MARYLAND Department of Juvenile Services

Successful Youth • Strong Leaders • Safer Communities

POLICY

SUBJECT: Drug and Alcohol Dependence, Intoxication, and Withdrawal Management
NUMBER: HC-326-18
APPLICABLE TO: All Residential Staff

APPROVED: /s/ signature on original
Sam Abed, Secretary
DATE: 4/4/18

I. POLICY

The Department of Juvenile Services (DJS) screens all youth for drug or alcohol dependence, intoxication, and withdrawal during the intake and admission process. DJS will medically monitor youth who are intoxicated, withdrawing, or at risk for withdrawal, and if appropriate will provide youth with medication to treat drug dependence following DJS somatic health guidelines. Any youth who requires care for drug use beyond what can be safely provided at a DJS facility will be referred for emergent care and possible hospitalization.

II. AUTHORITY

A. Md. Code Ann., Human Services, §9-203 and §9-204.
B. American Correctional Association (ACA) Standards, 4-JCF-4C-13.

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 DIRECTIVES/POLICIES RESCINDED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.	4/4/18

MARYLAND Department of Juvenile Services

Successful Youth • Strong Leaders • Safer Communities

PROCEDURES

SUBJECT: Drug and Alcohol Dependence, Intoxication, and Withdrawal Management
NUMBER: HC-326-18
APPLICABLE TO: All Residential Staff

APPROVED: _____
Linda McWilliams, Deputy Secretary
DATE: _____

I. PURPOSE

To identify youth with drug and alcohol dependence, intoxication, or withdrawal in order to medically monitor and when necessary, treat their drug dependence and withdrawal in accordance with best medical practices.

II. DEFINITIONS

Facility Initial Reception Referral Screening Tool (FIRRST) means an approved screening assessment instrument used by an admission's officer to screen a youth before facility admittance.

Health Care Practitioner means clinicians trained to diagnose and treat patients to include, physicians, dentists, psychologists, podiatrists, optometrists, nurse practitioners and physician assistants.

Health Care Professional means staff who perform clinical duties to include, health care practitioners, nurses, social workers, dietitians, emergency medical technicians in accordance with each health care professional's scope of training and applicable licensing, certification, and regulatory requirements.

Intoxication means the condition that follows the administration or consumption of a psychoactive substance or alcohol and results in disturbances in the level of consciousness, cognition, perception, judgment, affect, or behavior, or other psychophysiological functions and responses.

Massachusetts Youth Screening Instrument, 2nd edition, (MAYSI-2) means an approved self-report screening inventory used to identify youth who need a mental health assessment due to the possibility of serious mental health issues or suicide risk.

Substance Abuse Subtle Screening Inventory for Adolescents (SASSI-2) means a psychological screening measure that helps identify youth who have a high probability of having a substance use disorder.

Substance dependence means the state in which a person functions normally only in the presence of a drug or alcohol and is manifested as a physical disturbance when the drug or alcohol is removed.

Withdrawal means the development of unpleasant psychological and/or physical symptoms caused by the abrupt cessation of the use of a drug or alcohol in a person habituated or dependent on the drug. In some situations, withdrawal may require medical care or may be life threatening.

III. PROCEDURES

A. Identification of Drug and Alcohol Dependence, Intoxication, and Withdrawal

1. Prior to facility admission:
    a. Admission staff assess youth for intoxication and withdrawal using the **DJS Facility Initial Reception/Referral Screening Tool (FIRRST) (Appendix 1)**.
    b. If the youth screens positive on the FIRRST, the nurse is called to further assess the youth using the **DJS Pre-Admission Medical Assessment Form (Appendix 2).**
    c. If the nurse has concerns that the youth requires further assessment or care beyond what the facility can safely provide for drug dependence, withdrawal, or intoxication, the nurse shall contact the on-call physician for drug dependence to discuss the case.
    d. The physician will determine if the youth can be safely managed at the facility or requires referral to an emergency room.
2. During the admissions process:
    a. Nursing staff shall complete the **DJS Admission Nursing Assessment (Appendix 3)** which includes a section on current and past drug use, history of withdrawal and overdose, and risk of withdrawal in the facility. Nursing staff shall call the on-call physician if the youth appears intoxicated or is at risk for drug dependence or withdrawal.
    b. Behavioral health staff shall administer to youth and review the **Substance Abuse Subtle Screening Inventory (SASSI-2)** and the **Massachusetts Youth Screening Instrument, 2nd edition (MAYSI-2).** These screening tools further identify youth who may have concerning alcohol or drug use that requires further care.
    c. A physician or nurse practitioner shall conduct a history and physical examination on the youth within one week of every admission to provide an opportunity to identify significant substance use disorders.

3. After admission:
    a. If youth appear to be intoxicated or experiencing symptoms of alcohol or drug withdrawal at any time after admission, any facility staff shall refer the youth to nursing staff for medical assessment.
    b. Nursing staff shall assess youth who are referred by staff or who are self-referred through the sick call process for drug or alcohol dependence, intoxication or withdrawal.

B. Medical Monitoring

1. Drug testing
    a. Youth suspected of drug dependence, withdrawal, or intoxication shall undergo urine drug screening by a clinician or court orders.
    b. Medical staff at each DJS facility shall be able to perform rapid urine drug testing on-site as well as send specimens for toxicology testing to an off-site reference laboratory.
2. Other laboratory testing
    a. Youth suspected of drug dependence, withdrawal, or intoxication shall undergo other laboratory testing as ordered by the physician or nurse practitioner.
3. Withdrawal scales
    a. Youth with withdrawal or suspected withdrawal from opioids and/or alcohol, as well as benzodiazepine, shall be monitored using withdrawal scales until the withdrawal is well controlled.
    b. Nursing staff shall complete the withdrawal scales as ordered by the physician.
4. Nursing care
    a. Youth experiencing withdrawal or intoxication shall be managed at a facility where there is 24/7 nursing coverage to allow for round the clock nursing assessment as needed.
    b. If there is an infirmary on-site, the youth may be admitted into the infirmary.
    c. If there is no infirmary on-site and the youth does not require transfer to an infirmary, the youth may be managed on the unit with comfort measures as needed including bedrest and if necessary, one-on-one staff supervision.
    d. Youth experiencing opioid, benzodiazepine, or alcohol withdrawal shall not be managed at DJS committed facilities.

