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I. PURPOSE

The Health Services Manual provides policy and guidelines regarding delivery of health care services in all of the Florida Department of Juvenile Justice (“The Department” or “DJJ”) facilities and programs. It is intended to provide guidance and practical direction to Department of Juvenile Justice state and contracted health care service providers, clinicians, administrators, direct care staff and others involved in the supervision or treatment of DJJ youth with health care needs. The primary goals of this Manual are to: (1) Assure health care services provided in DJJ facilities and programs are rendered in accordance with state and federal health care regulations and rules, and professional standards of care; (2) Promote delivery of high quality health care services for delinquent youth under DJJ custody or supervision; and (3) Assist medical and clinical health care staff in developing and consistently implementing necessary and appropriate health care services in DJJ facilities and programs.

This Manual is designed to provide a resource that assists in establishing health care services within the DJJ continuum of services, which promote adolescent health, well-being and development.

II. AUTHORITY

The following statutory provision grants authority with regard to health services made available to youths in DJJ custody:

A. Section 985.01(1)(b) Florida Statutes (2006), is intended to provide for the health and wellbeing of youth in the state’s care. Specifically this section states the following:

“To provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; and to promote the health and well-being of all children under the state’s care.”

B. Section 985.145(c)2, Florida Statutes (2006), is intended to provide for the necessary comprehensive screening for youth in the State’s care. Specifically, this section states:

“During the intake process, the juvenile probation officer shall screen each child or shall cause each child to be screened in order to determine:… “The presence of medical, psychiatric, psychological, substance abuse, educational, or vocational problems or other conditions that may have caused the child to come to the attention of law enforcement or the department.”
C. Additionally, policy set forth in this Manual incorporates other Florida Statutes including those related to consent requirements, the provision of emergency medical care and treatment to minors without parental consent; consent and confidentiality requirements related to diagnosis and treatment of certain sexually transmitted diseases; and the requirement of documented informed consent prior to testing for identification of the human immunodeficiency virus (HIV) and confidentiality of test results which are subject to specific statutory exceptions.

III. SCOPE

A. APPLICATION

This Manual applies to all state and privately operated juvenile justice detention centers, residential commitment programs, probation and community corrections programs and temporary shelters (“DJJ Facilities”). The Manual is intended to assist Physicians, Physician’s Assistants, Advanced Registered Nurse Practitioners, licensed Nurses and other clinical and Departmental staff involved in the care or treatment of youth receiving health care services in DJJ facilities or programs. It is also intended to assist the Department’s regional Juvenile Justice staff that has responsibility for monitoring and ensuring the appropriate delivery of quality health care services to youth within the Department’s facilities and programs.

B. COMPLIANCE AND WAIVERS

All DJJ facilities, state and privately operated, must comply with the policies and provisions set forth in this Manual. The provisions of this Manual also apply to individual and corporate private health care professionals who provide services to DJJ youth through contract or other agreement.

When there are rate or unique circumstances in a program, facility, or service, a program/facility may request a waiver to Department policy and provide a compliance measure. Refer to DJJ Policy 1705 ("Waivers and Alternative Compliance Measures to Departmental Policy").

Exemptions or implementation of an alternative compliance measure to any provision of this Manual may only be authorized upon written approval from the Secretary. The Secretary may formally delegate this responsibility. Requests for exemptions must be submitted in writing through the Office of Health Services and must include, at a minimum, the following:

☑ The provision(s) of the Manual for which the exemption is being requested;
☑ The justification for the exemption;
☑ The time period for which the exemption is requested; and
☑ If applicable, alternative compliance measures proposed by the facility.
No exemption, unless otherwise specified in the written approval, shall extend more than one year from the date it was granted. Further, the Department reserves the right to withdraw approval of any waiver or alternative compliance measure at any time if it is determined that the waiver or alternative compliance measure is not effective or has a negative impact as specified in FDJJ-1705.

Unless a request for waiver or alternative compliance measure has been approved prior to the quality assurance (QA) on-site review, the applicable QA standard and key indicators will be applied as written. The applicable QA standard and key indicators will be evaluated from the date of the last QA review until the approval of the waiver or alternative compliance measure.

IV. LEGISLATIVE INTENT AND DJJ MISSION

A. LEGISLATIVE INTENT

The following statutory provisions provide legislative intent with regard to health services provided to youths in DJJ custody:

In Section 985.02, F.S., the expression of the legislative intent for the juvenile justice system includes the following:

1. General Protections for Children:
   - Protection from abuse, neglect, and exploitation.
   - A safe and nurturing environment, which will preserve a sense of dignity and integrity.
   - Effective treatment to address physical, social and emotional needs, regardless of geographic location.
   - Access to preventive services.
   - Gender-specific programming and gender-specific program models and services that comprehensively address the needs of a target gender group.

2. Juvenile Justice and Delinquency Prevention:

   Detention care, in addition to providing secure and safe custody, will promote the health and well-being of the children committed thereto and provides an environment which fosters their social, emotional, intellectual and physical development.

B. DEPARTMENT’S MISSION AND RESPONSIBILITY

The Department’s mission is: To protect the public by reducing juvenile crime and delinquency in Florida.

Because youths’ health issues and needs can have a significant impact on their daily functioning and rehabilitation, the Department’s mission to reduce juvenile crime and
delinquency must include the provision of necessary and appropriate health care services to youth through the establishment of health care delivery systems which are efficient and effective.

It is the Department’s responsibility to establish and maintain a structured health care delivery system for each DJJ facility, which is conducive to the health and safety of youth, and to provide quality, timely and professional health care, and services that promote wellness and enhance youth growth and development.

V. YOUTH RIGHTS

Each youth’s individual rights and dignity shall be respected and protected as prescribed by law and as set forth in DJJ policy 1100 entitled “Rights of Youths in DJJ Care, Custody or Supervision.” The Department’s expectations for officers, staff and contracted providers are as follows:

In addition to respect for all human rights prescribed by law, the following should be considered to be the expectations of this Agency in regards to our professional interactions with the youth we serve.

We recognize that every officer, staff member, employee and contracted provider has an obligation to serve as a role model to youth by his or her deportment and conduct. Having an obligation to show the youth the way we would like them to behave, we must in turn model this behavior. This means that:

☑ We will, at all times, use appropriate language when speaking to or in the presence of youth.

☑ We will always strive to speak in a calm and respectful tone towards and around youth.

☑ We will never be deliberately confrontational with youth, unless warranted therapeutically or programmatically.

☑ We will always use appropriate counseling and intervention techniques before resorting to physical force. Physical force (as defined in PAR) shall always be used as a last resort when all other options have been exhausted and safety is compromised.

☑ We will not make threatening statements to youth. We will explain options, alternatives, and consequences in a calm and professional manner. We will always strive to encourage positive and compliant behavior.

☑ Staff should help youth learn to make proper decisions for themselves.

☑ We will always strive to be respectful and courteous to fellow employees and towards youth in our care, even when we are faced with disrespectful conduct.
We will always provide for their basic needs, including food, clothing, shelter, medical care and security. We will not, through inaction or inattention, allow these needs to remain unmet.

VI. HEALTH CARE SERVICES IN DEPARTMENT FACILITIES

Necessary and appropriate health care services shall be provided in a timely and professional manner to youth who are in the care and custody of the Department of Juvenile Justice. For the purpose of this manual, necessary and appropriate health care are those essential medical and dental services which are reasonably expected to become vital in the course of the custody and care of juveniles. They are consistent in caliber of care with the generally accepted standards prescribed by nationally recognized medical and dental organizations. The responsibility to provide necessary and appropriate health care services applies to temporary shelters, facility based community corrections, detention centers and residential commitment programs. Each DJJ facility, whether Department owned/operated or contracted, must have in place an effective and efficient means of delivering the clinical and administrative components of health care to ensure that all youth receive this level of appropriate health care at all points in the juvenile justice continuum.

Many youth who enter the juvenile justice system are at high risk for adverse health consequences. Delinquent and committed youth have a higher incidence of physical health and mental health problems than youth in the general population. Delinquent youth are more likely to have experienced two or more serious adverse events such as trauma, loss of consciousness or hospitalization. Many of these youth have not experienced consistent preventive health care. They frequently have high rates of chronic illness, including some communicable diseases. Entry into the juvenile justice system and confinement may exacerbate pre-existing health problems or contribute to the onset of health problems.

Some youth entering DJJ facilities may also have permanent disabilities, such as vision, hearing or mobility impairments. As with acute illnesses or chronic conditions of a physical or mental health nature, these impairments require recognition, referral and the implementation of techniques that will assist these youth in improved functioning.

As is the case with the general population, an increase in the incidence of sexually transmissible diseases is occurring in youth in the juvenile justice system. Failure to adequately diagnose, contain and treat these conditions while youth are in the custody of the Department may result in an increase in adverse health consequences to the youth in custody, and ultimately an increased risk to the public.

There are three basic principles that apply to health care for juveniles who are confined. They are: (1) Access to care; (2) Provision of care that is ordered; and (3) Care based on professional medical judgment. These three basic principles have served as the basis for judicial analysis of the adequacy of a correctional facility’s health care delivery system. Simply stated, a youth has
a right to the same degree of medical care within DJJ facilities as they would receive in the community.

VII. HEALTH SERVICES COMPONENTS IN THE JUVENILE JUSTICE CONTINUUM

 Provision of health care services in the juvenile justice arena requires systems of delivery that are organized and which facilitate evaluation and accountability. Although the methods of delivery of health care services provided in the continuum of DJJ facilities are diverse, each facility must provide the basic components of health care and establish procedural mechanisms that facilitate efficient and effective health care delivery. Planning in a systematic fashion for the provision of necessary and appropriate health care should begin with the Department’s definition of the scope of services provided to youth in DJJ facilities.

To optimally utilize this definition in planning for the provision of health care services, two broad areas are required in the health care delivery system at each DJJ facility:

A. CLINICAL COMPONENT

A clinical component is an element of physical health care that must be available to youth.

Clinical components include the following:

- Intake Screenings for physical and dental health upon entry and at other specified times;
- Assessments that are used to identify youth needs, establish a clinical database and medically classify youth;
- Follow-up Evaluations for youth with chronic health conditions and on-going treatment by licensed health care professionals necessitated by the presence of a chronic condition, a change in a youth’s physical health status, the initiation of a new prescription or medication or pregnancy;
- Episodic Care (First aid and/or emergency care);
- Sick Call;
- Physician Referrals (for example, referrals from Sick Call or Chronic Illness Clinic);
- Consultation/ Specialty Care;
- Medication Management Systems which facilitate the safe, effective, and documented administration of medications, both prescribed and over-the-counter, for acute and chronic physical, mental and dental health conditions;
- Infection Control Measures;
- Health Education;
- Documentation and Record Management;
- Transition Health Care Planning.

While each of the clinical components is mandatory, there may be variation in the extent to which they are implemented on-site at each of the types of facilities (detention
centers, residential commitment programs, facility based community corrections programs and temporary shelters). This variation will depend upon several factors, including the primary purpose of the facility, the size of the facility, the particular component of care, the health care status and needs of particular youth, statutory requirements and the length of stay.

B. Administrative Component

An administrative component is an operational and/or procedural requirement that must be met in order to ensure the effective and consistent management of health care services at a DJJ facility.

NOTE: The basic components set forth in this Manual (2006) are already in place at many DJJ facilities. In many of these facilities and programs, all that may be required is increased organization of a specific component, refinement of existing procedures or improved documentation.

VIII. ROLE OF THE NURSE AND OTHER LICENSED HEALTH CARE STAFF

Nurses and other health care staff in juvenile justice settings should not view their role any differently than in traditional health care environments such as hospitals, nursing homes, home health or school settings. Nurses should be guided by the principle of patient advocacy. Youth in the custody of a juvenile justice setting are also patients when they receive health care. Once a nurse-patient relationship is established, the nurse’s main responsibility is to his or her patient. Nurses are autonomous to the extent that they are practicing within the Nurse Practice Act (Chapter 464, Florida Statutes [2006]) and applicable administrative rules implementing Chapter 464. For these reasons, the nurse’s perspective toward DJJ youths is inherently different from that of correctional/security staff.

When nurses are practicing within a facility, it is important that nurses collaborate with custodial or non-health care/direct care staff. However, nurses must never lose sight of their role as a health care provider and patient advocate. Failure to maintain this role may lead to inappropriate health care, indifference to true illness and distress, the assumption that youth are malingerers, and other non-patient oriented perspectives. Every youth must be treated as a patient.

IX. ROLE OF NON-LICENSED HEALTH CARE STAFF RELATING TO HEALTH CARE

Direct care staff constitutes a critical part of the provision of health care to youth in the custody of the Department. Because direct care staff are with the youth on a constant basis, they often are first to notice behavior changes that indicate the need for physical or mental health care. Additionally, they assist in the self-administration of some medications when nursing staff is not present, accompany youth to medical appointments, and monitor youth who are placed on medical alert. They are also often in the best position to render first aid and/or begin cardio-
pulmonary resuscitation (CPR) and notify Emergency Medical Services (EMS) by calling “911” when an emergency occurs. As it pertains to the health and wellbeing of youth who are in the care and custody of the Department, direct care staff has a key role in ensuring that a youth’s health and safety is paramount.

X. THE IMPORTANCE OF URGENCY

Both health care staff and direct care staff have an obligation to protect the health and safety of youth at all times. This means that if a situation arises where a youth’s health is compromised or life is in jeopardy, staff must immediately respond to the emergency and access Emergency Medical Services by calling 911. No staff should be faulted for acting too quickly or accessing EMS for a situation that was ultimately less critical than it appeared. Delays in calling 911, for whatever the reason, are unacceptable and place valuable lives in jeopardy unnecessarily.

