in December, or even later, will still be beneficial in most years.

Adults and older children need one dose of influenza vaccine each year. But some children younger than 9 years of age need two doses to be protected. Ask your healthcare provider.

Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

4 Some people should not get inactivated influenza vaccine or should wait

- Tell your healthcare provider if you have any **severe** (life-threatening) allergies. Allergic reactions to influenza vaccine are rare.

- Influenza vaccine virus is grown in eggs. People with a **severe egg allergy** should not get influenza vaccine.
- A severe allergy to any vaccine component is also a reason not to get the vaccine.
- If you ever had a severe reaction after a dose of influenza vaccine, tell your healthcare provider.

- Tell your healthcare provider if you ever had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS). Your provider will help you decide whether the vaccine is recommended for you.
- People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. If you are ill, talk to your healthcare provider about whether to reschedule the vaccination. People with a mild illness can usually get the vaccine.

5 What are the risks from inactivated influenza vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.

Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you cannot get influenza from the vaccine.

Mild problems:
- soreness, redness, or swelling where the shot was given
- hoarseness; sore, red or itchy eyes; cough
- fever • aches

If these problems occur, they usually begin soon after the shot and last 1-2 days.

Severe problems:
- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

One brand of inactivated flu vaccine, called Afluria, **should not be given** to children 8 years of age or younger, except in special circumstances. A related vaccine was associated with fevers and fever-related seizures in young children in Australia. Ask your healthcare provider for more information.

The safety of vaccines is always being monitored. For more information, visit:
http://www.cdc.gov/vaccinesafety/Vaccine_Monitoring/Index.html
and
http://www.cdc.gov/vaccinesafety/Activities/Activities_Index.html

6 What if there is a severe reaction?

What should I look for?

Any unusual condition, such as a high fever or behavior changes. Signs of a severe allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** the doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your healthcare provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS website at **http://www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) was created in 1986.

People who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382**, or visiting the VICP website at **http://www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your healthcare provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **http://www.cdc.gov/flu**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

LIVE, INTRANASAL INFLUENZA VACCINE

WHAT YOU NEED TO KNOW 2010-11

Vaccine Information Statements are available in Spanish and many other languages. See http://www.immunize.org/vis
Hojas de Información Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite http://www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease.

It is caused by the influenza virus, which can be spread by coughing, sneezing, or nasal secretions.

Anyone can get influenza, but rates of infection are highest among children. For most people, symptoms last only a few days. They include:

- fever
- sore throat
- chills
- fatigue
- cough
- headache
- muscle aches

Other illnesses can have the same symptoms and are often mistaken for influenza.

Infants, the elderly, pregnant women, and people with certain health conditions – such as heart, lung or kidney disease or a weakened immune system – can get much sicker. Influenza can cause high fever and pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children. Each year thousands of people die from seasonal influenza and even more require hospitalization.

By getting vaccinated you can protect yourself from influenza and may also avoid spreading influenza to others.

2 Live, attenuated influenza vaccine - LAIV (nasal spray)

There are two types of influenza vaccine:

1. **Live, attenuated** influenza vaccine (LAIV) contains live but attenuated (weakened) influenza virus. It is sprayed into the nostrils.
2. **Inactivated** (killed) influenza vaccine, or the "flu shot," is given by injection into the muscle. *This vaccine is described in a separate Vaccine Information Statement.*

Influenza viruses are always changing, so annual vaccination is recommended. Each year scientists try to match the viruses in the vaccine to those most likely to cause flu that year.

The 2010 – 2011 vaccine provides protection against A/H1N1 (pandemic) influenza and two other influenza viruses– influenza A/H3N2 and influenza B. It will not prevent illness caused by other viruses.

It takes up to 2 weeks for protection to develop after the vaccination. Protection lasts about a year.

LAIV does not contain thimerosal or other preservatives.

3 Who can receive LAIV?

LAIV is recommended for healthy people **2 through 49 years of age**, who are not pregnant and do not have certain health conditions (see #4, below).

People who got the 2009 H1N1 (pandemic) influenza vaccine, or had pandemic flu in 2009, should still get the 2010-2011 seasonal influenza vaccine.

4 Some people should not receive LAIV

LAIV is not recommended for everyone. The following people should get the inactivated vaccine (flu shot) instead:

- **Adults 50 years of age and older or children from 6 through 23 months of age.** (Children younger than 6 months should not get either influenza vaccine.)
- Children younger than 5 years with asthma or one or more episodes of wheezing within the past year.
- Pregnant women.
- People who have long-term health problems with:
  - heart disease
  - kidney or liver disease
  - lung disease
  - metabolic disease, such as diabetes
  - asthma
  - anemia, and other blood disorders
- Anyone with certain muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems.
- Anyone with a weakened immune system.
- Anyone in close contact with someone whose immune system is so weak they require care in a protected environment (such as a bone marrow transplant unit). *Close contacts of other people with a weakened immune system (such as those with HIV)* ***may*** *receive LAIV. Healthcare personnel in neonatal intensive care units or oncology clinics may receive LAIV.*
- Children or adolescents on long-term aspirin treatment.

Tell your healthcare provider if you have any severe (life-threatening) allergies. Allergic reactions to influenza vaccine are rare.