C. Treatment of Drug and Alcohol Dependence, Intoxication, and Withdrawal

1. Overview
    a. The DJS Medical Director shall maintain written guidelines for the management of drug and alcohol dependence and withdrawal in DJS facilities.
        1) The written guidelines shall be available at every DJS facility medical unit for reference.

2) Treatment shall be individualized to the need of each youth.

b. Every DJS detention center shall have at least one physician or nurse practitioner assigned to it who can manage drug withdrawal and dependence and who has a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000.

c. Treatment of youth with drug and/or alcohol dependence, intoxication, and/or withdrawal will be interdisciplinary involving both somatic and behavioral health staff.

d. **DJS committed facilities shall not accept youth who are experiencing opioid, benzodiazepine, alcohol, or other significant drug withdrawal**.

2. Intoxication and overdose

a. DJS medical staff shall provide a youth experiencing intoxication that does not require ER referral with symptomatic and comfort care such as rest, oral hydration, non-steroidal inflammatory medication for headaches or pain, and if necessary, one on one staff supervision.

b. DJS medical staff or any other DJS staff trained to administer naloxone shall administer naloxone (Narcan) to any youth suspected of an opioid overdose which will be kept on stock at DJS facilities. Staff administering naloxone shall call 911 and then the poison center for any youth given naloxone or suspected of an opioid overdose.

3. Opioid dependence and withdrawal

a. DJS shall provide acute medication management of opioid withdrawal under the direction of a physician or a nurse practitioner experienced in treating opioid withdrawal.

b. If withdrawal is mild to moderate, medical staff will provide initial treatment consisting of oral hydration, comfort care, and medications to treat symptoms such as body aches, gastrointestinal upset, anxiety, and sleep problems.

c. If opioid withdrawal progresses to moderate to severe withdrawal, a physician or nurse practitioner with a buprenorphine waiver may start the youth on buprenorphine (Bup).

1) Prior to starting Bup, the nurse or physician shall counsel the youth on the indications for and risks and benefits of buprenorphine, and have the youth sign a buprenorphine consent form.

2) The nurse or physician shall order baseline laboratories to evaluate liver function and Hepatitis C function in addition to urine drug screening.

d. A physician or nurse practitioner with a Bup waiver may start or continue a youth on maintenance medication for opioid dependence.

1) Youth who are admitted already on Bup that has been

prescribed to them shall be initially continued on the medication and then maintained or tapered off the medication depending on each individual case and taking into consideration the youth's preferences and placement options.

2) Youth admitted on methadone shall either be transitioned over to Bup or continued on methadone if the treating methadone clinic is able to dispense the methadone to DJS to administer to the youth. Like Bup, the methadone shall either be maintained or tapered off.

3) Youth admitted already on naltrexone or Vivitrol may be continued on the medication. Any youth continued or started on Vivitrol shall be counseled on the indications, risks and benefits of the medication and must sign a Vivitrol consent form. Baseline laboratories shall be ordered to evaluate liver function and Hepatitis C function.

4) Prior to discharge from a DJS facility, youth may be started or continued on naltrexone/Vivitrol or Bup for maintenance medication in the community to prevent relapse and overdose; this must involve a coordinated discharge plan including referral to another substance abuse treatment provider.

4. Benzodiazepine (sedative-hypnotic) dependence and withdrawal

a. DJS shall provide acute medication management of benzodiazepine withdrawal under the direction of a physician experienced in treating drug withdrawal.

b. A physician or nurse practitioner experienced in treating benzodiazepine dependence shall medically manage youth with benzodiazepine dependence to treat withdrawal symptoms and prevent the development of seizures.

1) Medication options include but are not necessarily limited to benzodiazepine or phenobarbital taper.

2) The use of benzodiazepines shall be avoided if the patient is taking buprenorphine or methadone or is otherwise taking or under the influence of an opioid including narcotic pain medication.

c. Medical staff shall provide youth with benzodiazepine dependence and withdrawal comfort care (rest, quiet) and medications to treat symptoms such as non-steroid anti-inflammatory medication for headaches.

5. Alcohol dependence and withdrawal

a. Medical staff shall refer youth with significant or severe alcohol withdrawal to the emergency room for in-patient management.

b. A physician experienced in treating alcohol withdrawal or a DJS medical staff, in consultation with a physician experienced in

treating alcohol withdrawal, may treat a youth suspected of mild to moderate alcohol withdrawal on-site.

1) Medication options include but are not necessarily limited to benzodiazepine and/or anticonvulsant tapers.
2) Medical staff shall provide youth with alcohol withdrawal with comfort care (rest, quiet), hydration, nutritional supplements (e.g., thiamin and folate), and medications such as non-steroid anti-inflammatory medication to treat symptoms (e.g., headaches).