XI. THE OFFICE OF HEALTH SERVICES

At the time of this printing, the Office of Health Services is a relatively new addition to the Department. It should be utilized as a resource for state and contracted, health and non-health care staff and providers to ensure the provision of necessary and appropriate health care for youth in DJJ facilities. It is an office designed to offer guidance, supervision, updated health information, and assistance in clinical decision-making, etc. This Manual is a resource generated from the Office to assist in serving that purpose. Please refer to the “Health Services” link on the Department of Juvenile Justice website for updates, resources and medical, mental health and substance abuse advisories from this office.
I. INTRODUCTION

In order to provide for the health care needs of the youth in the Department’s care and custody, critical staffing and infrastructure must be in place in all DJJ facilities. Thus, the Department of Juvenile Justice requires that every detention center and residential commitment program have specific health care staff and administrative components in place to ensure that the medical services provided to all youth meets constitutional, national and the Departmental standards. The administrative component consists of the administrative, managerial and medical oversight of the health care delivery system at a given facility. This is an operational requirement that ensures the effective and consistent management of health care services. The focus of this chapter is on health care staffing requirements, credentialing and accountability.

In the case of state-operated facilities, the superintendent, in conjunction with the detention or residential Regional staff are responsible for ensuring that these administrative components are implemented in an effective manner, responsive to the changing needs of the respective facility. Similarly, in the case of privately-operated programs, the Program Director shares this responsibility with the contracted Provider operating the program.

Given the diverse types of DJJ facilities and the various kinds of health care delivery arrangements, it is critical that specific mechanisms are in place to provide an effective administrative component. The Superintendent or Program Director is ultimately accountable for ensuring that the Designated Health Authority (DHA) has mechanisms in place to oversee and deliver appropriate health care services.

The purpose of the administrative components include the following: (1) to ensure that the organizational lines of authority and accountability are clarified among diverse health care providers and facility, regional, and headquarters staff; (2) to ensure that there are established means of developing, maintaining and communicating current policy and facility operating procedures related to health care; (3) to ensure that there is a process at each facility and regional office for ensuring that health care providers have the appropriate credentials; and, (4) to ensure that there are effective means of interdisciplinary communication and collaboration in place at each DJJ facility.

II. THE DESIGNATED HEALTH AUTHORITY

The Designated Health Authority (DHA) shall be a state employed or contracted Physician with the appropriate training and knowledge to be accountable for ensuring the delivery of administrative, managerial and medical oversight of the facility health care system. The DHA
shall ultimately be responsible for the provision of necessary and appropriate health care to youth in the care of a detention center or residential commitment program.

A. ROLE AND RESPONSIBILITIES OF THE DHA

The DHA has the clinical responsibility for all program physical health and medical services. “Clinical responsibility” is defined as the oversight of the medical care of all youth within a DJJ facility. This individual shall be responsible for the overall clinical direction, policies, and protocols for the medical services provided. Final clinical judgments shall rest with this single individual. The Designated Health Authority must visit the DJJ facility at least once per week when youth are present, including vacation or scheduled absences, when coverage must be arranged. For wilderness/expedition programs, the DHA shall be on-site at the facility once bi-weekly, at a minimum; during the weeks that the DHA is not on-site, the DHA will be available at an off-site location to perform the duties as stated above. Specific duties of the Designated Health Authority are:

1. Conducting on-site Medical Evaluation and Treatment, to include the following:
   a. Performing Comprehensive Physical Assessments, (CPA), initial and then annually;
   b. Conducting Sick Call (if Sick Call is being conducted when on-site);
   c. Conducting Periodic Evaluations for youth with acute and chronic illnesses as clinically indicated;
   d. Reviewing currently prescribed medication(s) and ordering new prescription medication(s), excluding psychotropic medications.

2. Assist in the development of the Facility Operating Policies, and Procedures for Medical and Dental episodic (non-emergent illnesses and injuries) and emergency care, including annual review/revision of episodic and emergency Protocols, Policies and Procedures.

3. Communicating regularly with the facility Superintendent/Director and/or Assistant Superintendent/Director on all matters relative to the medical needs of the youth in the facility.

4. Availability for consultation by electronic means twenty-four hours per day, seven days per week, for acute medical concerns, emergency care, coordination of off-site services and other responsibilities."

5. Unless the Designated Health Authority at a given facility or program is a Psychiatrist, the DHA shall not be responsible for:

   - The development or review of facility operating procedures or other protocols related to psychiatric services;
   - The management of psychiatric conditions;
   - The prescribing of psychotropic medications.
6. The above services shall be the responsibility of the facility Psychiatrist or psychiatric ARNP, duly licensed/certified in the State of Florida.

7. Only the clinical responsibilities of the Designated Health Authority may be delegated to a designee and only to the following type of practitioners:

   - Another Physician (MD or DO);
   - A Physician Assistant;
   - An Advanced Registered Nurse Practitioner.

   *Note: For the purposes of this manual, when the responsibilities require a physician only, the designee is referred to as “Physician Designee”.*

8. Policy and protocol development and administrative oversight may not be delegated.

9. If a youth’s clinical condition falls beyond the scope of training and expertise of the designee, then it is the Designated Health Authority’s responsibility to ensure that the youth receives appropriate care in a timely manner.

10. Neither a Registered Nurse, Advanced Registered Nurse Practitioner nor Physician Assistant may serve as a facility’s Designated Health Authority.

11. Corporate Physicians, who do not perform clinical/administrative duties on-site, may not be the Designated Health Authority.

B. **DELEGATION OF CLINICAL RESPONSIBILITIES TO A PHYSICIAN ASSISTANT (PA)**

1. The DHA may name the facility Physician Assistant (PA) as his/her designee for clinical responsibilities only.

2. This person shall not become the Designated Health Authority in title. The Physician will remain the Designated Health Authority of record. The DHA shall have a supervisory relationship with the PA. For the purposes of this manual, “Supervision” means responsible supervision and control and requires the easy availability (by telephone or pager) or physical presence of the licensed Physician for consultation and direction of the actions of the PA.

3. The DHA must come on site for administrative responsibilities and clinical duties that are beyond the scope of expertise and training of the PA.

4. Each Physician supervising a licensed Physician Assistant must be qualified in the medical areas in which the Physician Assistant is to perform and shall be individually responsible for the performance and the acts and omissions of the Physician Assistant.

5. Pursuant to Chapter 64B8-30.012 FAC, the supervising Physician shall delegate only tasks and procedures to the Physician Assistant which are within the supervising Physician’s scope of practice. The decision to permit the Physician Assistant to perform a task or procedure under direct or indirect supervision is made by the supervising Physician based
on reasonable medical judgments regarding the probability of morbidity and mortality to the patient. Furthermore, the supervising Physician must be certain that the Physician Assistant is knowledgeable and skilled in performing the tasks and procedures assigned.

6. The following duties are not permitted to be delegated at all, except where expressly authorized by statute:
   - *Prescribing, dispensing, or compounding medicinal drugs.
   - Final Diagnosis (the diagnosis becomes final once the Physician verifies and signs the PA’s note).

   **Note:** Prescribing of medicinal drugs by Physician Assistants shall occur only after completion of requisite training as defined in statute.

7. The following duties are not permitted to be performed under indirect supervision:
   - Final interpretation of laboratory tests, X-ray studies and EKG without the supervising Physician’s interpretation and final review.

8. All tasks and procedures performed by the Physician Assistant must be documented in the appropriate medical record. The supervising Physician must review, sign and date all documentation by the Physician Assistant in the Individual Health Care Record within 30 days.

9. All prescriptions must be written in a form that complies with Chapter 499 and must contain, in addition to the supervisory Physician’s name, address, and telephone number, the Physician Assistant’s prescriber number. The Physician Assistant must note the prescription in the appropriate medical record, and the supervisory Physician must review and sign each notation.

10. Physician Assistants are not authorized to prescribe:
    - Controlled Substances as defined in Chapter 893, F.S.;
    - Antipsychotics;
    - Any parenteral preparations except insulin and epinephrine.

11. The DHA may not supervise an ARNP and/or PA in more than four facilities in addition to the Physician’s primary practice location.

12. A Physician that supervises a Physician’s Assistant must post his or her current schedule of the regular hours that the Physician plans to be present in the facility, and the hours that the medical clinic is open when the Physician is not present.

**C. Delegation of Clinical Responsibilities to an Advanced Registered Nurse Practitioner (ARNP)**
1. The DHA may name the facility Advanced Registered Nurse Practitioner (ARNP) as his/her designee for clinical responsibilities only. This ARNP must have education, experience and certification in Family Health or Pediatrics.

2. This person shall not become the Designated Health Authority in title. The delegation must be articulated and specified in a current and valid Collaborative Practice Protocol (CPP) between these two individuals. The CPP must specifically state the name of the facility at which the Physician is the DHA and that the ARNP is his/her designee at said facility. The Physician will remain the Designated Health Authority of record. The DHA shall have a supervisory relationship with the ARNP that shall be defined in the collaborative practice protocol.

3. The DHA must come on site for administrative responsibilities and for clinical duties that are beyond the scope of expertise and training of the ARNP.

4. The DHA may not supervise an ARNP and/or PA in more than four facilities in addition to the Physician’s primary practice location.

   Note: “Supervision” means responsible supervision and control and requires the easy availability or physical presence of the licensed Physician for consultation and direction of the actions of the ARNP.

5. Collaborative Practice Protocols: Pursuant to Chapter 64B8-35.002, F.A.C., the ARNP shall have a written protocol signed by all parties, and on file with the Department of Health, representing the mutual agreement of the Physician and the ARNP. Copies of these protocols shall be maintained at the Facilities and in the Regional offices.

   The protocols shall include, at a minimum, the following components:

   - General Data: ARNP name, address, ARNP certificate number;
   - Physician name, address, license number, and DEA number;
   - Date developed, and dates amended, with signatures of all parties;
   - Location of facility, stating that the Physician is the DHA and ARNP is the designee;
   - Description of duties of the ARNP;
   - Description of duties of the Physician;
   - Management areas for which the ARNP is responsible;
   - Conditions for which therapies may be initiated;
   - Treatments that may be initiated by the ARNP;
   - Drug therapies that the ARNP may prescribe, initiate, monitor, alter, or order;
   - A provision for annual review by the parties;
   - Specific conditions and a procedure for identifying conditions that require direct evaluation or specific consultation by the Physician to insure acceptable standard of supervision and medical care, and;
A copy of the protocol or amendments shall be signed by the ARNP and Physician and a copy kept at the location of the practicing ARNP. A copy of all protocols shall be maintained for a period of four years.

THE ROLE OF THE FACILITY SUPERINTENDENT OR PROGRAM DIRECTOR

A. ORIENTATION TO THE HEALTH SERVICES MANUAL

The facility Superintendent or Program Director is responsible for ensuring that the DHA is clearly informed of all of the Department's health care requirements at the time of the negotiation of the agreement/contract. This responsibility can be shared with supervisors at the Regional level. It is required that a copy of the Health Services Manual and all additional medical directives be provided to and reviewed by all health care professionals who are employed by DJJ, employed by a contracted program or provide health care services by other arrangements, including fee-for-service, capitated payments or other contractual arrangements. The DHA and other health care professionals should be given an opportunity to review this manual at the time he/she agrees to provide services. Orientation to the mandatory forms is essential for the prospective DHA's understanding of required services.

The DHA, in conjunction with the facility superintendent/program director, is accountable for the development, review and approval of all health-related procedures and protocols to be used at the facility.

B. COMMUNICATION WITH THE HEALTH CARE STAFF

To review the important medical issues pertaining to youth at the facility there shall be a formal procedure that allows for regularly scheduled communication, at regular intervals, a minimum of every other week, between the Superintendent/Program Director, or their designee, and the health care staff. The Superintendent or Program Director should be aware of ongoing medical concerns about any youth in their facility.

C. VERIFICATION OF CREDENTIALS:

1. The facility Superintendent or Program Director or designee and Regional contract monitor are responsible for ensuring that the proper verification of credentials occurs prior to contract execution for all health care providers. Required documentation shall be maintained in the provider’s service agreement file and at the regional offices. Unless otherwise specified, it is not necessary to verify the individual credentials/licensures of the individual health care providers who function as employees of licensed facilities, such as licensed hospitals, licensed ambulatory care centers, or licensed community mental health facilities. Unless otherwise specified, it is not mandatory for the DJJ contract manager, facility Superintendent or Program Director or other DJJ personnel who manage, monitor or otherwise oversee a program’s operation to verify the credentials of ancillary health care providers (for example, radiological services or laboratory services) with which a contracted medical provider has an arrangement.
Verification of the credentials of these providers is the responsibility of the medical provider that arranges for their services.

2. The facility Superintendent or Program Director or designee shall ensure that all procedures and protocols are reviewed annually. Individuals from each discipline who are providing health care services shall sign and date a cover page that lists all of the facility manuals, including but not limited to the facility policy and procedures, health services manuals, and health services protocols signifying that they have read all the manuals as identified on the given list.

3. The facility superintendent/program director and the Designated Health Authority share the responsibility for ensuring that corporate facility operating policies, procedures and protocols conform to Departmental policy and are adapted for the DJJ facility at which they are implemented. NOTE: Corporate Physicians who do not come on site are not acceptable to serve as Designated Health Authorities in DJJ facilities, even if by proxy through an on-site primary care provider.

IV. PROTOCOLS AND PROCEDURES

A. The DHA, the Psychiatrist (if applicable) and the Dentist (if applicable), must sign and date all of their respective written protocols. This process must be followed each time a new policy, procedure or protocol is developed and/or an existing one is changed at a time other than the annual review. Nursing staff must review, sign and date a cover page on which all FOPs, treatment protocols, and other procedures are listed. New policies or changes in policies that are made during the year must be reviewed, signed, and dated by each nurse on the individual policy.

B. At a minimum, an annual review of all procedures and protocols is required. It is demonstrated by the signature and date of the DHA, facility superintendent and other representatives from relevant disciplines. Individuals from these disciplines may sign and date a cover page that lists all of the facility operating procedures (FOPs), signifying that they have read the FOPs and any new health-related DJJ policies.

C. All newly employed health care personnel, must receive a comprehensive clinical orientation to DJJ health care policies and procedures, given by a Registered Nurse or designated, licensed health care professional. This orientation must be provided during a time frame when clinical duties are not required. Preferably, the new health care employee should observe, review policies and then conduct duties after this review. Contracted health care staff shall be oriented in the same manner by a representative from the parent company who is a licensed clinical professional and versed (with proficiency) in Departmental health care policies and procedures.