- Influenza vaccine virus is grown in eggs. People with a **severe egg allergy** should not get influenza vaccine.
- A severe allergy to any vaccine component is also a reason not to get the vaccine.
- If you ever had a severe reaction after a dose of influenza vaccine, tell your healthcare provider.

Tell your healthcare provider if you ever had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS). Your provider will help you decide whether the vaccine is recommended for you.

Tell your healthcare provider if you have gotten any other vaccines in the past 4 weeks.

Anyone with a nasal condition serious enough to make breathing difficult, such as a very stuffy nose, should get the flu shot instead.

People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. If you are ill, talk to your healthcare provider about whether to reschedule the vaccination. People with a mild illness can usually get the vaccine.

5 When should I receive influenza vaccine?

Getting the vaccine as soon as it is available will provide protection if the flu season comes early. You can get the vaccine as long as illness is occurring in your community.

Influenza can occur any time, but most influenza occurs from November through May. In recent seasons, most infections have occurred in January and February. Getting vaccinated in December, or even later, will still be beneficial in most years.

Adults and older children need one dose of influenza vaccine each year. But some children younger than 9 years of age need two doses to be protected. Ask your healthcare provider.

Influenza vaccine may be given at the same time as other vaccines.

6 What are the risks from LAIV?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.

Live influenza vaccine viruses very rarely spread from person to person. Even if they do, they are not likely to cause illness.

LAIV is made from weakened virus and does not cause influenza. The vaccine can cause mild symptoms in people who get it (see below).

Mild problems:
Some children and adolescents 2-17 years of age have reported:

- runny nose, nasal congestion or cough
- fever
- headache and muscle aches
- wheezing
- abdominal pain or occasional vomiting or diarrhea

Some adults 18-49 years of age have reported:

- runny nose or nasal congestion
- sore throat
- cough, chills, tiredness/weakness
- headache

Severe problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the vaccination.
- If rare reactions occur with any product, they may not be identified until thousands, or millions, of people have used it. Millions of doses of LAIV have been distributed since it was licensed, and the vaccine has not been associated with any serious problems.

The safety of vaccines is always being monitored. For more information, visit:
http://www.cdc.gov/vaccinesafety/Vaccine_Monitoring/Index.html
and
http://www.cdc.gov/vaccinesafety/Activities/Activities_Index.html

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What should I look for?
Any unusual condition, such as a high fever or behavior changes. Signs of a severe allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

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- **Tell** the doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your healthcare provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS website at **http://www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

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Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382**, or visiting the VICP website at **http://www.hrsa.gov/vaccinecompensation**.

9 How can I learn more?

- Ask your healthcare provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **http://www.cdc.gov/flu**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Vaccine Information Statement (Interim)
Live, Attenuated Influenza Vaccine (8/10/10) U.S.C. §300aa-26

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES DIVISION OF YOUTH SERVICES OAKLEY YOUTH DEVELOPMENT CENTER	
Subject: **Medical Services Review, Monitoring, and Reporting**	**Policy Number: 40**
Number of Pages: 4	**Section: XI**
Attachments Health Services Supervisor's Weekly Report XI.40.A, Health Care Services Monthly Report XI.40.B, Medical Records Review Monitoring Tools XI.40.C.1-14,	**Related Standards & References** ACA Juvenile Health Care Performance Based Standards 2009: 4-JCF-4C-22, 4-JCF-4C-28, 4-JCF-4C-36, 4-JCF-4C-37, 4-JCF-4C-38, 4-JCF-4C-39,4-JCF-4C-40, 4-JCF-4C-42, 4-JCF-4C-51
Effective Date: 09/01/06 **Revision Date: 05/01/07, 04/14/08, 12/1/09, 1/25/10, 05/01/11, 11/01/13**	**Approved:** **James V. Maccarone**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, for the Agency's Director of Medical Services to develop and implement a system to review health care services. This systematic review shall be designed not only to monitor medical policies and procedures compliance, but also facilitate the provision of quality health care and programs. The necessary elements shall include, but are not limited to, the following activities: (4-JCF-4C-38)

- Staff credentialing (4-JCF-4C-51) Refer to policy XI.3, Health Care Personnel Qualification;
- Reviewing, monitoring and evaluation of medical data on a regular basis through:
  - Health records review by the Health Authority/designee including investigations of health complaints and grievances review
  - Prescribing and medication administration practices review (4-JCF-4C-28) Refer to MDYS Policy XI.30, Pharmaceutical Prescribing, Procurement, Administration and Documentation Procedures.
  - Complaints and grievances review (4-JCF-4C-40). Refer to policy XV.2, Youth Grievance.
  - Statistical reports and outcome measures (4-JCF-4C-38)
  - Contagious disease management (4-JCF-4C-22) Refer to policy XI.33, Communicable Disease Management.
  - Deaths in custody, suicides or suicide attempts, illness outbreaks, and youth injury experience review
  - Creating corrective action plans (CAP) based on findings to address and resolve identified problems and concerns, including educational and training activities;
  - Re-evaluating problems or concerns to determine whether the corrective measures have achieved and sustained the desired results.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply: None

III. PROCEDURE

A. The Director of Medical Services /designee shall be responsible for conducting ongoing monitoring visits in the medical clinic.

1. Ensure that at least annually, the Medical Services Review Monitoring Tool Form XI.40.C is completed and reviewed with the Facility Administrator.

