



Successful Youth • Strong Leaders • Safer Communities

POLICY

SUBJECT: Chronic Care and Special Health Care Needs

NUMBER: HC-325-18

APPLICABLE TO: Somatic Health Services Staff

APPROVED: _____ /s/ signature on original

Sam Abed, Secretary

DATE: _____ 2/27/18

I. POLICY

A health-care treatment plan shall be developed for youth who require medical supervision for chronic and convalescent care.

II. AUTHORITY

A. Md. Code Ann., Human Services, §9-203 and §9-204.

B. American Correctional Association (ACA) Standards 4-JCF-4C-16, 4-JCF-4C-17, 4-JCF-4C-20, and 4-JCF-4C-41.

III. DIRECTIVES/POLICIES RESCINDED

None

IV. FAILURE TO COMPLY

Failure to comply with the Department's Policy and Procedures shall be grounds for disciplinary action up to and including termination of employment.

V. STANDARD OPERATING PROCEDURES

Standard operating procedures have been developed.

VI. REVISION HISTORY

| DESCRIPTION OF REVISION | DATE OF REVISION |
|--------------------------------|-------------------------|
| New policy issued. | 2/27/18 |
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PROCEDURES

SUBJECT: Chronic Care and Special Health Care Needs

NUMBER: HC-325-18

APPLICABLE TO: Somatic Health Services Staff

APPROVED: _____ /s/ signature on original

Linda McWilliams, Deputy Secretary

DATE: _____ 2/27/18

I. PURPOSE

To provide procedures for identifying youth who have special health care needs, and developing an individualized written health care treatment plan. Information sharing shall be within the guidelines of confidentiality.

II. DEFINITIONS

Nurse means an employed or contractual Registered Nurse (RN) or Licensed Practical Nurse (LPN) responsible for the provision of health services at the facility.

Medical and dental adaptive devices include but are not limited to, eyeglasses, hearing aids, dentures, wheelchairs and other prosthetic devices.

Qualified Health Care Professional includes physicians, physician's assistants, dentists, nurses, nurse practitioners, nurse midwife, mental health professionals and others who by virtue of their education, credentials, licensure, and experience are permitted by law to evaluate and care for youth.

III. PROCEDURE

A. **HEALTH STATUS ALERTS**

1. Youth with special health care needs shall be identified during the admissions process and ongoing by a qualified health care professional(QHCP).
2. The identification of the youth's special health care needs shall be noted on the **Master Problem List (Appendix 1)** in the youth's health record by the QHCP.
3. When a youth has a special health care need identified, the **Health Status Alert (HSA) form (Appendix 2)** shall be completed and distributed by the nurse to the appropriate facility staff as indicated on the form.
4. The original HSA form shall be placed in the youth's health record with a copy in a master binder in the health center.
5. The distributed copies of the HSA form shall be maintained by the recipient in a binder designated for that purpose. HSA forms shall be distributed only to facility staff who have a need to know the youth's health information. *All health care information must be maintained confidentially.*
6. The nurse shall review the HSA forms in all disciplines binders weekly for accuracy, and document the review on the **Health Status Alert Log Weekly Checks form (Appendix 3)**.
7. Facility staff who have questions about a HSA form shall contact the nursing staff for clarity.

B. **SPECIAL NEEDS TREATMENT PLANS**

1. All youth who have chronic illnesses or conditions such as asthma, diabetes and other diseases, receiving periodic care and treatment or are ordered to be housed in an infirmary for somatic health reasons shall have a **Special Needs Treatment Plan (Appendix 4)** initiated and completed by physicians, nurse practitioners and nursing staff.
2. Special Needs Treatment Plans shall include:
 - a. Identification of the problem or need.
 - b. Description of the goals or the expected outcome for treatment.
 - c. Description of planned interventions including instructions, in collaboration with physician's orders, laboratory testing, specialist consultation, as needed, and medication monitoring.
 - d. Description of medical and dental adaptive devices to be provided when medically necessary as determined by the health care professional.
 - e. Evaluation of progress including the frequency of follow-up for medical evaluation and any adjustment to be implemented in the treatment modality. Documentation of the problem or need as resolved or ongoing.

- f. Date and clinician's initials completed by the QHCP that completed the Special Needs Treatment Plan.
- g. The plan for the next review completed by the physician/nurse practitioner and includes the next review date, which shall not be less than 30 calendar days from the date of the last review.
3. The youth's ongoing progress related to the identified goals and interventions shall be documented in the youth's health record in the progress notes section by a QHCP.
4. The nursing staff at each facility shall keep a master list of youth who have Special Needs Treatment Plans that identify the youth's special needs. While the youth is in a DJS residential placement, the Special Needs Treatment Plan shall be placed in the medication administration record for review by all nursing staff.
5. The Special Needs Treatment Plan and the HSA form shall be filed in the youth's health record when no longer applicable.
6. All Special Needs Treatment Plans shall be kept confidential as protected health information in accordance with federal law, state laws and regulations, and the DJS *Confidentiality Policy and Procedure*.