D. Approval of clinical protocols or standing procedures (for example, a list of approved over-the-counter medications or procedures to follow for commonly encountered minor medical problems) must be written and authorized by the Designated Health Authority and may not be delegated to any other person. If an Advanced Registered Nurse
Practitioner (ARNP) is providing primary care at a DJJ facility, and the DHA requests that the PA or ARNP draft a list of treatment procedures, this is acceptable when in accordance with all applicable state and federal laws and rules, as long as this is clearly understood to be a collaboration between the DHA, PA/ARNP and the treatment protocols are within the scope and practice.

E. The review and development of facility operating procedures, or other protocols related to psychiatric services and psychotropic medication management may only be performed by the facility’s Psychiatrist or Psychiatric ARNP, duly licensed/certified in the State of Florida, either of whom must be the prescribing practitioner for psychotropic medications at the specified facility.

F. “Blanket” or general corporate policies, procedures, or protocols are not acceptable for individual facilities.

V. SERVICE AGREEMENTS

A. The facility Superintendent or Program Director or designee is responsible for ensuring that service agreements are in place with health care providers that are routinely and/or frequently utilized by the facility.

B. Service agreements must contain, at a minimum, a general description of the services to be rendered, fees or fee schedules, and a statement as to the lines of communication with regard to other health care providers and administrative staff within the DJJ facility.

C. The facility Superintendent or Program Director or designee is responsible for ensuring that health care providers that function under service agreements are kept informed of changes in departmental policy that directly, or indirectly, affect their provision of health care services.

D. It is expected that individuals who negotiate service agreements will work collaboratively with the health care provider and ensure that the health care provider is informed of Departmental policy that may affect the manner in which she/he provides and documents services.

E. Additional requirements or modifications of this section related to the provision of mental health care pursuant to service agreements shall be in accordance with the Department’s Mental Health and Substance Abuse Services Manual (2006).

F. The facility Superintendent or Program Director or designee is responsible for ensuring that licensure, credentialing and background screening of all providers who provide health care services to youth in the custody of a DJJ facility pursuant to a service agreement shall be conducted as specified by Department policy. Required documentation shall be provided to the Regional Contract Manager before the execution of the contract with copies maintained in the provider’s service agreement file. Unless otherwise specified, it is not necessary to verify the individual credentials/licensures of
health care providers who function as employees of licensed facilities such as licensed hospitals, licensed ambulatory care centers, or licensed community mental health facilities. Unless otherwise specified, it is not mandatory for the DJJ Contract Manager, facility Superintendent or Program Director or other DJJ personnel who manage, monitor or otherwise oversee a program’s operation to verify the credentials of ancillary health care providers (for example, radiological services or laboratory services) with which a contracted medical provider has an arrangement. Verification of the credentials of these providers is the responsibility of the medical provider that arranges for their services.

G. ANCALLARY SERVICE AGREEMENTS MAY BE UTILIZED FOR:

- Service provision contracts or written agreements with health care professionals in the community to provide additional health care services, as needed;
- A contract or written agreement with an appropriately licensed local hospital to be utilized in the event of an emergency or for services, which cannot be addressed on-site through basic, minor first aid or through, established sick call procedures;
- A contract or written agreement with a dentist duly licensed in the State of Florida to provide primary dental care and emergency dental care, when needed;
- A contract or written agreement with an ophthalmologist or optometrist duly licensed in the State of Florida to provide eye care services, as needed, for consultation and/or treatment.

VI. HEALTH CARE PROVIDER LICENSURE, SPECIALTIES AND CREDENTIALING

A. VERIFICATION

1. The facility superintendent/program director or designee is responsible for ensuring that an operating procedure is in place which clearly delineates the credentialing confirmation process for health care providers at that facility. Where applicable, copies of current licenses and/or certifications of health care providers shall be furnished by the health care provider to the Regional Contract Manager for the facility and retained on site in confidential files.

2. The licensure/credentials of all health care providers who provide physical and/or mental health care to youth in the custody of a DJJ facility must be verified. This requirement applies to:

- On-site providers;
- Off-site providers;
- Licensed mental health facilities;
- All providers, whether working through state or private employment, private contracts, or service agreements.

3. Verification of licensure/credentials is accomplished using the Department of Health website at www.doh.state.fl.us. If there is a disciplinary history reported by the Department of Health (DOH), it is the responsibility of the facility
superintendent/program director or designee and the Regional contract manager to investigate this history further. The Regional staff shall be notified when an issue such as this arises.

4. The licensure/credentials of individual health care providers who are employed by tertiary care facilities (hospitals), ambulatory care clinics, family planning or abortion clinics, or crisis stabilization units do not require verification. However, the licenses of the facilities must be verified annually through the Agency for Health Care Administration’s web-site at www.floridahealthstat.com (at the time of this edition). A health care facility’s accreditation status by an accrediting body such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA) does not eliminate the need for verification of the state license.

B. LICENSURE REQUIREMENTS AND GENERAL RESPONSIBILITIES

For reference purposes, the following section identifies credential requirements and additional information with regard to various types of health care providers/disciplines:

1. The Designated Health Authority (DHA) must be a board certified Physician (MD) who holds an active, unrestricted license under Chapter 458, Florida Statutes, or an osteopathic Physician (DO) who holds an active, unrestricted license under Chapter 459, Florida Statutes and meets all requirements for practice in the State of Florida. The Physician’s specialty training should be in Pediatrics, Family Practice or Internal Medicine (with experience in adolescent health). If this is not the case, then there must be a demonstrated prior experience in treating the primary health care needs of adolescents.

2. A Psychiatrist who holds an active, unrestricted license under Chapter 458, 459, Florida Statutes may serve as the DHA (under the conditions specified) of a facility that provides specialized mental health services, as long as the Psychiatrist has current experience in medically treating the physical health care needs of adolescents. If this is not the case then there MUST be an arrangement for a pediatrician, family practice Physician or internist (with experience in adolescent health) to provide those services. In the event that a Psychiatrist wishes to utilize a psychiatric ARNP as a designee for clinical responsibilities only, the ARNP’s education, experience, and certification/licensure must be in psychiatry/mental health as stated on the Department of Health website. The psychiatric ARNP may not serve as the DHA’s designee for non-psychiatric purposes. In these instances, there MUST be an arrangement for a pediatrician, family practice Physician or internist (with experience in adolescent health) to provide the primary care services.

3. Dentists (DMD, DDS) must hold active, unrestricted licenses under Chapter 466, Florida Statutes and meet all requirements for practice in the State of Florida.
4. **Physician Assistants** (PAs) must hold active, unrestricted licenses under Section 458.347, Florida Statutes and meet all requirements for practice in the State of Florida. Physician Assistants may not serve as a facility's DHA, but may provide clinical services, to the extent that these services fall within their scope of practice and to the extent that their respective supervising Physicians delegate them. A Physician Assistant shall be supervised by his, or her, delegating Physician in accordance with, governing statutory regulations and cannot practice independently.

5. **Advanced Registered Nurse Practitioners** (ARNPs) must hold active, unrestricted licenses as Registered Nurses and meet all requirements for practice in the State of Florida and hold an applicable specialty certification as an ARNP pursuant to Chapter 64B9-4.002(2) F.A.C. effective July 1, 2006. Advanced Registered Nurse Practitioners may only provide services for which they are trained/educated and which fall within their certification/licensure (for example, psychiatric ARNPs provide mental health services and family practice ARNPs provide family/physical health services).

6. **Nursing Requirements** All facilities shall have on-site nursing coverage to be provided by Registered Nurses (RNs) or, at a minimum, Licensed Practical Nurses (LPNs). When LPNs are providing healthcare, they must be under the direction of a licensed healthcare professional at a higher licensure level than LPN; i.e., RN, ARNP, PA, MD, or DO. The licensed healthcare professional that is providing the direction to the LPN is responsible for reviewing all medical cases daily with the LPN, and available on-call for consultation and, when necessary, provides on-site assessment and management of medical cases. As per Ch. 464, F.S., and Ch. 64B9, F.A.C., a LPN is not allowed to make patient assessments and/or final clinical decisions regarding medical care. Each facility shall have on-call medical coverage for nights and weekends when no nurse is on-site. There shall be a staff person on every night or weekend shift responsible for accessing medical services or personnel. For specialty facilities and intensive medical facilities, a higher level of nursing coverage may be indicated and shall be clearly articulated per a contractual agreement with the department.

7. **Certified Nursing Assistants** (CNAs) must hold (an) active, unrestricted Certification(s) pursuant to Florida Statute 464.2 and meet all requirements for practice in the State of Florida and shall not perform in any health care capacity, without the direct, continuous on-site supervision of a Registered Nurse, ARNP, PA or Physician at all times. Pursuant to Chapter 464.201(5) F.S. and for the purposes of the Department, the practice of a Certified Nursing Assistant is limited to those tasks associated with providing care and assisting persons with tasks relating to the activities of daily living (e.g. bathing, grooming, dressing), CPR, data gathering, reporting abnormal signs and symptoms (to an RN, ARNP, PA or Physician) and documentation of nursing assistant services. Additionally, Chapter 64B9-15.008 F.A.C. permits a Certified Nursing Assistant to measure and record a youth’s vital
signs and weight. The CNA shall not administer medications in the capacity of a Nurse.

Thus, a Certified Nursing Assistant may ONLY be utilized as a support person, to the licensed health care professional (at or above the level of an RN), but must demonstrate competency of assigned tasks by performing a validation competency skills checklist pursuant to Chapter 64B9-14 F.A.C. A Registered Nurse must document the validation and competency verification of each CNA. This documentation must be maintained in the staff member’s on-site personnel record.

A Certified Nursing Assistant (CNA) is responsible for practicing within the scope of his or her respective practice act, training and experience. CNA’s are never to act in the capacity of or assume the role and responsibilities of a Licensed Practice Nurse or a Registered Nurse.

8. **Emergency Medical Technicians** (EMTs) and Paramedics who wish to perform health promotion activities, such as blood pressure screening, may do so only if duly certified in the State of Florida, under the direction of a medical director who is a Physician, and under the limitations described in Chapter 401, Florida Statutes. Certified emergency technicians and paramedics may not perform routine medical services to youth in a DJJ facility.

9. Individuals who hold licenses in the State of Florida to practice any of the health care professions and who provide services to youth in the custody of a DJJ detention center and/or residential commitment program are responsible for practicing within the scope of their respective practice acts, training, and experience.

10. Verification of appropriate malpractice insurance is required during the credentialing process.

C. **Students or Interns in Health Related Training Programs**

1. For students in health care professions (Nurses, MDs, DOs, ARNPs, etc) the same training requirements for licensure verification apply to the preceptor/supervising instructor from the academic institution. All students must be in good academic standing. All student observation experiences must be pursuant to a written agreement with the academic institution. The written agreement must clearly articulate the goals and objectives and scope of activities permitted, and must be signed by the facility superintendent, Designated Health Authority, the students and the individual at the academic institution responsible for oversight of practice settings and/or observational experiences. Their respective preceptors/teachers must directly supervise students at all times. For the purposes of this arrangement, “direct supervision” means that the preceptor must be on the premises, in the immediate area, with direct observation of the student whenever the student is conducting any kind of clinical activity other than observation. A facility officer must escort all students. The student may directly observe the clinical interaction, only with the
youth’s verbal consent. All youth in any kind of observational experiences by students may refuse at any time. The youth’s consent is not implicit. The youth must be asked if it is permissible for the student to observe. No punitive actions of any kind (such as loss of level, loss of privilege) may be taken against a youth who refuses.

2. Departmental background screening is required for all students who enter a DJJ facility for observation, clinical rotation, internship, or any other educational or professional experience. Verification of licensure/credentials of health care providers is in addition to the required Departmental background screening.

VII. INTERDISCIPLINARY RISK REDUCTION/QUALITY IMPROVEMENT PROCESS

A. A facility operating procedure must be in place that explains the process whereby representatives from all disciplines that provide or oversee the provision of physical and mental health care, programming/operations and behavior management meet. The explicit purpose of this meeting is to communicate/collaborate on methods of reducing or eliminating programmatic, operational or practice risk factors, including those that have been demonstrated to result from lack of communication and coordination. This process is not to be used for management directives or for disciplinary purposes. It is to identify and solve potential and actual problems.

B. Meetings must be held no less than quarterly and more frequently as the need arises. For example, if the superintendent, or program director, health care or non-health care staff person recognizes a trend that has the potential for compromising the safety of the youth or the staff, that person may request that this topic be addressed in a meeting that is not on the quarterly schedule.

C. Meetings must be documented in minutes that are dated and signed by the individual designated as the chairperson. Documented topics of discussion should include, but not be limited to the following:

- Risk reduction measures;
- The identification of potentially harmful or otherwise notable trends noted by any discipline;
- Recent developments in the respective disciplines which may impact other disciplines and/or staff at the facility;
- Discussion and analysis of actual adverse or sentinel events;
- Medical treatment errors;
- Medication errors;
- Discussion and critique of the quarterly mock medical emergency drills;
- Discussion and planning for a particular youth, or disease, or condition.

D. Facilities shall address risk factors as they occur thru an established health services quality assurance process. Pertinent data and identified trends should be shared and discussed. If one of the topics is an event that actually occurred, simple root cause
analyses should be conducted. Documentation must be retained at the facility. Although the minimum frequency is quarterly, meetings should be conducted when an acute event occurs, the potential for an acute event is recognized, or there is information that requires interdisciplinary discussion or clarification.
I. INTRODUCTION

Many youth who enter the juvenile justice system have not had adequate or consistent preventative health care. Screening at admission (or re-admission to a detention center or residential commitment program) is an opportunity to assess for medical conditions, and also to screen for anticipated health care needs. Additionally, screening at admission assists in preventing the introduction of infectious and communicable diseases into the custodial setting.