2. At least annually, completing the Medical Records Review Monitoring Tool Form XI.40.D.

   a. The reviewer shall monitor at least ten (10) percent of the youth medical records or the records of all youth admitted during the monitoring period and complete the Medical Records Review Monitoring Tools XI.40.D.1-15 (all auditing tools may not be completed at the same intervals) Results of the monitoring tools shall be communicated to the Director of Medical Services in a memo of corrective actions to be.

   b. Director of Medical Services may develop additional medical records monitoring tools to review selective indicators relevant to health care service delivery.

3. The Director of Medical Services shall prepare a written corrective action plan within thirty (30) days after receiving the written report, if indicated. The action plan/s shall be forwarded to the Facility Administrator.

4. The Director of Medical Services /designee shall be responsible for:

   a. Weekly, completing the Weekly Report Form XI.40.A and submitting the report either via hard copy or electronically by the Wednesday of the following week to the Facility Administrator/designee. The Health Care Services Weekly Report Form XI.40.A shall minimally addresses:

      - Statistical data collection for admissions and discharges;
      - Statistical data collection for intake Physician exams and visits;
      - Statistical data collection for intake for dental screenings and visits;
      - Statistical data collection for initial psychiatric evaluation and follow-up visits;
      - Statistical data collection for nursing, physician, dental, and psychiatric services;
      - Statistical data collection for identification of any and all issues of communicable diseases;
      - Numerical tabulation of number of pregnant youth;
      - Numerical tabulation of number of medication doses administered; and
      - Cumulative measure of contacts with the medical department staff.

b. Monthly, completing the Health Care Services Monthly Report Form XI.40.B.

- Statistical data collection for admissions and discharges;
- Statistical data collection for intake Physician exams and visits;
- Statistical data collection for intake for dental screenings and visits;
- Statistical data collection for initial psychiatric evaluation and follow-up visits;
- Statistical data collection for nursing, physician, dental, and psychiatric services;
- Statistical data collection for identification of any and all issues of communicable diseases;
- Numerical tabulation of number of pregnant youth;
- Numerical tabulation of number of medication doses administered; and
- Cumulative measure of contacts with the medical department staff.

c. At least monthly, reviewing the following forms and logs to ensure accountability and policy and procedure compliance:

- Autoclave Log (XI.4.B)
- Medical Equipment Check List Form (XI.C.1 and 2)
- First Aid/Spill Kit Inspection Record Form (XI.5.B)
- AED Unit Inspection Form (XI.5.C)
- Supply Control Form (XI.6.A)
- Supply Control Monitoring Form (XI.6.B)
- Sharps Inventory Control Form (25) Count (XI.7.A)
- Sharps Inventory Control Form (50) Count (XI.7.B)
- Medical Instrument/Sharps Inventory Daily Count Form (XI.7.C)
- Dental Instrument/Sharps Inventory Count Form (XI.7.D)
- Medical Instrument Sigh-Out Form (XI.7.E)
- Dental Instrument Sigh-Out Form (XI.7.F)
- Health Call Log (XI.13.B)
- Physician Health Call Referral Log (XI.13.C)
- Laboratory Logs
- Admission Log (XI.15.B)
- Dental Visit Log (XI.19.B)
- Medical Department Off-Campus Log (XI.25.A)
- Medication Error Report Form (XI.30.C)
- Non-Prescription Pharmaceuticals Control Form (XI.31.A)
- Contingency Medication and Controlled Substance Daily Count Sheet (XI.31.B)
- Non-Prescription Pharmaceuticals Supply Monitoring Form (XI.31.C)

i. Corrective action plans (CAP) shall be completed on any findings of noncompliance with the medical policies and procedures.

ii. The Director of Medical Services may develop additional forms or accountability tools to review selective indicators relevant to health care service delivery.

d. At least quarterly, meeting with the Facility Administrator and Director of Medical Services to discuss the health care delivery system and any health environment issues. Meeting minutes are maintained. Any condition that poses a danger to staff or youth health and safety are reported immediately to the Facility Administrator. Refer to policy XI.2, Health Care Services Program and Responsible Health Authority. (4-JCF-4C-37)

e. The Director of Medical Services may develop additional monitoring tools to review selective indicators relevant to health care services delivery.

B. Quality Assurance Records or actions that emanate from quality assurance activities shall be maintained in a confidential manner. Aggregated statistical information shall not disclose the identity or persons receiving or providing medical or mental health services in state institutions. Any questions regarding the appropriateness of release of such confidentiality materials should be directed to the agency's Health Authority and Chief Counsel.

C. The Director of Medical Services shall revise this policy as necessary.

OTS Medical Weekly Report

Week of _____

Health Call	Triage	Physician	Dentist	Psychiatrist	TOTAL

# of Physician Exams / Follow-ups:	Current Obstetrical:
# of Dental Screenings / Work:	# of Psychiatric Evaluations / Follow-ups
# of Hygienist Cleanings/Sealants/X-Rays:	Communicable Diseases:
# of ER Visits / True Emergencies	Off-Campus Referrals

Admissions	Discharges	# Seen For Medications/Lab/Other	TOTAL # Seen For Week

OTS Medical Monthly Report

Month of _____

Health Call	Triage	Physician	Dentist	Psychiatrist/ Psychologist	TOTAL

# of Physician Exams / Follows-ups:	Current Obstetrical: 0

# of Psychiatric Evaluations:	# of Psychiatric Follow-ups:

# of Dental Screenings/Work:	# of Hygienist Cleanings/Sealants/X-Rays:

Communicable Diseases:

# of ER Visits	True Emergencies	Off-Campus Referrals

Comments:

Immunizations				Lab Work	
Hepatitis A		MMR		Routine	
Hepatitis B		Meningococcal		Special	
Tetanus		Influenza		Pregnancy tests	
Tdap		TB skin test		Positive STDs	
Varivax		HPV		Positive TB skin tests	

Infirmary/Observation		Isolation		Hospital Stays	

Fractures		X-Rays		Sutures	

Admissions	Discharges	# Seen For Medications/ Labs	TOTAL # Seen For Month

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES

DIVISION OF YOUTH SERVICES

Medical Services Review and Monitoring Tool

CONFIDENTIAL REPORT

FACILITY: _____ DATE OF SITE VISIT(S): _____

REPORT COMPLETED BY: _____

The purpose of this evaluation is to provide objective feedback based on a review of current Policies, ACA Health Care Standards and practice compliance.

Health Authority (MDYS Policy XI.2; ACA Standards 4-JCF-4C-33, 34, 36)

1. The facility employees a Registered Nurse (RN) as the on-site Health Services Coordinator. Yes ☐ No ☐
2. The facility contracts with a physician for on-site services. Yes ☐ No ☐
3. The Health Services Coordinator attends weekly Facility Department Head Meetings with the Facility Administrator. Date of last Meeting Attended: _____ Yes ☐ No ☐
4. The Health Services Supervisors complete the Statistical Reports Timely. Yes ☐ No ☐
5. The Health Services Supervisors meets with nursing staff at least monthly; agenda maintained. Yes ☐ No ☐
6. The Health Services Coordinator reviews the Health Care Policies Procedures annually. Yes ☐ No ☐

COMMENTS

Personnel Qualifications (Policy XI.3; ACA Standards 4-JCF-4C-34, 50, 51, 52)

1. The Health Services Supervisors annually reviewed all professionals' licenses and completes documentation on Form XI.3.A. Yes ☐ No ☐
2. The Health Services Supervisor maintains a listing of community specialty physicians. The resource listing is posted with in the clinic setting and is updated annually.
   Date of Last Review: _____ Yes ☐ No ☐
3. The Health Services Coordinator maintains a copy of the current physician's contract. Yes ☐ No ☐

COMMENTS

The staffing pattern is consistent with the various youth populations and adolescent health care needs. The Staffing plan is reviewed annually to determine the number and type of staff needed to provide adequate medical services provision for the identified need and mission. A letter of review signed by the Health Services Coordinator is forwarded to each Health Services Supervisor during the first quarter of the calendar year. The following report reflects the Approved Table of Organization and Nursing Vacancies:

Approved Table of Organization:

Med. Dept. Staff (FTE)	
Health Service Coordinator	1
Health Service Supervisor	1
RNs	
LPNs	2
Clerical Support	
TOTALS	

Nursing Staff Vacancies: [Report Date: _____]

Med. Dept. Staff (FTE)	
Health Service Coordinator	0
Health Service Supervisor	0
RNs	
LPN's	0
Clerical Support	
TOTALS	

* Agency nurses are being utilized to supplement staffing requirements. The vacant positions are posted and have been advertisement in local news papers.

Medical Facilities, Equipment, and Environment (Policy XI.4; ACA Standards 4-JCF-4C-59, 60M)

1. The Health Services Supervisor maintains necessary health publication as outlined in policy. Yes ☐ No ☐
2. The Health Services Supervisor maintains a medical equipment inventory list. Yes ☐ No ☐
3. Equipment is maintained in good working order. Yes ☐ No ☐
4. The Health Services Supervisor forwards requests to purchase major equipment to the Facility Administrator (who approves major equipment requests). Yes ☐ No ☐
5. The facility will provide adequate space for the Medical Department's needs. Yes ☐ No ☐
   - Space to allow for the private examination of youth.
   - Space to allow for private dental examination of youth.
6. Sufficient secured storage space is available for medical supplies and pharmaceuticals. Only health care professionals have keys to pharmaceutical storage areas. Yes ☐ No ☐
7. Medical Department keys are stored separate from facility keys. Yes ☐ No ☐
8. Clinic area is neat and clean. Yes ☐ No ☐
9. Laboratory areas are safe and are equipped with appropriate staff protection items. Yes ☐ No ☐
10. Medical instruments are routinely counted and inventoried. Inventory logs are maintained to verify count. Yes ☐ No ☐

COMMENTS

Health Screening, Appraisal, and Examination (Policy XI.15. and XI.16; ACA Standards 4-JCF-4C-01M, 02M, 03M, 04)

1. Youth are screened by a Nurse upon admission to the facility. Yes ☐ No ☐
2. Youth are examined by a Physician/designee within 14 day of admission. Yes ☐ No ☐
3. The facility's Physician/designee reviews and signs the youth's medical record on intake. Yes ☐ No ☐
4. The Admission Log (XI.15.B) is completed and available for review at the nursing station. Yes ☐ No ☐
5. Annual physical exams are completed on each youth. Yes ☐ No ☐

COMMENTS

Access to On-Site Health Care (Policy XI.13; ACA Standards 4-JCF-4C-05M, 06)