6. Stimulant abuse and withdrawal
   a. Medical staff shall monitor youth with suspected stimulant withdrawal.
   b. Treatment for stimulant withdrawal shall consist of comfort care (hydration, nutrition, rest) and symptomatic care as needed such as medications for headaches, sleep difficulty, and depression.
   c. DJS medical staff shall evaluate youth who are abusing cocaine and who develop persistent chest pain or severe headaches for possible ischemia or infarct.
7. Nicotine dependence and withdrawal
   a. On a case-by-case basis and with input from behavioral health staff, a physician or nurse practitioner shall consider a youth who has significant nicotine dependence and withdrawal for nicotine replacement therapy and/or psychotropic medication approved for the use of nicotine dependence (e.g., Bup SR).
8. Marijuana (THC) withdrawal
   DJS medical staff shall provide supportive care and if needed, medications for sleeping problems or mental health disorders that may become apparent with cessation of use and withdrawal from marijuana or synthetic marijuana.

D. Referral

1. A physician or nurse practitioner shall refer a youth who cannot be safely cared for at a DJS facility or who needs additional assessment that cannot be provided at the facility to a local emergency room.
   a. Intoxication and overdose
      1. Youth requiring referral to the emergency room for intoxication or suspected intoxication include those youth who appear to be under the influence of a drug or alcohol and who have altered mental status, psychotic signs or symptoms, unstable vital signs, concerning hypertension, depressed respiration, seizures or seizure like activity, inability to ambulate independently, suicidal thoughts/gestures/attempts, intractable vomiting or dehydration requiring intravenous fluids, are pregnant, or if other concerns exist regarding overdose or adverse

consequences due to the drugs ingested or drugs thought to be ingested.

2. Staff shall call 911 for transport if there is respiratory depression, unstable vital signs, seizure, loss of consciousness, inability to ambulate independently, or other potentially emergent situation.
3. Staff shall administer naloxone (Narcan) for suspected opioid overdose and call 911 and then the poison center.
4. Staff may call the poison center for consultation for any youth suspected of ingesting a drug or medication that was not prescribed to them.

b. Withdrawal

Staff shall refer youth to the emergency room when youth are in active withdrawal and have intractable vomiting, unstable vital signs, seizures or seizure-like activity, withdrawal from multiple classes of drugs simultaneously, suicidal thoughts/gestures/ attempts or are pregnant.

2. Community Case Management Specialists (CMS) or the court may refer a youth requiring non-urgent in-patient or residential substance abuse treatment to an appropriate placement.

E. Treatment of pregnant youth

1. A physician or nurse practitioner shall treat pregnant youth with opioid, alcohol, or benzodiazepine withdrawal or dependence with medication to prevent withdrawal from occurring. The medication can be initiated either at a DJS facility or at a hospital. Pregnant youth with opioid dependence shall be maintained on medication, either buprenorphine or methadone, for the duration of the pregnancy.
2. DJS medical staff shall refer a pregnant youth who is intoxicated or in active opioid, alcohol, or benzodiazepine withdrawal to an emergency room for fetal monitoring and initial stabilization. The emergency room used for referral must have medical providers who can monitor and treat drug dependence and withdrawal during pregnancy (e.g., the University of Maryland Medical Center).

F. Discharge planning and follow-up care

1. Youth discharged from a DJS facility on medication for the treatment of drug dependence or withdrawal shall be referred to a community provider for continuity of care and prevention of relapse. DJS health and/or community case management staff shall facilitate this referral and may involve Maryland Behavioral Health Administration Prevention Coordinators, the local health department, or the local addictions authority in the discharge planning process.
2. A DJS physician or nurse practitioner shall prescribe or dispense naloxone to a youth with opioid dependence or risk of opioid overdose if the youth

is returning to the community. Parents/guardians/custodians of opioid dependent youth may also be trained on opioid overdose and/or prescribed or dispensed naloxone.

G. Consent and confidentiality

1. Under Maryland law, youth have the same capacity as an adult to consent to treatment and advice about drug abuse and alcoholism (Md. Code Ann., Health-General §20-102).
2. The youth may not refuse treatment for drug abuse or alcoholism in an inpatient alcohol or drug abuse treatment program **if the parent or guardian has given consent**.
3. Without the consent of or over the express objection of the youth, a health care practitioner **may**, **but need not**, give a parent, guardian, or custodian the information about treatment needed by the youth or provided to the youth. If, however, the youth is putting themselves in danger, for example by overdosing, or requiring treatment for drug dependence or withdrawal, then DJS medical staff shall inform the parents/guardians/custodians in addition to Community CMS of the treatment being recommended and/or provided.

IV. RESPONSIBILITY

The DJS Medical Director, DJS Health Administrator and Superintendent are responsible for implementation and compliance with this procedure.

V. INTERPRETATION

The DJS Deputy Secretary for Operations and Medical Director shall be responsible for interpreting and granting any exceptions to these procedures.

VI. LOCAL OPERATING PROCEDURES REQUIRED

No

VII. DIRECTIVES/POLICIES REFERENCED

No policies referenced.

VIII. DJS FORMS & MANUALS REFERENCED

1. Facility Initial Reception/Referral Screening Tool (FIRRST)
2. Pre-Admission Medical Assessment Form
3. Admission Health Screening and Nursing Assessment

MARYLAND Department of Juvenile Services

Successful Youth • Strong Leaders • Safer Communities

DJS POLICY AND STANDARD OPERATING PROCEDURES

Statement of Receipt and Acknowledgment of Review and Understanding

SUBJECT: Drug and Alcohol Dependence, Intoxication, and Withdrawal Management
NUMBER: HC-326-18
APPLICABLE TO: All Residential 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
FACILITY INITIAL RECEPTION/REFERRAL SCREENING TOOL (FIRRST)
HEALTH CARE