Each detention center and residential commitment program must have in place procedures to ensure that every youth is thoroughly screened upon admission in order to determine if the youth has an acute injury or illness, a chronic condition that requires immediate evaluation and treatment, and/or medication needs to be met. Youth are also then to be re-screened whenever physical custody changes and they are subsequently returned or readmitted to their respective DJJ facility. For the purpose of this manual, change in physical custody would be moving from one facility (detention or residential) to another with an anticipated stay of 24 hours or more. For example, if a youth is transferred from a residential commitment program, travels to a detention center (where they are also screened) then returns to the residential program, they must be re-screened at the program. Similarly, if a youth is being transferred across the state and requires an overnight stay at a detention center, the detention center must screen him or her on admission.

II. SCREENING BY OBSERVATION AND INTERVIEW

A. At the time of admission to a facility, each youth will receive a facility entry screening by the staff member (health care or non-health care) admitting the youth to the detention center or residential commitment program. In detention facilities this screening is to be performed using the Medical and Mental Health Admission Screening form found on the Detention Facilities Management System (DFMS) Wizard; in residential commitment programs, this screening shall be performed using the Facility Entry Physical Health Screening form. It shall be performed as soon as possible after a youth’s admission.

B. The purpose of this screening is also to ensure that the youth does not have any health conditions that would require emergency services. The Medical and Mental Health Admission Screening or Facility Entry Physical Health Screening does not take the place of the Comprehensive Physical Assessment or other required evaluations.

C. A direct care staff person may conduct the screening however, if a licensed nurse is on duty at the time of the admission, he or she may conduct the screening if available. Otherwise, it is expected that the entry screening will initially be reviewed by the licensed
nurse within 24 hours of admission to a detention center or residential commitment program. The purpose of the review is to ensure that, if the youth does not access any further health care (e.g., sick call), additional screening or treatment is not overlooked.

Note: See the Mental Health and Substance Abuse Services Manual (August 2006) for the admission screening process as it pertains to mental health and substance abuse issues.

III. MEDICAL EMERGENCIES ON ADMISSION OR DURING SCREENING

A. EMERGENCY RESPONSE FOR YOUTH UPON ADMISSION

Certain conditions, if encountered during the screening and/or admission process, require immediate emergency professional assessment and/or transfer by Emergency Medical Services (EMS) to the nearest hospital. If the facility has a licensed nurse on-site at the time of a youth’s admission, the LPN or RN may first conduct a preliminary triage examination before contacting EMS and the Designated Health Authority, PA or ARNP. However, EMS must be called immediately if the youth’s condition is such that immediate transfer to an emergency room is warranted, regardless of whether the RN is on the premises. In all situations, the staff shall not wait for a response from the Designated Health Authority, PA or ARNP prior to calling 911 and contacting EMS. The Designated Health Authority or designee is to be contacted at the next possible opportunity.

The following complaints, signs and/or symptoms require immediate communication with the facility Designated Health Authority or designee, PA or ARNP and an urgent assessment of the youth if this staff is available on-site. Immediate transfer of youth to the nearest facility that provides emergency care shall occur if the above-mentioned health care staff is not on-site or after their evaluation, if the condition so warrants.

This list includes, but is not limited to:

1. Acute injuries such as deep or penetrating puncture wounds or wounds that occur with and/or in contaminated materials.
2. Lacerations that are gaping and/or bleeding profusely.
3. Severe infections (redness, pain, draining pus, etc.).
4. Signs of physical distress (such as shortness of breath, wheezing, extreme paleness or sweating, profuse bleeding, complaints of severe pain).
5. Any neurological impairment (such as difficulty talking or moving, difficulty in remaining awake, disorientation, or the inability to inform the reviewer of the date).
6. Any penetrating eye injury or non-penetrating eye injury resulting from a blow to the head or any loss of vision.
7. Severe abdominal pain prolonged vomiting or diarrhea vomiting blood or bloody diarrhea.
8. Chest pain or complaints of “heart racing,” extremely slow pulse, or irregular pulse.
9. Hemoptysis (actively coughing up blood).
10. Suspected drug overdose or intoxication.
14. Syncope (loss of consciousness, fainting or “passing out”).
15. Reported, observed or confirmed recent sexual assault by another youth or adult.
16. Lack of a prescribed medication for a chronic condition that cannot be suddenly stopped (e.g., insulin).
17. Onset of labor, premature labor, or vaginal bleeding in a pregnant youth.
18. Any symptoms in a pregnant youth that may indicate pre-eclampsia, such as headache, hypertension, hyperglycemia, ketosis, etc.
19. Obvious musculoskeletal deformity, injury or fracture presumably associated with the arrest process.
20. Dental injuries in which a tooth or teeth are avulsed and are potentially salvageable.
21. Severe Extra Pyramidal Symptoms or Dystonic movements (involuntary clenching of jaw, cramping of hands/feet, torticollis, difficulty breathing).
22. Rapid repetitive movements associated with possible methamphetamine withdrawal (“punding”).
23. Communicable diseases (in accordance with local health department guidelines).
24. Recipient of Electronic Stun gun (Taser) prior to admission.

IV. ROUTINE NOTIFICATION OF DESIGNATED HEALTH AUTHORITY (DHA)

A. PROCEDURES AND TIMEFRAMES

In situations where a youth does not require immediate emergency transfer, the Designated Health Authority or designee must be notified of all youth admitted with any of the conditions listed below, unless prior notice has been given. This notification may be by telephone, or verbally, if the Designated Health Authority or designee is on the premises.

If contact is not initially made, the notification must be verified (for example, the office of the Designated Health Authority must call back acknowledging the admission). If the youth is admitted after 8:00 PM, and the youth has no immediate medication or health-related needs, notification of the Designated Health Authority shall take place no longer than twelve (12) hours after admission and in no case shall notification exceed 12:00 PM (noon) of the day following admission. The purpose of the notification is to keep this person updated about the types of medical conditions existing within the facility.
B. THE CONDITIONS REQUIRING ROUTINE NOTIFICATION ARE AS FOLLOWS:

1. Asthma
2. Allergies with Anaphylaxis
3. Adrenal Insufficiency
4. Cancer (including a history of cancer)
5. Cardiac (Heart) Arrhythmias, Disorders or Murmurs
6. Congenital Heart Disease
7. Cystic Fibrosis
8. Developmental Disabilities/Mental Retardation
9. Diabetes (Insulin and Non-Insulin Dependent)
10. EpiPen (History of Use)
11. Current Eating Disorders (Anorexia Nervosa and Bulimia)
12. Head Injuries Which Have Occurred During/Within the Previous Two Weeks
13. Hearing, Speech or Visual Deficits
14. Hemophilia (Bleeding Disorder)
15. Hepatitis
16. HIV/AIDS
17. Hypo or Hyperthyroidism
18. Hypertension
19. Kidney Failure (with or without Dialysis)
20. Neuromuscular conditions (i.e. Cerebral Palsy, Muscular Dystrophy, Multiple Sclerosis)
21. Pregnancy (or Within Two Weeks Post Birth)
22. Seizure Disorders
23. Sickle Cell Anemia
24. Spina Bifida
25. Systemic Lupus Erythematosis
26. Tuberculosis (active)

V. NON-EMERGENT REFERRALS

A. Referrals to the facility’s Physician, PA or ARNP must be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission. If a current Comprehensive Physical Assessment (CPA) is not already on file in the Individual Health Care Record (IHCR), these youth will also require scheduling of a Comprehensive Physical Assessment.

B. A system must be in place that ensures that youth who are referred by admitting staff are seen within reasonable time frames; such timeframes must be included in the facility operating procedure regarding the admission process. (See Chapter 5 Health Related History, Comprehensive Physical Assessment.)
VI. TUBERCULOSIS (TB) CONTROL AND SCREENING

All detention superintendents and residential commitment program directors shall be responsible for developing and implementing facility-operating procedures for Tuberculosis. The procedures shall generally address the routine screening of all youth for latent and active tuberculosis as well as environmental controls in the case of a youth with active Tuberculosis. They shall be developed in accordance with the Centers for Disease Control and Prevention new 2006 recommendations and OSHA Occupational Safety and Health Standards.

The facility procedures shall incorporate all of the following components:

- Youth initial symptom screening
- Mantoux Tuberculosis skin testing (TST) with Purified Protein Derivative (PPD)
- Annual re-screening of youth
- Treatment for latent and active TB infection
- Environmental controls to prevent transmission of TB
- Facility TB annual risk assessment
- Respirator protection for health care workers and staff
- Precautions for transporting youth with suspected or confirmed infectious TB

A. INITIAL SYMPTOM SCREENING METHOD (TIER I): INTERVIEW WITH YOUTH

1. The second page of the Facility Entry Physical Health Screening form shall be utilized for a youth's initial Tuberculosis (TB) symptom screening. Emphasis should continue to be on thorough, standardized symptom screening upon each admission to a detention center and residential commitment program (including re-entry after temporary transfers or releases).

2. Youth with symptoms suggestive of active Tuberculosis would have the following findings on the entry screening:

   - A cough productive of mucous for greater than 3 weeks
   AND
   - Any three (3) of the following symptoms:

   1. Fever greater than 101 degrees
   2. Significant weight loss without dieting
   3. Fatigue
   4. Night or early evening profuse sweating

3. Youth with these symptoms shall not be placed in the general population until medically assessed by the facility DHA or designee, PA or ARNP.

4. If this evaluation cannot be accomplished immediately, then the youth must be immediately transported to the nearest hospital or local county health department for evaluation. It is advisable to contact the chosen facility prior to departure. While
awaiting evaluation or transport, the youth may be placed in an Airborne Infection Isolation Room (a room with a verified effective negative pressure airflow system) or outside in the open air (provided the youth can be accompanied).

5. If the facility DHA or designee, PA or ARNP are on-site, then based on the subsequent medical evaluation the following should occur as clinically indicated: a Tuberculin Skin Test or QuantiFERON-TB Gold blood test (QFT-G), a chest x-ray and, if indicated, sputum examinations. If this extensive an evaluation is warranted, then the youth should be transported to the nearest hospital or local county health department. It is advisable to contact the chosen facility prior to departure.

6. For those youth known to be infected with HIV, a chest x-ray shall be part of the initial admission screening. Youth who have x-ray results suggestive of TB shall be isolated immediately and the facility shall consult with the DHA or designee, PA or ARNP for further instructions. CDC Recommendations indicate that sputum-smear and culture examinations should be performed for these youth who are symptomatic and whose chest x-rays are consistent with TB disease regardless of their PPD/QFT-G results.

7. All youth with the following conditions are at increased risk for latent TB infection and the risk of progression from latent to active Tuberculosis disease. They will require further screening with a PPD, a QFT-G or chest x-ray within 7 days of arrival to a detention center or residential commitment program.

These conditions include the following:

✓ Recent immigration
✓ History of Tuberculosis
✓ Recent close contact with a person with tuberculosis disease
✓ Injection-drug use
✓ Diabetes Mellitus
✓ Conditions requiring immunosuppressive therapy
✓ Hematologic malignancy or lymphoma
✓ Chronic renal failure
✓ Medical conditions associated with substantial malnutrition
✓ A person with a history of gastrectomy or jejunoileal bypass

Note: Do not place youth who have a strong index for active disease in any kind of confinement room unless that room has a negative pressure airflow system, verified to be effective.

B. VERIFICATION OF PRIOR TST/PPD TESTING

If after screening there is a low index of suspicion for active TB disease, the facility shall determine if a TST/PPD is warranted, based on existing records.
1. All youth should have on file in the DJJ Individual Health Care Record, one (1) verified PPD skin test result, measured and documented in millimeters (unless skin testing is medically contraindicated). This documentation may come from prior records, including private health care practitioners, county health departments, or from prior PPD tests administered in DJJ detention centers or residential commitment programs. If a county health department or private health care practitioner has a PPD on file for a youth, a facsimile copy is acceptable and should be filed in the youth’s Individual Health Care Record (IHCR), and recorded on the Infectious and Communicable Disease (ICD) form in the core health profile.

2. An appropriately documented and interpreted tuberculin skin test result from another DJJ facility’s aggregate Tuberculosis Testing Log may be accepted by telephone from one licensed nurse to another licensed nurse and then recorded in the youth’s Individual Health Care Record (on the Infectious and Communicable Disease Form), located in the Core Health Profile.

C. **Administration and Interpretation of the Mantoux / Tuberculosis Skin Testing (TST) with Purified Protein Derivative (PPD)**

1. If no record of a prior PPD skin test result within the past 12 months is located, or identified after a youth enters a detention center or residential commitment program, and the youth’s juvenile probation officer (JPO) has made a reasonable attempt to obtain test results from outside providers, the two-step tuberculin skin test shall be administered in detention or the residential commitment program (if youth was on community corrections status).

2. All facilities and programs shall develop operating procedures to ensure that youth who have received PPD skin tests (unless medically contraindicated) and whose skin tests results/interpretations can be retrieved and included the youth’s Individual Health Care Record do not receive duplicative skin tests, unless their respective medical conditions, history, or other findings by the practitioner suggest a need for the two-step PPD.

3. Tuberculin skin testing using 0.1 mL of 5 tuberculin units of purified protein derivative shall be utilized when testing for TB infection. Multiple-puncture tests (e.g. tine test) shall not be used. Youth who have a documented history of a positive PPD/TST result, history of TB disease, or a reported history of a severe necrotic reaction to tuberculin shall be exempt from a routine PPD/TST. Youth with a history severe necrotic reactions and without a documented positive result with a millimeter reading, shall have a QFT-G blood test to substitute for the PPD/TST.

4. A facility may choose to implement a Physician standing order for the administration of PPD to youth being admitted to a facility. Otherwise, the administration of the skin test must be pursuant to a youth-specific order by the Designated Health Authority, or designee, PA or ARNP. If the facility operating procedures are to take the youth to the local county health department (CHD), it is not required that an order is written.
in the youth’s DJJ Individual Health Care Record. However, the youth’s Individual Health Care Record must be provided to the CHD staff. The results of the skin test should be recorded on the departmental form (ICD), regardless of the (medical) provider.