1. Accessing health care is explained to youth upon arrival to the facility. Yes ☐ No ☐
2. Nursing Health Call is conducted at least five (5) days per week. Youth who sign-up for Health Call are seen timely. Yes ☐ No ☐
3. Physician Health Call is scheduled at least one (1) day per week. Youth who are referred to Physician Health Call are seen timely. Yes ☐ No ☐

COMMENTS

Inpatient and Outpatient Hospital Services and Specialty Consultants (Policy XI.25; ACA Standards 4-JCF-4C-07, 08, 14)

1. A current "Letter of Hospital Agreement" is available for review. List below: Yes ☐ No ☐ N/A ☐

   The hospitals listed below are utilized as needed for in-patient services:

2. When health care is required beyond the resources available in the facility, as determined by a Physician, the youth is transported timely to a medical facility where such care is provided. Yes ☐ No ☐
3. Facility staff provide supervision and security when youth are admitted to a hospital or while receiving outpatient services. Yes ☐ No ☐

COMMENTS

Dental Screening and Examination (Policy XI.19; ACA Standards 4-JCF-4C-15)

1. The facility contracts with a Dentist for on-site services. Yes ☐ No ☐
2. A nurse on intake completes an admission dental screening. Yes ☐ No ☐
3. Dental exams are completed within fourteen (14) days of admission to the facility. Yes ☐ No ☐
4. Dental Cleaning is completed bi-annually. Yes ☐ No ☐
5. Youth who are referred to Dental Health Call are seen timely. Yes ☐ No ☐
6. Dental instruments are routinely counted and inventoried. Inventory logs are maintained to verify count. Yes ☐ No ☐
7. Dental X-ray equipment is licensed by the Mississippi Department of Radiological Safety Yes ☐ No ☐

COMMENTS

Female Health Services (Policy XI.21; ACA Standards 4-JCF-4C-19)

1. Gynecological services are provided as needed. Yes ☐ No ☐ N/A ☐
2. Obstetrical Services are provided as needed. Yes ☐ No ☐ N/A ☐

COMMENTS

Administration of Treatment (Policy XI.14; ACA Standards 4-JCF-4C-10, 19)

1. Standing Orders are maintained and updated annually. Date of last update: _____ Yes ☐ No ☐
2. Standing Orders are activated according to the prescribed treatment signed off by the Physician. Yes ☐ No ☐
3. Medication Formulary is maintained and available to nursing and physician. Yes ☐ No ☐ N/A ☐

COMMENTS

Informed Consent/Authorization to Treat (Policy XI.11; ACA Standards 4-JCF-4C-43)

1. Parents are informed by phone and/or written notification when a youth requires significant off-site medical care required in Department Policy. Yes☐ No☐
2. The Facility Administrator or designee signs all Consent/Authorization to Treat Forms. Yes ☐ No ☐

COMMENTS

Pharmaceutical & Medical Supplies (Policy XI.29, XI.30, XI.31 and XI.32; ACA 4-JCF-4C-27M, 28, 29)

1. Pharmaceuticals are prepared by the contracted pharmacy. Yes ☐ No ☐
2. Pharmacy Policy Manuals are current and up-to-date. Yes ☐ No ☐
3. Medications are only administered by licensed nurses or trained personnel. Yes ☐ No ☐
4. Medication Administration Records (MAR's) are utilized for documentation. Yes ☐ No ☐
5. Medications are administered timely and in accordance with the physician order and Agency Policy. Yes ☐ No ☐
6. Medications are properly maintained in a clean and neat order. Medication and storage areas are locked when not in use. Yes ☐ No ☐
7. Continuous inventory control is maintained on all prescription and over-the-counter medications. Count is correct. Yes ☐ No ☐
8. Contingency medications are inventoried by nursing staff daily, Monday through Friday. Yes ☐ No ☐
9. Continuous inventory control is maintained on all medical sharps. Count is correct. Yes ☐ No ☐
10. Sharps inventory is completed on each shift; log records are maintained for count verification. Yes ☐ No ☐
11. Pharmaceutical disposal records are maintained. Yes ☐ No ☐

12. All Pharmacy licenses are current and posted. Yes ☐ No ☐

COMMENTS

First Aid and Emergency Care (Policy XI.26; ACA Standards 4-JCF-4C-12, 14, 52, 58)

1. Emergency Medical Services are locally available for transporting youth. Yes ☐ No ☐
2. First Aid Kits and AED are inspected monthly. Yes ☐ No ☐
3. All required staff are trained in First Aid and CPR as outlined in MDYS Policy. Yes ☐ No ☐

COMMENTS

Specialized Health Programs & Education (Policy XI.20 and XI.22; ACA Standard 4-JCF-4C-16, 17, 18, 26)

1. The Physician completes Medical Treatment Plans on youth with special needs. Yes ☐ No ☐
2. Youth with special needs are provided individual education/training by a nurse. Yes ☐ No ☐
3. Health education is provided to the youth by nursing staff. Yes ☐ No ☐
4. Special Diets are available when written by the physician. Yes ☐ No ☐
5. The Health Services Supervisors and nurses are familiar with MDYS Policy XI.23, Therapeutic Diets and Dietary Referrals. Yes ☐ No ☐
6. The Health Services Supervisors and nurses are familiar with MDYS Policy XI.24, Juvenile Participation in Medical Research. Yes ☐ No ☐