This form shall be used at the time of a youth's initial arrival to a DJS facility. It provides information that will determine, by observation and questioning, whether the Department will officially admit a youth to a facility or because of a need for emergency health care instruct an escorting officer to transport a youth to a hospital. The Department shall deny admittance of a youth who is unconscious, semiconscious, bleeding, mentally unstable or otherwise urgently in need of medical attention and shall instruct a transporting officer to transport a youth for immediate hospital care. A youth referred to a hospital shall have a written medical clearance prior to an admission or return to a DJS facility. **If an answer is yes to any Observations or Questions 1 through 6 below, a youth may not be admitted to a facility but transported to a hospital for emergent care.**

Youth Name _____ Admission Date _____

Observations

	No	Yes	Describe
1. Is the youth unconscious?	___	___	_____
2. Does youth have any obvious injury(ies)?	___	___	_____
3. Does youth appear to be under the influence of alcohol/drugs?	___		_____
4. Does youth exhibit visible signs of alcohol and/or drug withdrawal (e.g. profuse sweating, vomiting, shakes, doubled over with cramps)?	___	___	_____
5. Does youth exhibit bizarre or unusual behavior (e.g. confused, incoherent or violent)?	___	___	_____
6 Do you, an arresting and/or transporting officer have information (e.g. from observed behavior) that indicates a youth is a medical, mental health or suicide risk **now?**	___	___	_____

Questions

1. Are you thinking of hurting and/or killing yourself **now?**	___	___	_____
2. Are you bleeding?	___	___	_____
3. Do you have a serious injury (e.g. severe sprains, fractures, open wounds)?		___	_____
4. Do you currently have a communicable disease? (e.g. Mumps, Chickenpox, Tuberculosis/active TB)?	___	___	_____
5. Do you have a serious dental problem (e.g. severe pain, gum swelling, abscessed tooth)?	___	___	_____
6. Are you thinking of hurting and/or killing anyone **now?**	___	___	_____

If yes to question #6, admit youth and place under close observation and refer to clinical for assessment.

Reception/Referral

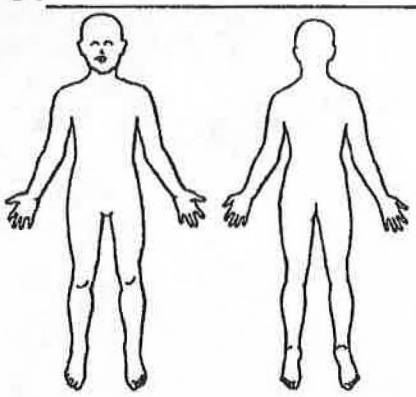
_____ Admitted to Facility _____ Referred for Emergent Care

_____ Admitted for Observation and Evaluation by clinical staff

Examiner Signature _____ Date/Time completed _____

Department of Juvenile Services
Pre-Admission Medical Assessment Form
(Complete this form if youth flags on the FIRRST Form)

Assessment Date: _____ **Time:** _____
Youth Name: _____ **DOB:** _____
Youth Complaint:
S: _____
_____
_____
_____ **Pain scale (1-10):** _____
O: _____



A: _____
_____
_____
_____
P: _____
_____
_____
(If abuse suspected or alleged, call CPS per DJS protocol)

Nursing Supervisor Notified: _____
Date and time of RN Notification: _____
MD Notified: _____
Date and time of MD Notification: _____
☐ **Denied Admission until Medically Cleared**
☐ **Accepted for Admission to Facility**

RN Name (Printed): _____
RN Signature: _____

MARYLAND Department of Juvenile Services
Successful Youth • Strong Leaders • Safer Communities

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

Name: _____ **DOB:**_____ **Current Age:** _____
(Last, First, MI)
Date of Admission: _____ **Time:** _____ **Facility:** _____

Sex (Biological): ☐Male ☐Female **Place of Birth:**_____ **Hispanic/Latino:** ☐NO ☐YES
Primary language spoken: ☐English ☐Spanish ☐Other:_____ ☐Needs Interpreter

Race: ☐Black or African American ☐White ☐Asian ☐American Indian or Alaska Native
☐Native Hawaiian or Pacific Islander ☐Other: _____
Color of Hair:_____ **Color of Eyes:**_____

Read the following statement to the youth and check that done: *"I want you to know that if you report to me or to any DJS staff person that you have been physically or sexually abused, neglected, or sexually assaulted before the age of 18, then we will need to report the incident to child protective services."* ☐**Statement read to youth, RN initials:**_____

CURRENT HEALTH STATUS

VITAL SIGNS: Temperature_____ Pulse_____ Resp _____ BP_____/_____ Wt_____ Ht_____ BMI_____
(Update/Complete Growth Charts)

Vision Screen	**Left Eye**	**Right Eye**	**Both Eyes**	***Record Vision Screen & Vitals on Admission Physical Exam form. Triage optometry referral if vision 20/40 or worse or if other vision problem.***
Without glasses:	/	/	/	
With glasses/contacts on:	/	/	/	
Has youth been given glasses or corrective contact lenses in the past? ☐NO ☐YES If yes: When & where prescribed, & location & condition of glasses/lenses:				

CHIEF COMPLAINT: Does youth have any current health complaints? ☐NO ☐YES, Specify:

PAIN: Does the youth have any pain? ☐NO ☐YES, If yes, rate pain on scale of 0 to 10:_____
Specify and describe pain:

CURRENT MEDICATION/SUPPLEMENTS: Is youth prescribed or taking any medication? ☐No ☐Yes:

Medication Name	**Dosage**	**Frequency**	**Reason for Med**	**Prescriber**	**Last Taken**

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

ALLERGIES: Check off below		**Specify What Allergic to:**	**Reaction to Allergen:**
	No allergies		
	Latex allergy		
	Medication Allergy		
	Insect Allergy (bee, wasp, ant, etc)		
	Food Allergy		
	Environmental (dust, mold, etc)		
	Seasonal (pollen, grass, etc)		
	Other Allergy (cat, dog, etc)		