5. A trained and proficient, licensed health care professional (LPN, RN, ARNP, PA, Physician) shall administer the TB skin test and interpret the reaction 48 hours after the injection by measuring the area of induration (e.g. palpable swelling) at the injection site. The diameter of the indurated area shall be measured across the width of the forearm. Erythema (redness) of the skin should not be measured. All reactions, even those classified as negative, should be recorded in millimeters of induration, (e.g. 0 mm). The test results shall then be documented on the Infectious and Communicable Disease form and on the facility Tuberculosis Testing Log.

6. A PPD/TST reaction of greater than 10mm induration is considered a positive result in youth. However, an induration of greater than 5 mm is considered a positive result in the following persons:

- Persons infected with HIV;
- Youth or employees with fibrotic changes on a chest x-ray consistent with previous TB disease;
- Individuals who have had recent contacts with someone that has TB disease;
- Organ transplant recipients and individuals with other immunocompromising conditions (e.g. persons receiving greater that 15mg/day of prednisone for greater than one month;
- Anyone suspected of having TB disease.

7. For any youth that has a positive PPD/TST result and no symptoms suggestive of TB disease, the Physician or designee, PA or ARNP shall be notified and an order obtained for a chest x-ray to be performed as soon as possible but no longer than 24 hours after the skin test is interpreted. Persons who have symptoms suggestive of TB disease shall immediately receive a medical evaluation and shall be placed in an Airborne Infection Isolation Room or outside in the open air provided the youth can be accompanied) while awaiting evaluation or transport.

8. PPD/TST skin testing is not contraindicated for persons who have been vaccinated with BCG, and the PPD results of such a person shall be used to support or exclude the diagnosis of tuberculosis infection. A diagnosis of tuberculosis infection and treatment for latent TB infection should be considered for any BCG vaccinated person who has a positive PPD reaction.

D. **Two Step PPD/TST Skin Testing: Tier II**

1. The use of two-step skin testing shall be utilized to reduce the number of positive PPD/TST skin tests that would otherwise be misclassified as recent skin test conversions during future periodic screenings.
2. Two-step testing, a second PPD/TST skin test, shall be conducted for youth who report no PPD skin test within the past year. Additionally, a youth that tests positive to initial and/or annual PPD/TST skin test shall be administered a second PPD seven days following the PPD that has been identified as being positive.

3. Retesting of youth who have a documented negative test result on file from within the past 12 months should not be routinely conducted at any admission (or re-admission) unless there is reason to believe that the youth has been exposed to active, infectious tuberculosis and/or the youth otherwise meets one of the following high-risk criteria:

✔ Recent immigrant (within the last 5 years) from TB endemic area.
✔ Frequent visitor to TB endemic area.
✔ Frequent contact with adult who is at high-risk for disease.
✔ Resides with individual(s) who have active disease.
✔ Has a medical condition that increases the risk of progress from infection to disease (e.g., immunosuppression, hematological or other malignancy).
✔ Has recently been placed in a short-term, high-risk jails or adult residential commitment program facility (i.e. youth 18yrs. of age transferred from jail to juvenile detention center).

**NOTE:** The phrase, “short-term, high-risk facility” refers to jails and residential commitment programs that detain or house adults. It does not include detention centers and residential commitment program commitment programs that house only children and adolescents.

4. Repeat PPD tuberculin skin tests administered to youth, who already have a prior negative PPD test on file, must be ordered by the facility’s Designated Health Authority or designee (must be a Physician, P.A., or ARNP).

E. **MEDICAL EVALUATION AND TREATMENT FOR TB**

1. The medical evaluation and treatment of latent or active TB shall be the responsibility of the Designated Health Authority or designee. The physician shall collaborate with the local Department of Health in the medical management of a youth for TB disease and shall provide medical treatment in accordance with the Department of Health and Center for Disease Control standards and regulations.

2. The Designated Health Authority or designee shall be responsible for the reporting all youth with confirmed TB disease to the Department of Health. The departmental facility shall utilize the Department of Health reporting form to report TB infection in accordance with DOH policy and procedures.

*(The Disease Report Form can be found at the Florida Department of Health website, Epidemiology link: http://www.doh.state.fl.us/disease_ctrl/epi/index.html.)*
3. If the youth is prescribed anti-tuberculosis medication, this should be noted on the Infectious and Communicable Disease form. Additionally, the actual administration of TB medications should be documented on the Medication Administration record (MAR).

F. RESPIRATORY PROTECTION

1. Each facility shall develop, implement, and maintain a respiratory protection program for health care workers or other staff who use respiratory protection as required by the U.S. Occupational Safety and Health Administration (OSHA) and Center for Disease Control.

2. The required (OSHA) components of the Respiratory Protection Program include:
   - Assignment of responsibility
   - Youth and Employee training
   - Respiratory Protection

3. NIOSH (National Institute for Occupational Safety and Health) approved disposable particulate TB respiratory mask without exhalation valves, labeled N, R, or P, shall be utilized to provide respiratory protection to youth and staff to facilitate the prevention and transmission of Tuberculosis. Each facility shall maintain a supply of small, medium, and large mask to assure the availability of proper size mask for all youth and employees.

4. Individual mask fit testing (done individually or in groups) shall be performed by the facility nurse at the time that the mask is provided to the youth or employee. The licensed health care professional or trained staff member shall assure that the youth and/or employee receives a mask that appropriately fits in accordance with manufacturer’s standards for use.

G. ENVIRONMENTAL CONTROLS

1. Environmental controls shall be used to remove or inactivate tuberculosis in areas in which the organism can be transmitted. Primary environmental controls consist of controlling the source of infection by using local exhaust ventilation and diluting and removing contaminated air by using general ventilation. These controls help prevent the spread and reduce the concentration of airborne infectious droplet nuclei (see glossary). Secondary environmental controls consist of controlling the airflow to prevent contamination of air in areas adjacent to the source (negative pressure air flow rooms) and cleaning the air.

2. Each detention and residential commitment program facility shall have written TB environmental infection control plans as applicable to a given facility. The detention superintendent and/or residential program director shall be responsible for the
development and implementation of TB environmental controls in accordance with Center for Disease Control, OSHA, and Department of Health rules and regulations. (Refer to CDC MMWR report Prevention and Control of Tuberculosis in Correctional and Detention facilities, 2006).

3. Regional Detention or Residential staff shall be notified of any youth with active TB in a detention center or residential commitment program to determine if the facility is adequately equipped for a youth with TB.

H. TRANSPORTATION

Youth with suspected or confirmed infectious TB disease shall be transported by an ambulance whenever possible. Respiratory precautions shall be maintained when transporting a youth with suspected or confirmed infectious TB disease. Drivers or other persons who are transporting these youth in a closed vehicle shall wear a disposable respirator mask. If the youth has signs or symptoms of infectious TB disease the youth shall wear a TB particulate respirator mask during transport and when around other persons. Any bio-hazardous materials shall be disposed of appropriately.

I. TRANSFER TO ANOTHER FACILITY

1. If a youth receives a PPD test, but is to be released from detention prior to reading and interpreting the test result, the youth’s JPO and the parent/guardian shall be informed that the youth should report to the local CHD for reading of the test with specific instructions on the date and location for the interpretation.

2. In the event that the youth does report to the CHD as directed, the telephone report from the nurse at the CHD where the test is read to the nurse at the detention center from which the youth was released is acceptable, for record purposes.

3. If a youth was released from detention prior to having the PPD skin test administered, the residential commitment program at which the youth is placed may accept the youth, as long as symptom screening from detention is on file in the Individual Health Care Record (or Commitment Packet) and symptom screening is conducted upon admission to the residential commitment program. The residential commitment program shall be responsible for having the youth tested. The residential commitment program shall develop facility-operating procedures (FOP) to ensure that youth who have never received a PPD skin test receive them, within appropriate timeframes.

4. If a youth has received a tuberculin skin test, but is transferred directly from detention to a residential commitment program prior to the test's interpretation, the transferring facility nurse shall notify the receiving facility nurse by telephone to facilitate the timely reading of the youth’s PPD skin test. If a youth is housed in a detention center during transport the interpretation shall be performed there as warranted. It shall also be noted on the Health Discharge Summary/Transfer Note.
J. DISCHARGE FROM DEPARTMENT OF JUVENILE JUSTICE

The facility shall notify the Department of Health of any youth with suspected or confirmed active TB disease that is being discharged from the Department of Juvenile Justice custody. A youth receiving medication therapy for latent TB infection shall be referred to the local county health department upon release into community.

VII. THE HEALTH RELATED HISTORY

Chapter 5 entitled “Health-Related History and Comprehensive Physical Assessment” outlines in detail the process for conducting or reviewing the admission history.

Generally, the Health-Related History (HRH) shall be conducted or reviewed by a nurse through interview of the youth and then made available to the practitioner (Physician, PA, or ARNP) prior to conducting or reviewing the Comprehensive Physical Assessment (CPA). The practitioner shall review the Health-Related History and indicate this on the CPA. Any time a youth is subsequently placed in another facility, a nurse, together with the youth shall review the Health-Related History. Corrections and revisions are made at this time and documented on the page reserved for this purpose. Nursing assessments, or a summary of the health-related issues of the youth, if applicable, are to be documented. At this time, Medical Alerts (See Section XV of this chapter for further details) based on this history are to be implemented according to the facility operating procedures, as applicable. The outside jacket of the record should be checked to ensure that allergies, name alerts (meaning two youth with similar names), the Para I TB test date (when obtainable), the word “Confidential” and other information is noted. The outside jacket can also be used to note the medical grade and the next due date for the Comprehensive Physical Assessment.

VIII. SCHEDULING YOUTH FOR A COMPREHENSIVE PHYSICAL ASSESSMENT

Refer to Chapter 5, Health Related History and Comprehensive Physical Assessment, which outlines in detail, the requirements of the Comprehensive Physical Assessment and the Medical Grade Classifications. Existing Medical Grades can and will change. To determine if, and when, a youth should be scheduled for a Comprehensive Physical Assessment, the following guidelines can be followed:

A. MEDICAL GRADE UNDETERMINED

If the Medical Grade has not been determined or is not known at the time of this admission and the youth does not indicate any acute (new) or chronic (existing) injuries or illnesses or require medications, the youth must be scheduled for and receive a Comprehensive Physical Assessment, 7 (seven) calendar days of admission to a facility.

The Comprehensive Physical Assessment must always be completed prior to a youth’s release from a detention center pending placement or transfer for placement.
B. **MEDICAL GRADE 1**

1. If the youth has had a prior admission, check the Individual Health Care Record to determine if there is a current CPA on file. The CPA may also be in the Commitment Packet. If the CPA is in the Commitment Packet, it should be moved and filed in the IHCR.

2. The *Comprehensive Physical Assessment* is current if performed within the last two years.

3. Current CPAs must be reviewed, initialed, and dated as reviewed by the receiving facility’s Designated Health Authority or designee, PA or ARNP who is providing primary care at the facility.

4. If a *Comprehensive Physical Assessment* has not been performed or is not current then the youth shall have a CPA as soon as possible but no longer than (7) seven calendar days of admission.

5. A physical assessment may also be repeated at a practitioner’s discretion, using the Department’s standardized form, or a focused medical evaluation may be conducted by the practitioner and documented in the chronological progress notes (there is no standard form for a focused medical evaluation).

C. **MEDICAL GRADES 2, 3, 4, 5**

1. If the youth has had a prior admission, check the Individual Health Care Record to determine if there is a current CPA on file. The CPA may also be in the Commitment Packet. If the CPA is in the Commitment Packet, it should be moved and filed in the IHCR.

2. The *Comprehensive Physical Assessment* is current if performed within the past 12 months.

3. Youth who have been assigned these medical grades will have a *Comprehensive Physical Assessment* conducted at least annually.

4. Current CPAs must be reviewed, initialed, and dated as reviewed by the receiving facility’s Designated Health Authority or designee, PA or ARNP who is providing primary care at the facility.

5. If a *Comprehensive Physical Assessment* has not been performed, or is not current, then the youth shall have a CPA as soon as possible but no longer than (7) seven calendar days of admission.

6. A *Comprehensive Physical Assessment* may also be repeated at the practitioner’s discretion, using the Department’s standardized form. Alternatively, a focused
medical evaluation may be conducted by the practitioner and documented in the chronological progress notes (there is no standard form for a focused medical evaluation.

D. PHYSICIAN REFERRAL TRACKING

All referrals to the Physician, PA or ARNP, (regardless of origin or type) are to be tracked on the Sick Call/Referral Log (or a facility log specifically dedicated for this purpose) with the date of the appointment listed. A designated individual must be assigned to check the log no less than two times weekly to assure that all referrals are accomplished. This individual must initial the log whenever it is checked and when a youth’s referral is accomplished.

IX. MEDICATION VERIFICATION AND PROCUREMENT UPON ADMISSION

A youth’s medication regimen must be ascertained upon admission to a secure detention center and/or a residential commitment program. Communication on admission, with the existing community practitioners is a critical component of this process. (For further details, please refer to Chapter 11: Medication Management.)

X. CONSENT REQUIREMENTS (REFER TO CHAPTER 4: CONSENT AND NOTIFICATION REQUIREMENTS)

When a youth is admitted to a detention center or residential commitment program, a current signed, witnessed and dated Authority for Evaluation and Treatment Form should be available either in the existing Individual Health Care Record, the Commitment Packet or from the JPO. The JPO and JPO Supervisor shall be contacted if the AET is not available. It ultimately shall be placed in the Individual Health Care Record.

XI. IMMUNIZATION / VACCINATION ASSESSMENT (REFER TO CHAPTER 4: CONSENT AND NOTIFICATION REQUIREMENTS)

The process of determining a youth’s immunization history and status should begin at the time of admission to the facility. Immunization records should be gathered from parents or guardians, school records or available on-line resources, such as www.doh.state.fl.us, My Florida Shots link to determine if any vaccinations are warranted.

As a youth must be fully vaccinated, (unless contraindicated for religious or medical reasons), in order to attend school, records should be verified as soon as possible. The facilities have a thirty-day grace period from the time of admission, to obtain and verify records and subsequently provide necessary vaccinations (with parental/guardian consent).