COMMENTS

Contagious and Infectious Diseases, Management of (Policy XI.33, XI.34, XI.35, XI.36, and XI.37; ACA Standards 4-JCF-4C-22, 23, 24, 25)

1. HIV testing of youth is completed after a doctor order has been written. Yes ☐ No ☐
2. Youth pre-counseling is held prior to HIV testing as evidence by chart documentation. Yes ☐ No ☐
3. Youth post-counseling is held only when positive results are received as evidence by chart documentation. Yes ☐ No ☐

4. There are no youth in the facility requiring medical isolation. Yes ☐ No ☐
5. Youth receive PPD Skin Testing on admission. Yes ☐ No ☐ N/A ☐
6. Youth yearly PPD Skin Testing is completed, when applicable Yes ☐ No ☐
7. Staff yearly PPD Skin Testing is completed. Yes ☐ No ☐ N/A ☐
8. Youth immunizations are complete and update as required. Yes ☐ No ☐
9. Staff Hepatitis B shots are offered and provided when requested. Yes ☐ No ☐ N/A ☐
10. MDH Disease Control Manual is available on line. Yes ☐ No ☐

COMMENTS

Exposure Control (Policy XI.38; ACA Standards 4-JCF-4C-61)

1. Spill Kits are inspected monthly. Yes ☐ No ☐
2. Standard Precautions signs are posted throughout the facility. Yes ☐ No ☐
3. Management of Biohazardous Waste is maintained. Yes ☐ No ☐

COMMENTS

Health Records and Confidentiality (Policy XI.8; ACA Standards 4-JCF-4C-31, 32)

1. Medical records are maintained confidentially in the Medical Department and separate from the commitment records. Yes ☐ No ☐
2. Medical Records are kept under a lock system and accessible only by health care professionals. Yes ☐ No ☐
3. Medical Records are maintained under hard cover and stamped "confidential". Yes ☐ No ☐
4. Medical Records are transferred within the system as youth leaves the institution. Yes ☐ No ☐ N/A ☐
5. Medical Records are maintained in a neat and orderly manner. Yes ☐ No ☐

COMMENTS

Health Department Inspections and/or Visits from other out-side Local and/or State Agencies:

Date(s)	Agency	Comments

File Review:

Date(s)	Comments

Medical Services Review, Monitoring, and Reporting (MDYS Policy XI.39):

The following monitoring tools and reports are complete and/or reviewed timely by the Health Services Supervisor(s) as required by Department Policies and Procedures:

At least annually, the following form is completed:

- Health Care Personnel Licensure Verification Form (XI.3.A) Yes ☐ No ☐

At least annually, the following form is reviewed:

- Medical Services Review and Monitoring Tool (XI.40.C) Yes ☐ No ☐

At least monthly, the following forms and logs are completed and/or reviewed:

- Laboratory Logs reviewed and monitored for compliance of returned lab results(XI.17) Yes ☐ No ☐
- Health Care Services Monthly report (XI.40.A) Yes ☐ No ☐
- Health Care Services Statistical data Report (XI.40.C) Yes ☐ No ☐
- Medical Records Review Monitoring Tool Form (XI.40.C) Yes ☐ No ☐
- Autoclave Log (XI.4.B) Yes ☐ No ☐
- Medical Equipment Check List Form (XI.4.C.1 and 2) Yes ☐ No ☐
- First Aid/Spill Kit Inspection Record Form (XI.5.B) Yes ☐ No ☐
- AED Unit Inspection Form (XI.5.C) Yes ☐ No ☐
- Supply Control Form (XI.6.A) Yes ☐ No ☐
- Supply Control Monitoring Form (XI.6.B) Yes ☐ No ☐
- Sharps Inventory Control Form (25) Count (XI.7.A) Yes ☐ No ☐
- Sharps Inventory Control Form (50) Count (XI.7.B) Yes ☐ No ☐
- Medical Instrument/Sharps Inventory Daily Count Form (XI.7.C) Yes ☐ No ☐
- Dental Instrument/Sharps Inventory Count Form (XI.7.D) Yes ☐ No ☐
- Medical Instrument Sigh-Out Form (XI.7.E) Yes ☐ No ☐
- Dental Instrument Sigh-Out Form (XI.7.F) Yes ☐ No ☐
- Health Call Log (XI.13.B) Yes ☐ No ☐
- Physician Health Call Referral Log (XI.13.C) Yes ☐ No ☐
- Admission Log (XI.15.B) Yes ☐ No ☐
- Dental Visit Log (XI.19.B) Yes ☐ No ☐
- Medical Department Off-Campus Log (XI.25.A) Yes ☐ No ☐
- Medication Error Report Form (XI.30.C) Yes ☐ No ☐
- Non-Prescription Pharmaceuticals Control Form (XI.31.A) Yes ☐ No ☐
- Contingency Medication and Controlled Substance Daily Count Sheet (XI.31.B) Yes ☐ No ☐
- Non-Prescription Pharmaceuticals Supply Monitoring Form (XI.31.C) Yes ☐ No ☐

Medical Contract Services Schedule:

Contractors	Monday	Tuesday	Wednesday	Thursday	Friday
Physician Health Call and Intake Examinations					
Dental Health Call					
Psychiatry Health Call					
Nurse Practitioner Health Call & Examinations					