Ever Used or Prescribed an Epi-Pen before: ☐No ☐Yes/Specify:

CHRONIC HEALTH CONDITIONS: Does the youth have any chronic health conditions? ☐No ☐Yes:

	Asthma		Eczema/Skin Problem		Seizure Disorder
	Autoimmune Disorder (e.g. Lupus)		Heart Disease		Sickle Cell Anemia or Trait
	Cancer		Hypertension (High Blood Pressure)		Stomach/Intestinal Problem
	Clotting/Bleeding Disorder		HIV/Immune Deficiency		Thyroid Disorder
	Cystic Fibrosis		Kidney/Urologic Disorder		Other:
	Diabetes		Liver Disease or Hepatitis B or C		Other:

Doctors/Specialists taking care of conditions above:

Primary Care Doctor/Provider (if known):

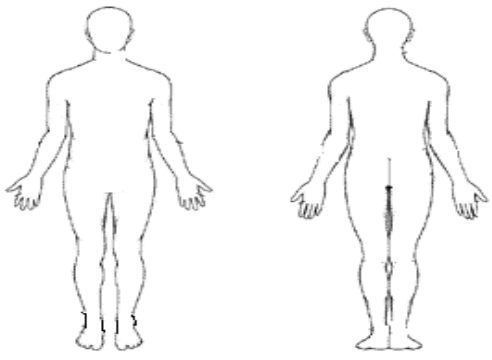
Additional Comments:

SKIN/BODY EXAMINATION: Check off below

	Acne		Dry skin		Piercing(s)
	Alopecia (hair loss)		Erythema (redness)		Rash
	Bites (animal, human, insect)		Excoriations (scratches)		Scar
	Blisters		Hives		Sutures/staples
	Boils/pustules		Jaundice		Swelling
	Bruises		Laceration/wound		Tattoo
	Burns		Lice		Warts
	Casts/splints		Nail problem		Other:
	Draining sores		Needle/track marks		Other:

DESCRIBE & Document Location of Physical Findings Above on Body Chart Below:

1. Bruise 2. Tattoo 3. Laceration/Wound 4. Scar 5. Rash 6. Piercing 7. Other (specify)



MARYLAND Department of Juvenile Services
Successful Youth • Strong Leaders • Safer Communities

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

APPEARANCE & MENTAL STATUS: Check off how the youth appears

Oriented to: ☐Person ☐Place ☐Time ☐Appears intoxicated or under the influence of drugs or alcohol

☐Alert ☐Tired/sleepy ☐Lethargic/difficult to arouse or awaken

☐Well-nourished ☐Pale ☐Underweight ☐Overweight

☐Poor hygiene ☐Disheveled ☐Sweating ☐Visible tremors

☐Cooperative ☐Uncooperative ☐Confused/difficulty answering & understanding questions

☐Calm ☐Agitated ☐Depressed ☐Withdrawn ☐Anxious

☐Other, specify:

PSYCHOSOCIAL HISTORY

Prior to admission residing with: _____ Last time home: _____
Ever homeless or runaway? ☐No ☐Yes: If yes, specify when and where_____
Parent/Guardian Name(s) & Telephone Number(s):_____
Siblings: # Brothers_____ # Sisters_____
Does youth have any children: ☐No ☐Yes: Specify DOB, sex, location: _____
Any parent, sibling, or child deceased? ☐No ☐Yes: Specify who, age, how died: _____
Any family member in DJS or jail? ☐No ☐Yes (Specify): _____
Last School Attended: _____ Last Grade Completed: _____
History of Learning Disability or Special Education Classes: ☐No ☐Yes: _____
Youth employed: ☐No ☐Yes (Specify): Sports Activities:

Previous Placements or Detention: ☐No ☐Yes: Check off below with # of times admitted and dates

	DJS Facility		**Other**
	Alfred D Noyes		Adult Detention Center/Jail (specify):
	Baltimore City Juvenile Justice Center		
	Carter		Youth Detention Center (YDC), Baltimore DOC
	Cheltenham		
	Hickey		Youth Services Center (YSC), Wash DC
	Lower Eastern Shore		
	Victor Cullen		Group Home:
	Waxter		Out of State:
	Western Maryland		Residential Treatment Center:
	Youth Centers/Allegany County*		Other:

*Backbone, Green Ridge, Meadow Mountain, Savage Mountain

MENTAL HEALTH HISTORY *(Contact Behavioral Health Staff if youth currently having suicidal/homicidal ideation)*
Prior Psychiatric Hospitalization/Placements/In-patient Evaluations: ☐No ☐Yes (Specify where, when):

Diagnosed Mental Health Illness: ☐Anxiety ☐ADHD ☐Depression ☐OCD ☐Disruptive Mood Dysregulation Disorder ☐Intermittent Explosive Disorder ☐Bipolar/Other Mood Disorder ☐PTSD ☐Other:
History of Suicidal Ideation/Gestures/Attempts: ☐No ☐Yes (Specify):
Ask: "Do you currently feel like hurting yourself or someone else?" ☐No ☐Yes (Specify):
History of Hallucinations (auditory, visual, tactile)? ☐No ☐Yes (Specify):
Ever on Psychiatric Medication? ☐No ☐Yes, Specify if not already listed on pg 1:

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

HISTORY OF ABUSE/ASSAULT *(Being sex trafficked under the age of 18 is a form of sexual abuse and needs to be reported)*
Ever been Abused, Assaulted, or Sex Trafficked: □No □Yes: Specify □Physical □Sexual □Neglect □Mental Injury
Describe above incident(s):