IV. RESPONSIBILITY

The Health Administrator is responsible for implementation and compliance with this procedure.

V. INTERPRETATION

The Deputy Secretary for Operations in consultation with the Health Administrator shall be responsible for interpreting and granting any exceptions to these procedures.

VI. LOCAL OPERATING PROCEDURES REQUIRED

No

VII. DIRECTIVES/POLICIES REFERENCED

DJS Confidentiality Policy and Procedure

VIII. APPENDICES

1. Master Problem List
2. Health Status Alert form
3. Health Status Alert Log Weekly Checks
4. Special Needs Treatment Plan



DJS POLICY AND STANDARD OPERATING PROCEDURES

Statement of Receipt and Acknowledgment of Review and Understanding

SUBJECT: Chronic Care and Special Health Care Needs

NUMBER: HC-325-18

APPLICABLE TO: Somatic Health Services Staff

I have received and reviewed a copy (electronic or paper) of the above titled policy and procedures. I understand the contents of the policy and procedures.

I understand that failure to sign this acknowledgment form within five working days of receipt of the policy shall be grounds for disciplinary action up to and including termination of employment.

I understand that I will be held accountable for implementing this policy even if I fail to sign this acknowledgment form.

SIGNATURE

PRINT FULL NAME

DATE

WORK LOCATION

SEND THE ORIGINAL, SIGNED COPY TO THE DIRECTOR OF THE DJS OFFICE OF HUMAN RESOURCES FOR PLACEMENT IN YOUR PERSONNEL FILE.

Maryland Department of Juvenile Services

Master Problem List

| DATE | Problem Number | Problem | Intervention/Treatment | Clinician's Initials | Resolution Date | Clinician's Initials |
|------|----------------|------------------------------------|---|----------------------|-----------------|----------------------|
| | 1 | ALLERGIES: | | | | |
| | 2 | | | | | |
| | 3 | | | | | |
| | 4 | | | | | |
| | 5 | | | | | |
| | 6 | | | | | |
| | 7 | | | | | |
| | 8 | | | | | |
| | 9 | | | | | |
| | 10 | | | | | |
| DATE | Problem Number | PAST PROBLEMS/ HOSPITALIZATIONS | Intervention/Treatment (e.g. old records obtained) | Clinician's Initials | Resolution Date | Clinician's Initials |
| | | | | | | |
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Youth's Name: _____ **DOB:** _____ **Facility:** _____

HEALTH STATUS ALERT

All information contained on this form must be kept confidential in accordance with federal laws, Maryland laws and regulations, and DJJ policy and procedures.

Date: _____

Name: _____ DOB: _____ Facility: _____ Unit: _____

HEALTH CONDITIONS

- Allergic To: _____ Reaction: _____
- Diabetes Sickle Cell Asthma Seizure Disorder Heart Condition
- Injury: Type/Location: _____
- Dental Appliance: Type: _____ Vision Impairment Contact Lenses Eyeglasses
- Hearing Deficit Speech Impairment
- Other Disabilities/Health Concerns: _____

RESTRICTIONS & INSTRUCTIONS

- From: _____ To: _____ No Sports No Lifting Bedrest Medical Isolation
- No Kitchen Detail (*Youth Centers Only*) Other: _____
- Comments: _____

DIETARY ORDERS

- Food Allergy: _____
- Lactose Intolerance Dietary Substitutions: _____
- Special Diet Ordered Type: _____ From: _____ To: _____
- Other Dietary Orders: _____
- Registered Dietitian Notified: Telephone Fax From: _____ To: _____
- Facility Food Service Department Notified: Date: _____ Time: _____ Via: _____
- Comments: _____

SELF ADMINISTERED MEDICATIONS

Please use with the Self-Administered Medication/Treatment Record form and must have a current physician's order.

From: _____ To: _____ Medication/Treatment: _____

Directions: _____

NOTIFICATION OF HEALTH STAFF

Notify Health Services if:

DISTRIBUTION

- Unit Control Center Registered Dietitian Food Service
- Recreation School Shift Commander Other: _____

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



Health Services

Health Status Alert Log Weekly Checks

Location of Health Status Alert Book _____

| Date | Time of Check | Update Completed | Nurse's Signature |
|------|---------------|------------------|-------------------|
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Nurse must check the HSA books for accuracy weekly and sign that the update has been completed.

**MARYLAND DEPARTMENT OF JUVENILE SERVICES
HEALTH SERVICES
SPECIAL NEEDS TREATMENT PLAN**

Name _____ **DOB** _____ **ASSIST#** _____

| Problem/Need | Goals | Intervention | Evaluation of Progress | Date & Nurse's Initials | Review Date |
|--------------|-------|--------------|------------------------|-------------------------|-------------|
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