Compliance Summary

Page #	Section (Health Services)	Total # of Indicators	Compliant	Non-compliant	Non-Applicable
1	Health Authority	8			
1	Personnel Qualifications	4			
2	Medical Facilities & Equipment	10			
3	Health Screening, Appraisal and Examination	5			
4	Access to On-site Health Care	3			
5	In/out Patient Hospital Services and Specialty Consultants	3			
5	Dental Screening and Examination	8			
6	Female Health Services	2			
6	Administration of Treatment	3			
6	Informed Consent/Authorization to Treat	2			
6	Pharmaceutical & Medical Supplies	13			
8	First Aid and Emergency Care	3			
8	Specialized Health Programs & Education	6			
9	Contagious and Infectious Disease Management	10			
10	Exposure Control	3			
11	Health Records and Confidentiality	5			
12	Medical Quality Assurance Monitoring and Reporting	29			

TOTAL Indicators	
Compliant	
Non-compliant	
Non-Applicable	

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
INTAKE/ADMISSION

Unit:
Reviewer:
Date:

	MDYS Number	MDYS Intake Date	Record Stamped Confidential	Nursing Intake Screen Date of Admit	Nursing Intake Notation Date of Admit	Child Health Inventory Present	Admission Lab Date W/I 7 days	PPD Skin Test Date	Hearing/Vision Screen Date	MD Exam Date W/I 7 Days	Comments
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
	Percent Compliance		%	%	%	%	%	%	%	%	

Form XI.40.D.1

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL

PROBLEM LIST

Unit:
Reviewer:
Date:

	MDYS Number	MDYS Intake	Chronic Problem	Problem Noted by MD/DMD	Consult Ordered	Consult Results on Chart	Plan for Chronic Illness	Nursing Care Plan	Acute Problem	Acute Problem Date	Date Seen by MD	Follow up	Date Resolved	Comments
1														
2														
3														
4														
5														
6														
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20														
	Percent Compliance		%	%	%	%	%		%	%	%	%	%	

Form XI.40.D10

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Health Call

Unit:
Reviewer:
Date:

	Date Signed up	Student Name	C/O	Triage Date/Time	Doc on IPN Y or N	Referral Y or N	Referral Completed Y or N	*Recurrent C/O	Comments
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
	*Recurrent Problems must be on the Medical Problem List Form XI.20.A		Percent Compliance	%	%	N/A	%	%	

Form XI.40.D11

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Health Call Boxes

Unit:
Reviewer:
Date:

	Date	Unit/Location	Box Location	Box Locked Y or N	Box for Blank Forms and Evelopes Present Y or N	Blank Forms Available Y or N	Medical Evelopes Available Y or N	Comments
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
	Precent Compliance			%	%	%	%	

Form XI.40.D12

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Health Care Plan and Medical Instructions

Unit:
Reviewer:
Date:

	Date Health Restrictions Identified	Student Name	Health Care Plan and Medical Insturctions Form Completed (XI.20.B) Y or N	Documentation noted by Nursing in the IPN Y or N	Form XI.20.B is distrubuted to all appropriate facility staff areas Y or N	Form XI.20.B is available and is current in all appropriate facility staff areas Y or N	Comments
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
	Percent Compliance		%	%	%	%	

Form XI.40.D13

Form XI.40.D.14- Psychology Forms in the Health Record

Column 1	MDYS number
Column 2	Date of admission to OTS
Column 3	Is the Initial Screening Protocol under the Psychology tab in section one (1) of the Health Record? Place a Yes or No in the data field
Column 4	Is the Programming Needs Assessment under the Psychology tab in section one (1) of the Health Record? Place a Yes or No in the data field
Column 5	Is the Service Plan under the Psychology tab in section one (1) of the Health Record? Place a Yes or No in the data field
Column 6	Is the Initial QMHP records/forms under the Psychology tab in section one (1) of the Health Record : 1) Are there any QMHP individual Progress Notes (NO group notes should be in this section) Place a 1 in the data field or No in the data field (i.e. if the form/s is/are present simply place a 1 in the data field- if this form is absent document 1- no) 2) Are there any QMHP individual Assessment (NO group notes should be in this section) Place a 2 in the data field or No in the data field (i.e. if the form/s is/are present simply place a 2 in the data field- if this form is absent document 2- no) 3) Are there any QMHP individual Evaluation (NO group notes should be in this section) Place a 3 in the data field or No in the data field (i.e. if the form/s is/are present simply place a 3 in the data field- if this form is absent document 3- no)
Column 7	Are there any Suicide Interview Form/s present. Not all students will have this form. Look on the Problem List as suicide alerts should be listed in the acute section. If this is determined that this form should be in the chart and is present place a Yes in the data field. If this is determined that this form should be in the chart and is NOT present place an No in the data field. If this is determined that this form should not be in the chart place an N/A in the data field.
Column 8	Are there any Suicide Re-assessment Forms/s present. Not all students will have this form. Look on the Problem List as suicide alerts should be listed in the acute section. If this is determined that this form should be in the chart and is present place a Yes in the data field. If this is determined that this form should be in the chart and is NOT present place an No in the data field. If this is determined that this form should not be in the chart place an N/A in the data
Column 9	Is there a Beck Scale Forms present. Not all students will have this form. Look on the Problem List as suicide alerts should be listed in the acute section. If this is determined that this form should be in the chart and is present place a Yes in the data field. If this is determined that this form should be in the chart and is NOT present place an No in the data field. If this is determined that this form should not be in the chart place an N/A in the data field.
Column 10	Are there any QMHP notes (individual) present. Not all students will have this form. Look on the Problem List as suicide alerts should be listed in the acute section. If this is determined that this form should be in the chart and is present place a Yes in the data field. If this is determined that this form should be in the chart and is NOT present place an No in the data field. If this is determined that this form should not be in the chart place an N/A in the data field.
Column 11	Is there a Post Suicide Safety Alert Forms present. Not all students will have this form. Look on the Problem List as suicide alerts should be listed in the acute section. If this is determined that this form should be in the chart and is present place a Yes in the data field. If this is determined that this form should be in the chart and is NOT present place an No in the data field. If this is determined that this form should not be in the chart place an N/A in the data