If past abuse/assault, was it reported to authorities? □No □Yes: When and by whom_____
If NOT reported or not verified that reported, report to CPS per DJS policy.
NOTE: ***If a sexual assault occurred <u>in the community</u> AND youth was 18 years or older at the time of the assault, then DJS health staff must obtain informed consent from the youth before reporting the assault to an outside agency.***
Offer Mental Health Referral for past Assault/Abuse: □Accepted or □Declined by youth □NA
If accepted, Mental Health Referral requested: Date of referral request_____, RN initials:_____
If Sexual abuse/assault has occurred in the past, ensure that MD/NP has been notified within 7 days of admission.
If Sexual abuse/assault has occurred in the past 2 weeks, call MD/NP on call now for consultation: Called □Yes □No □N/A
If appropriate, offer referral to SAFE/SANE nurse. Referral made to SAFE/SANE nurse? □Yes □No □N/A

SUBSTANCE USE HISTORY				
Substance Ever Used (Check below)	**Initial Use (Age)**	**Method/Route** IV, inhaled, po, nasal	**Amount Used & Frequency**	**Last Used**
❑ Tobacco				
❑ Alcohol				
❑ Marijuana ❑ Synthetic THC				
❑ Cocaine/Crack				
❑ Amphetamines (“Meth”)				
❑ Narcotics (Oxy, Percocet, etc)				
❑ Heroin ❑ Fentanyl				
❑ Suboxone (Buprenorphine)				
❑ Methadone				
❑ Benzodiazepines (Xanax, etc)				
❑ PCP				
❑ Ecstasy				
❑ LSD/Acid				
❑ OTC cough/cold med				
❑ Other:				
Any history of drug or alcohol withdrawal in the past (e.g., convulsions or feeling sick when stop using)? □No □ Yes:				
Does youth think that he/she may experience withdrawal while at the facility? □No □ Yes:				
Any history of drug overdose or use of naloxone/Narcan? □ No □Yes:				
Any history of past substance abuse treatment as out-patient, or in-patient/residential? □No □ Yes: Any past prescribed treatment with Vivitrol, buprenorphine, or methadone? □No □ Yes:				
Additional Comments:				
Call MD if youth appears intoxicated or at risk for withdrawal/drug dependence: **Called □No □ Yes: _____**				

FAMILY HISTORY (Check off below and specify if parent, sibling, grandparent, aunt, uncle, etc)					
Condition		**Relative**	**Condition**		**Relative**
	Asthma			Hepatitis B or C	
	Cancer			HIV/AIDS	
	Diabetes			Kidney Disease/Dialysis	
	Heart Disease			Mental Health Illness:	
	High Blood Pressure			Sickle Cell Anemia	
	High Cholesterol			Drug/Alcohol Disorder	
	Stroke or Clot			Other:	
Additional Comments:					

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

INJURIES/TRAUMA (Specify details, dates, treatment for past and current significant injuries)

	Head Injury /Concussion		Significant Lacerations/Knife Wounds
	Neck/Spine Injury		Gun-Shot Wounds
	Fractures		Retained Bullet Fragments
	Sprains/Dislocations		Elevated Lead Level/Poisoning
	Other (Specify):		No Significant Injury/Trauma in Past

Additional Comments:

INJURY PREVENTION: Review the following firearm safety tips with the youth

□ The best way to keep children safe from a gun injury is by having NO guns in a home where kids/teens live or may visit. If there is a gun in the home: □Guns should be kept UNLOADED and in a LOCKED cabinet, case, safe, or vault, and □Bullets should be stored in a separate locked location from guns.

PAST SURGERIES/HOSPITALIZATIONS (Specify below with dates, locations)

	No Surgeries		Surgeries:
	No Hospitalizations		Hospitalizations:

Additional Comments:

MUSCULOSKELETAL

	Arthritis		Joint Swelling
	Hand, Arm, or Shoulder Problem		Limitation of Movement in an Extremity or Body Part
	Foot, Leg, Hip/Pelvis Problem		Difficulty Walking
	Chest, Back, or Spine Problem		Amputation/Deformity/Prosthetic Device:
	Scoliosis/Back Brace		Any Physical Handicap:
	Other:		No Problems

Additional Comments:

EYE

	Wears eyeglasses or contacts		Eye burning or itching
	Has difficulty seeing		Eye erythema or redness on exam
	Blindness or severe vision impairment		Eye discharge on exam
	Other:		No Problems

Last Vision Exam: Date_____ Provider:_____

Additional Comments:

EARS/NOSE/THROAT

	Last Hearing Test:				Inflammation/swelling/erythema of ear
	Trouble Hearing		Deafness		Nasal congestion, difficulty breathing thru nose
	Uses Hearing Aid				Runny nose
	Tinnitus (ringing in the ear)				Hx of Frequent/Prolonged Nose Bleeds
	Ear Pain				Current epistaxis/nose bleed
	Ear drainage				Sore Throat
	Foreign body in ear or wax occluding ear				Obstructive Sleep Apnea/CPAP machine
	Other:				No Problems

Additional Comments:

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

ORAL/DENTAL			
	Last Dental Exam:		Breath: ❑ Normal ❑ Fruity ❑ Halitosis
	Braces/Retainer – Orthodontist:		Teeth: ❑ Broken ❑ Loose ❑ Caries ❑ Missing
	Has Dentures/Dental Appliance		
	Other:		Gums : ❑ Moist ❑ Pale ❑ Swollen ❑ Bleeding
❑ ***Review importance of brushing teeth twice per day***			No Problems
Additional Comments:			