Refer to Chapter 4: Consent and Parental Notification for further information on parental consent and the necessary process to follow when a parent or guardian is unavailable to provide consent.
XII. INFECTION CONTROL: LICE AND SCABIES

Each youth shall receive a visual assessment by detention center or residential commitment program staff for body lice and scabies prior to being placed in the general population.

A. **LICE (PEDICULOSIS)**

Head Lice and/or the lice eggs can be visually seen in the body hair. Lice are very small black insects that leave clear round eggs attached to the hair shaft. There are times that only eggs can be visualized. Frequently the youth will experience itching of the scalp.

It is not required or recommended that prescription medicated shampoo or body wash for “de-lousing” be used routinely on every youth with each admission. DJJ facilities may not prohibit youth from attending school pending clearance from head lice. In no case, shall there be routine prescription de-lousing for all youth. *(For treatment of Lice, refer to Chapter 14: Infection Control).*

B. **SCABIES**

Scabies frequently is only detected by a fine red body rash found predominately in the body creases and on the abdomen. The youth, in most cases, will experience itching of the affected body region. *(For treatment of Scabies, refer to Chapter 14: Infection Control).*

XIII. EXERCISE

A. If during the admission process, a staff member or nurse has concerns about a youth’s ability to tolerate routine or strenuous exercise based on information provided on the Facility Entry Health Screening, or Health-Related History, the youth shall be placed on restricted activity until medically cleared by a Physician, PA or ARNP.

Examples of such instances may include, but not be limited to, the following:

- Family History of Sudden Cardiac Death
- Shortness of breath, at rest, or with minimal exertion
- Profuse perspiration
- Chest pain, palpitations
- Acute Injury
- Complaints of physical ailments
- Obesity
- Chronic medical conditions
- History of syncope (fainting) at rest or while exercising
- Hypertension
B. If the existence of a medical condition, on admission, warrants the notification of the DHA or designee, then that youth should be restricted from activity until cleared by the DHA (in person or after a telephonic review).

C. The routine performance of a resting Electrocardiogram (EKG) for all youth in detention facilities and standard residential commitment programs (ones that do not use intense exercise as a component of the program) is not recommended. An EKG or serial EKGs should only be performed after a thorough history and physical exam that then raises concerns for a personal or family history of heart disease or complaints. The facility DHA or Physician designee, PA or ARNP shall determine the need for an EKG. For further details, please refer to Chapter 13, Environmental and Exercise Precautions.

XIV. DETERMINING VULNERABILITY OR PREDATORY BEHAVIOR

Facility operating procedures must be in place that enables the nurse who is admitting the youth to have access to a youth’s vulnerability, victimization, or predatory behavior scores as applicable, subject to the approval of the Department’s Prison Rape Elimination Act (PREA) policy. These scores may be recorded on the Problem List if the scores indicate a possible problem.

If the youth has a score that indicates there may be a high risk of vulnerability or victimization, the practitioner who provides care to the youth at any given point may include that information (the score) with his/her assessments as to the subsequent necessary interventions (e.g. Sick Call, Physician Referral, Emergency Care, etc.).

XV. MEDICAL ALERTS

The medical alert system is part of a facility’s overall alert system, to alert staff when mental health, medical or security issues exist which may affect the security and safety of the youth in the facility. The alert system is intended as a tool for staff to use in making treatment, security, and safety decisions as they relate to youth behavior and monitoring needs. It will not provide detailed information about the conditions that resulted in the youth’s inclusion in the alert system.

Each facility may design this system according to its needs. A system of this nature consists of maintaining a current list of youth who have medical needs that require close monitoring and attention by health care and direct care staff. A designated individual shall be responsible for updating this list daily and distributing it to all living units. This will provide the staff with a quick reference in the event that an unexpected situation arises with a youth.

A. PLACING A YOUTH ON MEDICAL ALERT

1. The decision to include a youth in the alert system due to medical issues or concerns should be made by the health care staff, if they are on the premises. However, non-health care staff may also identify the youth for inclusion in the alert system based on
information obtained during intake screening, upon return from an off-site medical appointment or as the need may arise.

2. The medical alert system is intended to be highly flexible and serve as a quick reference for staff to use in the event that an issue arises which might affect the youth’s health, safety, or daily staff interactions. Essentially, the medical alert system is a roster of youth’s names that have or may have a high-risk condition. This condition may be permanent, (for example, all diabetic youth will be placed in the facility’s medical alert system), or it may be temporary, (for example, the youth seen in sick call with symptoms of fever and nausea, placed on medical alert for 24 hours as a reminder for direct care staff to check on him periodically).

B. EXAMPLES OF CONDITIONS TO WARRANT PLACEMENT OF A YOUTH ON MEDICAL ALERT

1. Allergies/Anaphylaxis: The youth has any known medication, food, insect, plant or animal allergies. Specific allergies should be listed along with the youth’s name (Permanent placement).

2. Medication Interactions: The youth is prescribed medications that have the potential for adverse interactions if given with certain over-the-counter medications. The over-the-counter medication that is prohibited will be listed (Permanent placement).

3. Head Trauma/Injury: Within the preceding two weeks, the youth has sustained a head injury of any sort, whether or not an evaluation was obtained by a physician. For this alert, the potential complications of the injury should be listed (Blurred vision, nausea, vomiting, etc).


5. A Chronic Medical Condition or Disability (Permanent Placement): The youth has any of the following conditions; (this is not an all-inclusive list):

- Asthma
- Cancer
- Diabetes
- Dialysis
- Hearing Impairment
- Hemophilia
- Prothesis
- Seizure Disorder
- Sickle Cell Anemia
- Speech Impairment
- Tuberculosis
- Visual Impairment
- Any other chronic condition of which the Staff should be aware
6. **Medication Side Effects:** The youth is on a medication that has significant side effects for which the staff should monitor and then report to medical personnel (i.e. low blood pressure with positional changes, risk for bleeding, increased heart rate etc). This shall be at the discretion of the prescriber.

7. The youth has activity limitations or sport restrictions due to medical conditions or injuries.

8. The youth is aggressive and/or sexually acting out and presents a risk of harm to other youth.

9. Upon the direction of an off-site provider.

10. If the youth has demonstrated that he/she is a cheeker/palmer of medications.

11. Upon the direction of the facility superintendent/program director, or shift supervisor.

12. Upon the direction of the Designated Health Authority or designee, PA or ARNP providing services at the facility.

C. **Exclusions from the Medical Alert System**

Youth with a diagnosis of HIV/AIDS should not automatically be placed on the Medical Alert list as Florida Law has specific disclosure requirements. Pursuant to Chapter 381 F.S., HIV test results can be disclosed only to the youth and to the following entities:

- The youth’s legally authorized representative;
- Health care providers during the course of consultation, diagnosis or treatment of the individual;
- The Department of Health for purposes of reporting and control of spread of disease.
- Health facility staff committees that conduct program monitoring, evaluation, and service reviews.
- Medical personnel who have been subject to a significant exposure.
- Health care facility personnel or agents for the health care provider who have a need to know in the course of patient care activities or administrative operations.

The youth’s medical status should not be released, divulged, or discussed by anyone without the youth’s permission or when the above circumstances exist. After obtaining the youth’s permission, this information shall be conveyed to those who have a relevant need to know. The youth should sign a consent/release form for the release of this information to the individuals who are then listed in writing. Those seeking to obtain the consent shall explain to the youth the purpose of the release. The facility’s policy should clearly reflect awareness that youth who are HIV positive shall not have automatic placement on the Medical Alert list.
XVI. ORIENTATION OF YOUTH TO A FACILITY’S HEALTH CARE SYSTEM

Upon admission or at the next available opportunity, youth are to be oriented to the general process of health care delivery services at a given facility, preferably by a nurse. Each facility shall have an FOP that includes provisions for youth who are hearing or visually impaired, and for youth who are cognitively impaired. A variety of methods should be used, such as one-to-one education, orientation videos, pamphlets, going over the sick call request form, etc. Orientation must be provided in Spanish as well as any other language that youth uses as a primary language. For youth with cognitive defects, the school district personnel (or teachers employed by the facility) should provide information as to how to present this information to youth who are impaired.

The Orientation includes, but is not limited to:

A. Use of Sick Call for medical and dental complaints;
B. Means of accessing Sick Call, (including dental complaints);
C. What constitutes an “emergency”;
D. When and in what manner medications are administered;
E. The need to notify staff immediately if they are having side effects from medications;
F. The need to remind any staff member about their allergies and/or medical alert issues if the situation arises;
G. The need to notify staff of any chest pain, extreme shortness of breath, faintness while exercising;
H. The right to refuse care;
I. What to do in the case of a sexual assault or attempted sexual assault (immediate notification of staff, not showering, changing clothes or brushing teeth, etc.);
J. The non-disciplinary role of the health care providers;
K. Situations in which the health care staff will notify security and/or facility administration (being disrespectful or threatening to staff, being disruptive in the medical/nursing area or during the medication administration pass, and “cheeking,” “palming,” or otherwise hoarding medication for any reason);
L. Review of the list of Health Care Contacts to ensure accuracy.

Each facility shall develop a form to facilitate documentation of youth’s acknowledgement of his or her orientation to the facility’s health care system. The youth receiving orientation and the staff member providing the orientation shall sign and date the acknowledgement. This shall be filed in the education component of the Individual Health Care Record.
I. INTRODUCTION

The purpose of the consent process is to ensure that, to the fullest extent possible, parents and/or legal guardians are afforded the right to give or withhold consent with regard to the health care provided to their children. The consent also serves to afford youth who are in the physical custody of a Department of Juvenile Justice facility or program the opportunity to give consent after being duly informed, (including the right to refuse treatment, when applicable), in accordance with federal and state laws. Additionally, as the Department is committed to keeping the parent or guardian informed of and engaged in the health care provided to their children, an extensive notification process exists and is described in this chapter as well.

This chapter outlines Departmental requirements regarding the general authorization for the provision of necessary and appropriate health care services to youth in the physical custody of a DJJ facility. Such authorization is to be used in conjunction with required notifications to the parent/guardian when applicable health care services are ordered or provided.

II. SCOPE OF THE AUTHORITY FOR EVALUATION AND TREATMENT

A. GENERAL

The Authority for Evaluation and Treatment (AET) is the Department’s general consent form authorizing specific treatment for youth in the custody of the Department. For the purpose of the AET document, Departmental custody includes those DJJ facilities where youth are housed 24 hours per day, such as, Detention Centers and Residential Commitment Programs. Additionally, the AET also provides limited authority for youth in DJJ facility-based non-residential programs.

This form is a required and critical document to ensure that a youth’s health and mental health needs can be met and services can be rendered. To take effect, it necessitates the signature of the parent or legal guardian. Without the necessary signature, the provision of these services requires a court order. However, under no circumstances shall emergency services be withheld pending an unsigned AET.

B. SERVICES AUTHORIZED IN 24 HOUR PER DAY FACILITIES

1. Physical Examinations including:

   ✓ Evaluations to determine if a youth is ill or requires medical treatment;
   ✓ Obtaining a complete medical and mental health history;
Testing for drugs or alcohol;
Blood, urine, TB or other tests necessary for a complete physical examination;
Dental examinations and emergency dental procedures;
Vision and Hearing screening;
Gynecological examinations.

3. Treatment for illnesses (current and those that develop while in custody).
4. Mental health assessments, testing and treatment deemed necessary by mental health professionals.
5. Continuance and administration of existing medications.
6. Administration of the following over the counter medications: Acetaminophen (Tylenol), Ibuprophen (Motrin, Advil), Pepto-Bismol, Milk of Magnesia, Maalox, Triple Antibiotic Ointment.
7. Administration of over-the-counter and prescription medications by trained non-health care staff.
8. Access to relevant medical and mental health records.
9. Vaccinations, as long as the parent/guardian is provided with the appropriate Vaccine Information Statements at the time of signing the AET and initials consent accordingly.

C. ITEMS NOT IMPLICITLY AUTHORIZED BY THE AET

1. Vaccinations (See II.B.9. Above);
2. Choice of health care, mental health, and dental providers, by a youth’s parent or guardian.

D. SERVICES AUTHORIZED IN FACILITY-BASED NON-RESIDENTIAL PROGRAMS

1. Administration of prescription medications provided by the parent;
2. Emergency services while the youth is at that facility.

E. SERVICES PROHIBITED UNDER ALL CIRCUMSTANCES

1. Sterilization
2. Electroshock therapy
3. Psychosurgery
4. Experimental treatment
5. Withholding or withdrawing life support

F. SUBSTANCE ABUSE SERVICES

The Authority for Evaluation and Treatment does not give DJJ authority to assume responsibility for the provision of substance abuse evaluation and treatment services to
a youth within its custody. This youth must sign his/her own consent for these services. (See DJJ Mental Health and Substance Abuse Services Manual.)

III. OBTAINING SIGNATURES ON THE AET

A. The DJJ Juvenile Probation Officer (JPO) is responsible for ensuring that the Authority for Evaluation and Treatment (AET) is signed and dated by the parent or guardian and then forwarded to the location where the youth is in custody (facility-based non-residential program, detention center or residential commitment program) in order that the original, signed, dated, and witnessed document can be filed in the youth’s Individual Health Care Record (IHCR). If the youth is at home pending placement, the signed AET shall be forwarded to the location of the IHCR (or the Commitment Packet, pending eventual inclusion in the IHCR). The standardized AET will be signed by the parent/guardian at the first available opportunity. The JPO shall bear witness to the parent’s signature. Thus, it shall be completed during the initial intake conference, or when the youth who does not have an open case is presented for detention screening. If the parent/legal guardian is available, the youth’s juvenile probation officer (JPO), contract screening staff, or staff at the detention center must explain the AET to the parent/legal guardian, and obtain the signature.

B. If the parent or legal guardian is not available during detention screening, the assigned JPO needs to schedule an intake conference with the parent/legal guardian as soon as possible to complete the AET.