****If the answer to any of the above is No put this on the list of issues to be given to the Nursing Supervisors. A work order must be completed and turned in the day of the review.****

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
SPECIAL HEALTH NEEDS

Unit:
Reviewer:
Date:

	MDYS Number	MDYS Intake Date	Condition	Date Tx Plan Identified	Direction given to Staff	Nursing Care Plan in Chart	Lab/ Med Monitoring	Specialist Consult	Therapeutic Diet Order	Individualized Education	Physician monitoring	Comments
1												
2												
3												
4												
5												
6												
7												
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19												
20												
	Percent Compliance		%	%	%	%	%	%	%	%	%	

Form XI.40.D15

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Medication Continuity Review

Unit:
Reviewer:
Date:

	MDYS Number	Date of Admit	Medication on Admit	Bot-tle ?	RX ?	Last Dose	Automatic Stop	Order to Continue	First Dose at Facility	Date Eval by Doctor	Continue/ Restart/ D/C	Continuity Yes/ No/ N/A	Comments
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
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19													
20													

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Medication Administration

Unit:
Reviewer:
Date:

	MDYS Number	Date of Med Order	Medication	Med Dose	Med Route	Med Frequency	Order Transcribed to MAR	Order Stop Date	Amount of Medication to be Administered	Amount Administered as Noted on the MAR	# of Refusals or Med Held	Compliant Yes or No	Comments
1													
2													
3													
4													
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19													
20													

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
DENTAL WORK F/U

Unit:
Reviewer:
Date:

	MDYS Number	MDYS Intake Date	Dental Treatment Plan	How Many Needs Idenitified	Date of Prophy/Pan-B/W	Work Initiated by 30 days	Work Completed	Health Call Request	Dental Record Complete	Plan for Cont'd tx	On Appt Board	Treat-ment Refusal	Comments
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
	Percent Compliance		%	%	%	%	%	%	%	%	%	%	

Form XI.40.D.4

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Psychiatric Evaluations

Unit:
Reviewer:
Date:

	MDYS Number	MDYS Intake- - Eval date	Identity info	HX of Present Illness	Past Psy HX	Past medical HX	Develop-mental HX	Family/ Social HX	Mental Status Exam	DX Formulation	5 Axis Diagnoses	Assess ment & Plan	Call to Parents	Comments
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
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12														
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15														
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17														
18														
19														
20														
	Percent Compliance		%	%	%	%	%	%	%	%	%	%		

Form XI.40.D.5

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Psychiatric Progress Notes

Unit:
Reviewer:
Date:

	MDYS Number	Initial Eval Date/ Progress date	Identity info	Interim HX	Mental Status Exam	Assess ment	Diagnoses	PLAN	New Med Informed Consent	Med S/E Doc	SYM change doc	If new med call to Parents	Comments
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
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17													
18													
19													
20													
	Percent Compliance		%	%	%	%	%	%	%	%	%	%	

Form XI.40.D.6

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Psychiatric Protocols- Medication

Unit:
Reviewer:
Date:

	MDYS Number	Date of Med Order	New Med	Cont Home Med	Protocol (for SGA's & Stimulants)	Standing Orders on chart	Correct Testing Completed	Results on Chart	MD Reviewed Results	Med Start Date	Informed Consent	AIMS Testing	Comments
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
	Percent Compliance		%	%	%	%	%	%	%	%	%	%	

Form XI.40.D7

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Psychiatric Discharge

Unit:
Reviewer:
Date:

	MDYS Number	MDYS Intake/ D/C date	Identity info	HX of Illness	Hospital /Tx course	D/C DX	D/C DX Axis I	D/C DX Axis II	D/C DX Axis III	D/C Medications	Prognosis	D/C Plan w-F/U	Comments
1		/											
2		/											
3		/											
4		/											
5		/											
6		/											
7		/											
8		/											
9		/											
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19		/											
20		/											
	Percent Compliance		%	%	%	%	%	%	%	%	%	%	

Form XI.40.D.8

CONFIDENTIAL
Medical Records Review

Mississippi Division of Youth Services
Medical Record Review -- CONFIDENTIAL
Injury/Abuse- YIA forms

Unit:
Reviewer:
Date:

	MDYS Number	MDYS intake Date	Incident: Staff on Student Y or N	Accident or Fight	TO ER	Incident Date	YIAF done	YIAF Correct	Abuse alleged by student	Abuse suspected by Nurse	Call to hotline	PI Notified	Comments
1													
2													
3													
4													
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