GI/NUTRITION			
	Stomach/Gallbladder Problem		Nausea
	Bowel Disease		Vomiting
	Recent Weight Loss or Weight Gain:		Diarrhea
	Eating Disorder (Anorexia, Bulimia, Pica)		Constipation
	Hx of Anemia, or Iron or Vitamin Deficiency:		Blood in Stool
	On a Special Diet:		Encopresis (leaking stool)
	Other:		No Problems
Additional Comments:			

GU/KIDNEY			
	Urinary Frequency or Urgency		Kidney Disease/Stones/Dialysis:
	Burning/Pain on Urination		Genital/Vaginal Itching or Discharge
	History of UTI		Blood in Urine
	Enuresis (bed wetting)		Urine Color: Clear - Yellow - Brown - Red - Cloudy
	Other:		No Problems
Additional Comments:			

RESPIRATORY/CARDIOVASCULAR			
	Asthma: *If yes, Complete DJS Asthma Assessment Tool*		History of Pneumonia
	Chronic Cough		History of Heart Murmur or Palpitations
	Shortness of breath		Wheezing
	Chest pain		Coughing during assessment
	Breast problem (pain, mass, discharge):		Blood tinged sputum
	Other:		No Problems
Additional Comments:			

NEUROLOGIC			
	Dizziness/Vertigo		Tics
	History of Fainting		Tingling/numbness/paralysis
	Frequent/Chronic Headaches		History of Tremors/Convulsions
	Migraines		Weakness
	Other:		No Problems
Additional Comments:			

INFECTIOUS DISEASE HISTORY (Specify details, dates, treatment of past /current infections): "Have you ever had…?"			
	Chicken Pox/Shingles		Meningitis (brain infection)
	Lice		Mononucleosis
	Lyme Disease		Scabies
	MRSA		Tuberculosis *(Complete DJS TB Screening Form on all youth)*
	Measles, Mumps, or Rubella		Viral Hepatitis A, B, or C
	Other (Specify):		No Problems
Additional Comments:			

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

MALE REPRODUCTIVE HEALTH ASSESSMENT (Delete Page 8 if using this page)
Do you perform testicular self-exams? ☐No ☐Yes ☐*Reviewed importance of monthly self-exam w/youth*
Do you have: ☐ An undescended testicle (does youth have one or two testicles in scrotum)? ☐ A testicular, scrotal, or genital lump or mass? ☐ Other testicular or scrotal problems or concerns?
Have you ever had ☐Oral, ☐Vaginal, or ☐Anal sex? ☐No to all ☐Yes: If yes, complete this section # Sexual Partners in lifetime: ☐Female #_____ ☐Male #____ Do you currently have any sexual partners that are pregnant with your baby? ☐No ☐Yes: Age at first sexual intercourse?_____ When was last sexual intercourse?_____ Was condom used at last sexual intercourse? ☐No ☐Yes ☐Yes, but condom broke How often are condoms used? ☐Never ☐Sometimes ☐Always
☐ *Encourage/discuss consistent use of condoms to prevent sexually transmitted infection (STI) and unplanned pregnancy. Let youth know that we can provide condoms upon discharge or home pass.*
Self identifies as: ☐Male ☐Female ☐Heterosexual ☐Gay ☐Bisexual ☐Transgender ☐Intersex ☐Questioning ☐Lesbian ☐Other: Any history of hormone therapy/surgery for gender change: ☐No ☐Yes: Specify where/when/what
Have you ever had sex in exchange for: ☐Drugs ☐Money ☐Gang Initiation ☐Basic Survival/Other: Have you ever been forced to have sex? ☐No ☐Yes:
Ever had a STI? ☐No ☐Yes: ☐Chlamydia ☐Gonorrhea ☐Herpes ☐Syphilis ☐Trichomonas ☐HPV/Warts Date(s) of above:_____ Treated?_____
Are you worried you may have a STI? ☐No ☐Yes: Why?_____ Any current STI symptoms like penile sores, discharge, bumps, scrotal pain, burning, bleeding, or sore throat? ☐No ☐Yes (Specify):
Ever been tested for HIV? ☐No ☐Yes: Date_____ Result_____ *If high risk for HIV or not HIV tested in past 6 months with documented results, go over the* DJS Informed Consent & Pre-Test Information for the HIV Test *form with youth* (*unless already known HIV +).* *If youth does not fall in category above, still ask if youth wants an HIV test and if does, then complete the* DJS Informed Consent & Pre-Test Information for the HIV Test *form and perform HIV testing.*
If any lab results come back after you leave the facility, what is the best phone number to reach you? Phone number: _____ ☐Cell or ☐Home Specify who phone belongs to:

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

FEMALE REPRODUCTIVE HEALTH ASSESSMENT (Delete Page 7 if using this page)

Age at first period _____ Date of last period_____ How long do periods last_____
Days between periods_____ Are they regular? ☐Yes ☐No: Explain_____
Pain, cramps, or heavy flow with periods? ☐No ☐Yes: Describe_____

Are you currently on a form of hormonal birth control? ☐No ☐Yes
If yes, type of birth control? ☐Pills ☐Depo/Shot ☐Implant ☐IUD ☐Patch ☐Ring ☐Other_____
Last taken or when placed?_____ Have you been using it regularly? ☐Yes ☐No:

History of Pelvic Exam in past: ☐No ☐Yes: Results_____ ☐Don't know

Have you ever had ☐Oral, ☐Vaginal, or ☐Anal sex? ☐No to all ☐Yes: If yes, complete this section
Sexual Partners in lifetime: ☐Male #____ ☐Female #_____
Age at first sexual intercourse?_____ When was last sexual intercourse?_____
Was condom used at last sexual intercourse? ☐No ☐Yes ☐Yes, but condom broke
How often are condoms used? ☐Never ☐Sometimes ☐Always