C. The DJJ representative who obtains the parent/legal guardian signature on the AET is responsible for reviewing the basic components of the document with the parent using the “Guidelines for Obtaining Parental Signature on AET” (See Forms Appendix.)

D. As the AET is a core document in the commitment packet, the JPO supervisor is responsible for ensuring that this packet is complete prior to a youth’s arrival at a facility. If the youth arrives at a detention center or residential commitment program without a signed AET, the facility administrator or designee is to immediately contact the respective JPO Supervisor for assistance. If this person has a copy on file, that is an acceptable replacement once forwarded. The detention and residential staff shall also use every opportunity to obtain a parental signature. Again, the basic components of the AET must always be reviewed.

E. In the event that a parent/guardian refuses to sign the AET or cannot be located after all reasonable attempts have been made, the Department’s regional general counsel should be contacted to pursue a court order.

IV. DURATION OF THE AUTHORITY FOR EVALUATION AND TREATMENT

A. The AET is valid for as long as the youth is under any type of supervision, custody or other form of legal control by the Department; OR, for one year after it was signed by the parent/legal Guardian, whichever comes later, OR until the youth’s 18th birthday. Legal
control shall include probation and conditional release. The parent, legal guardian, or court may revoke or modify the AET at any time.

1. A new AET is not required when a youth has been transferred from one DJJ facility to another, as long as there have been no new modifications or revocations.

2. If the AET has expired at the time the youth re-enters the physical custody of the Department (that is, the youth has been under no form of supervision, control, custody, or legal control by the Department AND more than a year has lapsed since the signing of the first AET), the JPO must obtain parental signature on a new AET, following the steps above.

3. If the youth who has been released from DJJ physical custody and off all supervision commits an offense which brings him/her back under supervision or control, the original AET CAN be used as long as it was signed less than 1 year prior.

4. When a youth who turns 18 remains in the custody of the Department, the AET signed by the parent is immediately invalidated. The youth must sign a new AET for Youth 18 Years and Older consenting (or withdrawing consent) for him or herself. At this time, information may be provided to the parents only with the youth’s authorized and explicit written consent. The regional general counsel’s office must be consulted if this is the case for a developmentally disabled youth.

V. REVOCATION OF THE AUTHORITY FOR EVALUATION AND TREATMENT

An Authority for Evaluation and Treatment (AET) can be revoked in its entirety, or the revocation can apply to certain treatment or services. For example, a parent or guardian could rescind authorization for all mental health or physical health treatments, or for only a specific procedure or service. Revocation of the AET for only a specific service does not affect the validity of the remainder of the AET for other authorized services.

A. The following procedures should be followed in documenting revocation or modification of an AET and obtaining a new AET.

1. If the Department is aware that the parent or legal guardian has orally revoked the AET, that revocation must be honored, and the verbal revocation should be documented thoroughly in the progress notes of the Individual Health Care Record, with a witness to the oral revocation, if possible.

2. Every reasonable effort should then be made to obtain a written revocation. If a written revocation from the parent or legal guardian cannot be obtained, but the parent has verbally revoked the AET, the Department’s regional counsel should be notified.
3. Once the Department is aware that there has been a verbal revocation, it cannot rely on the AET as the authority to provide any health or mental health services identified in the revocation.

4. If a situation arises, whereby a medical, mental health or dental practitioner determines that a previously revoked procedure or treatment is necessary for a youth, and the parent or guardian is unwilling, unable or unavailable to sign a new AET authorizing that service, then the Facility Superintendent, Program Director or designee will request that the regional general counsel’s office apply for a court order authorizing the Department to provide the necessary services.

VI. FILING OF THE AUTHORITY FOR EVALUATION AND TREATMENT

The signed and witnessed Authority for Evaluation and Treatment is to be filed in the youth’s Individual Health Care Record, in the section known as the “core health profile”. Should a subsequent Authority for Evaluation and Treatment be obtained this AET should be filed directly in front/on top of the prior AET. (If a court order was obtained because an AET could not be obtained, the court order shall be filed in the same fashion/order as the AET.)

VII. COPIES OF THE AET

The original AET shall be filed in a youth’s Individual Health Care Record. If, for some reason, the original AET is not placed in the Individual Health Care Record, a legible copy will suffice, as long as the word “COPY” is legibly hand-written or stamped. It is particularly important that outside health care providers are aware of the parental consent and thus should be provided with a copy of the original. The JPO should also maintain a copy of the AET in their files.

VIII. THE AET AND MEDICATIONS (REFER TO CHAPTER 11 MEDICATION MANAGEMENT)

A. Medications Prescribed Prior to Admission

The Departmental form, the Authority for Evaluation and Treatment (AET), when properly executed and signed by the parent or guardian, provides consent to give a youth medications. This consent serves as the parent/guardian’s permission to:

- Continue the administration of ALL current medications for which the youth has a verified prescription at the time of admission to a facility.

- Renew and refill current medications prescribed prior to admission, for the life of the prescription(s) as long as there are no changes in the total dosage or route.

Note: Prescription renewals still require an automatic medical evaluation by the DHA or designee, PA or ARNP to assess the youth’s status while on the medication.
B. **NEW MEDICATIONS PRESCRIBED SUBSEQUENT TO ADMISSION OR CHANGES TO EXISTING MEDICATIONS NOT INCLUSIVE OF PSYCHOTROPIC MEDICATIONS (FOR THESE REQUIREMENTS, REFER TO CHAPTER 12)**

1. After a youth has been admitted, parents or guardians shall receive a notification whenever one of the following three actions are taken by a prescriber (Physician, Dentist, PA, or ARNP):

   - Makes a significant change in the dosage of prescription medication(s), (which the youth was currently prescribed at the time of entering the physical custody of the Department). A “significant change” in dosage of a medication is any increase or decrease in dosage beyond a small increment or beyond the normal dosage for youth of similar age; or

   - Prescribes or otherwise orders a prescription medication which the youth was not currently prescribed at the time of entering the physical custody of the Department; or

   - Discontinues those prescription medication(s), which the youth was prescribed at the time of entering the physical custody of the Department or discontinues medications, which the youth has been prescribed since entering the physical custody of the Department.

2. The purpose of this notification is:

   - To advise the parent or guardian of the health care professional’s recommendations;

   - To instruct the parent, or guardian, to notify the facility/program if they would like to request additional information;

   - To allow the parent or guardian to notify the facility/program of concerns or objections to a medication.

3. The health care staff should make all reasonable efforts to initially inform the parent/guardian verbally (in person or by phone). All contact attempts and/or actual telephone conversations shall be documented in the chronological Progress Notes in the Individual Health Care Record by the person attempting and/or making contact with the parent/guardian. A staff member should witness all telephone call attempts and conversations. If an additional staff member is unavailable to witness these call attempts then the facility or program shall have an internal process by which the attempts are verified.

   *Note: Smaller programs (25 youth or less) may utilize ancillary, non-health care staff to notify parents/guardians as long as the DHA or designee, PA or ARNP is available for parental questions.*
4. Parental notification shall then be provided in writing (even if verbal notification was accomplished) on the standardized form, *Parental Notification of Health-Related Care: Medication Management*. Written notification shall be mailed as soon as possible, but no later than two calendar days after the facility/program receives the Physician, PA or ARNP’s medication orders. The written notice may be mailed via regular mail except in the case of psychotropic medications, which require certified mail with return receipt requested.

a. The form allows for the prescribing practitioner to request written parental consent prior to administering or changing a medication if they so choose. In this situation, the administration of the medication shall not begin until the parent/guardian is given a reasonable time period to provide consent.

5. If parental notification is sent, the *Authority for Evaluation and Treatment* serves as consent to administer the medication unless the parent or guardian notifies the Facility or Program that he or she objects to the medication.

6. If a medication requires an immediate modification or commencement then the medication shall be initiated.

7. Again, once a youth has entered the physical custody of a DJJ facility, the *AET* cannot be used as the authorization to begin newly prescribed medication(s), to make significant changes to the dosage of existing medication(s), or to discontinue current prescription medication(s) without the notification of the parent/guardian.

8. Copies of all notification(s) (and parental responses) will be filed in the youth’s Individual Health Care Record behind the *AET*.

C. OVER-THE-COUNTER MEDICATIONS (OTCS) THAT ARE AUTHORIZED BY THE AET

1. The signed *AET* authorizes the administration of the following over-the-counter Medications during sick call or other nursing encounters:

   a. Acetaminophen (Tylenol)
   b. Ibuprophen (Motrin, Advil)
   c. Pepto-Bismol
   d. Milk of Magnesia
   e. Maalox
   f. Triple Antibiotic Ointment

   All of the above medications shall be administered in manufacturer’s recommended doses.
D. OVER-THE-COUNTER MEDICATIONS (OTCs) THAT REQUIRE SPECIFIC PARENTAL NOTIFICATION

1. Written parental notification is required for the administration of any and all other over-the-counter medications administered per approved protocols or practitioner’s order.

2. In these circumstances, the parent or guardian shall be provided a one-time notification by the DJJ facility. The parent or guardian shall be given time to notify the facility if they object to the administration of the additional specified over-the-counter medications.

E. All OTCs are to be administered under the following circumstances:

1. Pursuant to specified protocols for Sick Call, to be administered by a Registered Nurse, or a Licensed Practical Nurse, (with the manner of supervision outlined on the facility operating procedures).

2. Pursuant to specified protocols (pre-approved by the Designated Health Authority) and administered by trained non-health care staff, from a limited, secured supply of medication that shall be located in the shift supervisor’s office or Master Control room with the appropriate safeguards.

IX. ADMINISTRATION OF REQUIRED AND ORDERED VACCINATIONS

A. The AET provides an opportunity for parental consent to be obtained for missing vaccinations. At the time of signing the AET, the parent or guardian shall first be provided with the relevant Vaccine Information Statements (VIS) in order to inform them of the potential risks and side effects. The VIS forms can be accessed at [http://www.cdc.gov/nip/publications/vis/](http://www.cdc.gov/nip/publications/vis/). If the parent or guardian provides consent after reviewing the VIS then they shall indicate such by initializing those sections on the last page of the AET.

B. If the VIS are not provided OR the parent or guardian does not consent to the vaccinations at this time then the Parental Notification of Health Related Care: Vaccination/Immunizations must be utilized at a later date with the required VIS in order to obtain consent.

C. All youth in DJJ facilities or programs must attend school, and to do so the facility has 30 days in which to obtain the consent for and administer necessary vaccinations. It is recommended that the attempts to obtain this consent occur as soon as the youth arrives at a facility and it is verified that immunizations are not up to date. For the administration of required and ordered vaccinations, the standard departmental form, Parental Notification of Health-Related Care: Vaccinations/Immunizations must be sent in advance, by certified mail, along with the appropriate Vaccine Information Statements (VIS). Written permission from the parent/guardian must be obtained on
this form prior to the administration of vaccines. The parents have ten (10)
calendar days to return the form. The type of VIS statement(s) and the publication
date of each VIS form sent to the parent must be noted on the written consent form
which the parent signs and sends back to the facility. These Vaccine Information
Statements will be available on the Department’s website under the Office of Health
Services.

Note: It may be useful to send the notification forms by certified mail and registered
mail simultaneously for better response rate.

D. A copy of the completed form related to the administration of vaccinations that is sent
to the parent/guardian must be filed in the youth’s Individual Health Care Record
directly behind the AET, in reverse chronological order. Upon receipt of the written
consent from the parent, the signed parental notification should also be filed in the
Individual Health Care Record, in the same section, directly behind the AET.

E. In cases where the Parental Notification of Health-Related Care: Vaccinations
/Immunizations form is not returned, the licensed health care staff must make three (3)
witnessed attempts to obtain verbal consent. A staff member who is not a licensed
health care professional may obtain consent if the facility does not have a licensed
health care provider on staff and the vaccinations are to be administered by an off-site
medical provider.

F. A witnessed telephone call means that at least one other staff member is present,
listens to what the caller states to the parent/guardian, and then speaks directly to the
parent/guardian, informs him/her that the facility’s policy is that telephone calls in
which health care consent or permission are given are always verified with the
parent/guardian. The witness also asks the parent if they understand what has been
stated. Both the original caller and the witness must legibly sign and print their names
on the note. If the caller is unable to reach the parent then this must be documented
as witnessed and signed accordingly. All attempts shall be thoroughly documented in
the chronological progress notes of the Individual Health Care Record.

G. If, after three (3) witnessed attempts to reach the parents/guardian have failed, then
the Designated Health Authority may authorize the administration of the vaccination(s)
pursuant to Florida Statute 743.0645. The DHA shall write an order and document in
the progress note of the Individual Health Care Record the circumstances warranting
this type of authorization.

H. In the event that an off-site provider is utilized to administer a vaccination, the mailing
of the notification, accompanied by the VIS, the obtaining of the written consent of the
parent/guardian or authorization by the Designated Health Authority, must take place
prior to the appointment for the administration of the vaccination.

I. If a parent/guardian claims exemption and does not consent to vaccinations for
religious reasons, then they must complete the “Religious Exemption from
Immunization” Form provided by the County Health Department, have it signed and authorized there and then submit this to the facility or program. Copies of the exemption shall be filed in the Individual Health Care Record.

J. If a parent/guardian does not consent to a vaccination for medical reasons, then a signed letter must be provided to the facility or program by the youth’s Physician indicating the reason for the exemption. Copies shall be filed in the Individual Health Care Record.

K. Youth who are exempt for religious or medical reasons shall be allowed to attend school.

X. THE AET AND PSYCHOTROPIC MEDICATIONS
(REFER TO CHAPTER 12: PSYCHOTROPIC MEDICATION MANAGEMENT)

For the prescribing of all psychotropic prescription medication(s), which the youth was not currently prescribed at the time of entry into the physical custody of the department, a copy of the 3rd page of the standard form, Clinical Psychotropic Progress Note (CPPN) shall be sent via certified mail to the parent/guardian at the address on record, after completion by the prescriber.

Under no circumstances is a youth to have a psychotropic medication commenced or changed without parental consent. A court order is to be pursued if parental consent cannot be obtained.