☐ *Encourage/discuss consistent use of condoms to prevent sexually transmitted infection (STI) and unplanned pregnancy. Let youth know that we can provide condoms upon discharge or home pass.*

Self identifies as: ☐Female ☐Male ☐Heterosexual ☐Lesbian ☐Gay ☐Bisexual ☐Transgender ☐Intersex ☐Questioning ☐Other: ☐History of hormone therapy/surgery for gender change:

Have you ever had sex in exchange for: ☐Drugs ☐Money ☐Gang Initiation ☐Basic Survival/Other
Have you ever been forced to have sex? ☐No ☐Yes:

Are you pregnant or worried that you might be pregnant? ☐No ☐Yes: Why?
Have you ever been pregnant? ☐No ☐Yes: OB/GYN provider:
Number of: Pregnancies_____ Live births_____ Miscarriages_____ Abortions_____
If youth pregnant, perform prenatal labs, follow prenatal guidelines, & call MD/NP/Midwife for further orders

If youth reports that she has had sexual intercourse in the past 120 hours/5 days, then discuss Emergency Contraception (Plan B) using the "EC Fact Sheet" as a guide. If youth is interested in EC, proceed to the "Emergency Contraception Protocol" to offer EC as appropriate.
☐Not necessary/No sex in past 5 days ☐Youth not interested in EC at this time
☐Youth interested in Emergency Contraception - EC Protocol Initiated

Ever had a STI or PID (Pelvic inflammatory disease)? ☐No ☐Yes: ☐Chlamydia ☐Gonorrhea ☐Herpes ☐Syphilis ☐Trichomonas ☐HPV/Warts ☐PID ☐Other:
Date(s) of above:_____ Treated?_____

Are you worried you may have a STI? ☐No ☐Yes: Why?_____
Any STI symptoms now like vaginal sores, discharge, fishy odor, bumps, pelvic/rectal/vaginal pain, abnormal menstrual bleeding, or sore throat? ☐No ☐Yes (Specify):

Ever been tested for HIV? ☐No ☐Yes: Date_____ Result_____
If high risk for HIV or not HIV tested in past 6 months with documented results, go over the DJS Informed Consent & Pre-Test Information for the HIV Test *form with youth* (*unless already known HIV +).*
If youth does not fall in category above, still ask if youth wants an HIV test and if does, then complete the DJS Informed Consent & Pre-Test Information for the HIV Test *form and perform HIV testing.*

If any lab results come back after you leave the facility, what is the best phone number to reach you?
Telephone Number:_____ ☐Cell or ☐Home
Specify who phone belongs to:

MARYLAND Department of Juvenile Services
Successful Youth • Strong Leaders • Safer Communities

ADMISSION HEALTH SCREENING AND NURSING ASSESSMENT

NURSING DIAGNOSIS: Summarize Health and Psychosocial Issues and Record Nursing Impression	
1. 2. 3. 4.	
NURSING PLAN/DISPOSITION (Check off if done)	**COMMENTS** (Check off if done and add additional comments)
☐ DJS TB Screening Form Initiated	PPD placed: ☐Yes ☐No
☐ Obtain labs following the DJS Admission Lab Protocol: • Check off labs obtained, note date in lab log • Complete DJS Informed Consent & Pre-Test Information for the HIV Test form if due for HIV test, high risk, or youth wants test	☐Urine Gonorrhea/Chlamydia ☐Other: ☐Rapid Urine Pregnancy Test ☐Prenatal labs if pregnant ☐Urine Drug Screen per court or MD/NP order ☐CBC ☐RPR ☐HIV ☐MMRV if not done in past ☐Hep C AB if at risk ☐Lead level if retained bullet fragments
☐ Sick Call Procedure Explained to Youth	☐Written Sick Call Procedure Info Provided ☐Youth Sick Call Verification Signed
☐ Initiation Of Health Education (check off what reviewed)	☐Gun Safety ☐Oral Hygiene ☐Condom Use ☐HIV testing ☐Testicular Self-Exam ☐Other:
☐ Influenza vaccine offered (if flu season)	*Remember to request vaccine records*
☐ Physician/Psychiatrist Notified For Medication Orders: Note MD/NP contacted, Date/Time	MD/NP contacted Date/Time
☐ On-Call MD/NP Contacted For Consultation: Note MD/NP contacted, date/time, reason called	MD/NP contacted Date/Time Reason
☐ Scheduled For Admission History/Physical Exam	☐Vision screen and vitals recorded on PE form
☐ Referrals made (Specify to whom and why)	☐Behavioral Health ☐CPS ☐Dentist ☐Optometrist ☐Psychiatrist ☐Gyn/Midwife ☐Other:
☐ Appropriate Log Entries Made (Specify)	☐Lab log ☐GC/CT log ☐PPD log ☐Adm log ☐MD Phone log ☐Other:
☐ Medications Ordered From Pharmacy Per Physician/NP Orders	
☐ Medication Administration Forms Completed	
☐ Unit Advised Of Special Needs With Health Status Alert : Specify what alert(s) for	**Health Status Alerts for:** *Document allergies on Chart Cover and Problem List*
☐ Cleared for General Population	
☐ Admit To Infirmary for:	☐Infirmary Admission Orders Obtained
☐ Initiation of Special Needs Treatment Plan	For:
☐ Records requested from previous placement, detention center, hospital, emergency room, etc	Specify from where records requested and document in notes
☐ Referred to Emergency Room (Specify reason)	
☐ Other:	

NURSE'S SIGNATURE:_____ **Date and Time Completed** _____

PHYSICIAN'S SIGNATURE:_____ **Review Date**_____

Note: Page 7 or 8 may be deleted based on sex of youth. *Rev 4/2/18*