XI. ADDITIONAL REQUIREMENTS FOR WRITTEN CONSENT OF THE PARENT OR GUARDIAN

Additional written parental consent is required in certain circumstances. The respective health care professional(s) providing this care may utilize their standard forms. Otherwise, the Parental Notification of Health Related Care can be used for consent purposes. Examples of the types of respective care requiring additional, procedure-specific, written, informed parental consent include the following:

- Any time it is recommended that the youth be hospitalized (urgent hospitalization shall not be delayed);
- Any surgical procedure (with the exception of those types of procedures to which a youth may consent without parental knowledge);
- Dental services other than evaluations, routine prophylaxis and dental emergencies (e.g., dental extractions, fillings, endodontic services and periodontal services require additional parental/guardian consent);
- Any procedure or service of an invasive nature, for which one would reasonably assume that a parent would want to be informed and/or involved, (with the exception of those types of services to which a youth may consent without parental knowledge);
A. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever a youth has a chronic mental or physical health condition and a licensed health care practitioner has determined that a significant change has occurred in the chronic health condition of that youth. This shall not include those limited conditions to which, by statute, a youth can legally consent to screening, evaluation and/or treatment without the parent/guardian’s knowledge or consent (and which are to be protected from disclosure to the parent/guardian).

B. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever a youth has the same medical complaint in Sick Call, three (3) or more times during a two-week period.

C. A Parental Notification of Health-Related Care must be sent to the parent/guardian on any occasion in which the youth’s oral temperature equals or exceeds 102 degrees orally upon two sequential checks in one day, or the oral temperature equals or exceeds 102 degrees on two consecutive morning checks. An attempt should also be made to notify the parent by telephone.

D. A Parental Notification of Health-Related Care must be sent via certified mail to the parent/guardian if the parent/guardian has specifically prohibited certain types of care, or medication or requested that they be notified prior to the provision of certain types of care.

☐ Written permission from the parent/guardian must be obtained prior to the initiation of a treatment, which the parent has previously specifically prohibited. This may be in the form of a letter obtained from the parent/guardian, or facility staff may check the box on the bottom of the Parental Notification form, indicating that the parent is to sign the form and return it to the facility if the parent/guardian agrees to the care. Telephone consent should be attempted and documented. The Department’s regional general counsel should be notified if treatment is necessary and parent/guardian is unwilling or unable to consent.

E. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever the youth is taken off-site for medical treatment (for example, to a dentist, an emergency room, hospital or an off-site specialist). Exceptions include situations in which the reason for the transfer and treatment are related to the conditions which, by statute, a youth may consent to without parental knowledge or consent (assessment and treatment for sexually transmitted diseases, assessment/treatment for HIV/AIDS,
family planning services and those gynecological services that, in the opinion of the health care provider, are necessary for the health and well-being of the youth). In these situations, the youth must provide consent for the Department to notify the parent.

1. Telephone notification is required as soon as possible. When feasible, in the case of an upcoming appointment, telephone notification and mailing of the Parental Notification should be accomplished prior to the scheduled appointment date.

2. The written notice shall be sent regardless of the telephone notification.

3. In the case of a pregnant female, although statutorily the consent or notification of the parent or guardian is not explicitly required, the youth should be encouraged to allow this to occur. However, because of the Department’s unique responsibility for the health and safety of the youth and the unborn child, if the youth refuses, the facility superintendent, program director or designee shall consult with the regional general counsel’s office.

F. Written parental notification is required for the administration of all over-the-counter medications (OTCs) not specifically listed and consented for on the AET. These shall be administered per approved protocols or an order (unless the parent has prohibited the administration of OTCs on the Authority for Evaluation and Treatment in which case over-the-counter medications will not be administered).

G. Written parental notification is required if health care or facility staff determines that the parent guardian requires notification, regardless of the reason.

H. Mailing of a Parental Notification of Health-Related Care for visits is not required in the following situations:

- Youth who return for on-site follow-up of a sick call complaint at the instruction/direction of a Physician, PA, ARNP or RN where the condition is resolving;

- Youth who report to sick call for complaints, which are of such a nature that they are statutorily protected from disclosure to parents/guardians (e.g., evaluation/treatment of sexually transmitted illnesses/diseases);

- Youth who present to sick care for hygiene-related requests.

I. Written parental notification is not required for treatment or services which are court ordered.

J. All copies of the Parental Notification of Health-Related Care sent to the parent/guardian, and the returned form with the parent’s signature must be filed in the
Individual Health Care Record in the section reserved for parental notices, directly behind the Authority for Evaluation and Treatment, in reverse chronological order (most recent Parental Notification on top in that section).

XIII. WHEN PARENTAL NOTIFICATION OF HEALTH-RELATED CARE CANNOT BE ACCOMPLISHED BY TELEPHONE OR MAIL

When parental notification cannot be accomplished through telephone contact or by mail, the DJJ facility superintendent, program director or designee must contact the youth’s juvenile probation officer (JPO) and request that the JPO visit the parent or legal guardian for the purpose of providing the necessary parental notification. The JPO must document all efforts to provide parental notification to the parent or legal guardian.

XIV. PARENT NOTIFICATION WHEN THE YOUTH’S ILLNESS, INJURY OR SUICIDE ATTEMPT REQUIRES EMERGENCY MEDICAL SERVICES OR IS LIFE THREATENING

When the youth’s illness or injury requires emergency medical services or is life threatening, (after necessary medical treatment is obtained for the youth), the facility superintendent or program director must make every effort to immediately notify the parent/legal guardian. In the absence of the facility superintendent/program director, a person authorized in writing by the facility superintendent/program director to contact the parent/legal guardian regarding the emergency services will document the contact attempts and the documentation will be co-signed by the facility superintendent/program director. If the parent or legal guardian cannot be contacted, the following steps must be taken:

A. Use alternative contact methods as documented in the youth’s record. Such alternative methods may include, but are not limited to, contact via the parent’s or legal guardian’s work address, pager/cell phone or electronic notification or contact via a relative or neighbor.

B. Contact the youth’s juvenile probation officer to request assistance with notification. In the case where the youth’s family lives in close proximity to the JPO’s work location or area, request that the JPO drive by the parent’s or legal guardian’s home, place of work, school or other known location outside of the home.

C. Contact law enforcement to request assistance in locating the parent or legal guardian.

D. In all cases, the facility superintendent or program director must document all efforts to contact the parent or legal guardian.

XV. THE AET FOR THE RELEASE OF INFORMATION

A. When properly signed, the AET serves as a release of information. It serves as the Department’s authority to provide information to other health care providers that are or will be treating a youth. It is also a standard release to outside health care providers
for releasing medical records and relevant information back to the Department and DJJ facilities.

B. Whenever a youth is taken off-site to a health care provider, the health care provider shall be presented the original or a current copy of the signed AET, so the health care provider may provide information to the Department on the Summary of Off-Site Care, and provide any other instructions/orders necessary for the health care of the youth (e.g., discharge instructions, consultative reports, and the like).

C. In the event that the youth is taken to a health care provider for medical care and treatment that has been specifically court-ordered (in lieu of the AET, because the parent/guardian refused or was unavailable to sign the AET), a copy of that court order shall be furnished to the health care provider.

XVI. HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Part of this legislation, Title II known as Administrative Simplification, required that national standards be established for:

1. Data content and format for electronic health care transactions;
2. Privacy of confidential personal health care information;
3. Security and physical access to health care records; and
4. National identifiers for providers, employers, and health plans.

B. HIPAA established new health privacy rights, enforced by the Office for Civil Rights and, to ensure these rights, the Privacy Rule requires certain entities, who routinely handle protected health information, to:

1. Limit uses and disclosures of protected health information;
2. Develop reasonable safeguards, policies and procedures to protect privacy of health information;
3. Train personnel in the policies and procedures and document completion;
4. Designate personnel to handle health privacy violation complaints and issues;
5. Notify individuals about privacy practices and their health privacy rights;
6. Keep track of certain disclosures of protected health information not authorized by the individual or related to treatment, payment or health care operations.

C. However, the Department of Juvenile Justice and all contracted service providers operating under its authority are “correctional institutions” under HIPAA. As such, covered entities (e.g. health and mental health providers, hospitals, etc.) may disclose protected health information to the Department, and those acting under its authority, pursuant to 45 C.F.R. § 164.512(k)(5), without consent or authorization from the youth, his/her parent or guardian.
D. Thus, youth in the Department’s custody are exempt from HIPAA requirements. This means that disclosure of protected health information contained in a youth’s health care record is necessary and allowable for:

- The youth’s treatment;
- The health and safety of the youth or others in custody;
- The health and safety of officers, employees, law enforcement at the facility;
- The administration and maintenance of the safety, security and order of the facility.

E. Thus, in the above situations, the information can be shared, without prior authorization by the youth or parent:

- Between relevant DJJ personnel
- Between physicians, hospitals, offices, clinics, DJJ personnel or DJJ contracted providers

Note: Under the HIPAA Rule, “protected health information” is all individually identifiable health information that is created, received or maintained by a covered entity, regardless of its form, that relates to the past, present or future physical or mental health or condition of an individual or the provision of, or payment for, health care to an individual, living or dead.

F. Pursuant to federal HIPAA and CDC regulations, information related to a youth’s HIV status shall not be released without the youth’s specific consent.

G. With regard to access to records, the individual who is the subject of the PHI, or that individual’s personal representative (for youth under age 18, this is their custodial parent or guardian), has the right to access their health care record. Access should be limited to only health care information and must exclude:

- Psychotherapy notes (which are therapists’ impressions and not their reports);
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding;
- Substance abuse treatment records (unless a written consent for disclosures has been provided by the youth).

H. Any disclosures of information contained in a youth’s individual healthcare record shall only be made for the purposes of providing or obtaining health care for that youth or for evaluating health care delivery.

I. Within the Florida Department of Juvenile Justice, the right to a copy of the youth’s health care record may be denied, in whole or in part, if it “would jeopardize the health, safety, security, custody or rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate.” See 45 C.F.R. §164.524(a)(2)(ii). Under HIPAA, these denials are not reviewable.
J. HIPAA exemption does not preclude all individuals from maintaining a youth’s privacy.

XVII. YOUTH IN THE CARE OF THE DEPARTMENT OF CHILDREN AND FAMILIES

Pursuant to Chapter 39.407.F.S., as it pertains to the Authority for Evaluation and Treatment and any additional consent requirements for foster care youth, or those in the care of the Department of Children and Families (DCF), where there has been a termination of parental rights, the court must authorize all treatment and procedures. This includes the authorization of all medications, particularly psychotropic medications. The Department’s regional general counsel’s office should be contacted immediately when a DCF youth is brought into the custody of a DJJ facility to ensure that the consent process can be initiated in a timely manner. Under no circumstances is a DCF caseworker authorized to sign for consent in the place of the parent or court.
DEPARTMENT OF JUVENILE JUSTICE HEALTH SERVICES MANUAL

CHAPTER FIVE
HEALTH RELATED HISTORY AND COMPREHENSIVE PHYSICAL ASSESSMENT

OCTOBER 2006
Chapter 5
HEALTH RELATED HISTORY AND
COMPREHENSIVE PHYSICAL ASSESSMENT

I. INTRODUCTION

All youth admitted into the physical custody of a DJJ facility will have an individual, professional, Health-Related History and Comprehensive Physical Assessment conducted and documented on the Department’s standardized forms and filed in the Individual Health Care Record, within specified timeframes, in order to facilitate the following:

- Identification of acute, chronic and functional medical and dental problems and applicable treatment.
- Assignment of a Medical Grade, using the Department’s medical classification system.
- Assignment of Medical Alerts.
- Promotion of growth and development.
- Identification and subsequent prevention of communicable disease transmission within the confined environment of a facility.
- Identification of factors, which would potentially affect a youth’s ability to participate in sports, strenuous exercise, or other programmatic aspects.
- Determination of the need for health education.
- Facilitation of the efficient sharing of essential health-related information among diverse health care providers.

This chapter specifies and explains the required components of the standardized Health-Related History (HRH) and the Comprehensive Physical Assessment (CPA).

II. GUIDELINES FOR THE HEALTH-RELATED HISTORY

A. The Health-Related History (HRH) form is the standard departmental history form that accompanies the Comprehensive Physical Assessment. Although these two documents are utilized together, it is not mandatory that the HRH be repeated each time the CPA is performed and documented. However, the HRH must be reviewed and updated at each admission. Changes and updates to the HRH may be made directly on the form as they are identified, in the respective section, as long as each change is legibly made, signed, and dated. The printed name and credentials of the person making the notation should always accompany the change, as well as the printed name of the facility. The HRH should always accompany the CPA, and is to be filed directly behind the current CPA.

B. A new HRH may be completed at any time at the discretion of the health care provider or staff at a facility. A youth’s HRH should always be reviewed on admission to a detention
center or residential commitment program, in order to report any significant medical changes since the previous review.

C. The completion or revision of the Health-Related History should always be conducted and dated prior to, or at the same time as the CPA. The Physician, PA, or ARNP performing the CPA shall include a review of the Health-Related History to note any significant corresponding physical conditions on the CPA.

D. The Physician, PA or ARNP should pay particular attention to those illnesses marked in the “past” column of the HRH to ensure they are truly resolved and do not impact a youths current condition.

E. The Physician, PA or ARNP shall sign the CPA in the designated area indicating his/her review of the HRH.

Note: The standard Departmental Health-Related History Form shall be used by all practitioners.

III. GUIDELINES FOR THE COMPREHENSIVE PHYSICAL ASSESSMENT

The Comprehensive Physical Assessment (CPA) is the standardized physical assessment of a youth, conducted by a Physician, an Advanced Registered Nurse Practitioner or Physician Assistant at Departmentally specified intervals.

A. REQUIRED COMPONENTS

1. The required components of the CPA are noted on the standard form. The following data elements should be recorded on the CPA, in addition to the full physical examination:

- Allergies
- Weight/Body Mass Index (BMI)
- Snellen Eye Examination
- Tuberculosis Screening Results with Date
- Blood Glucose Finger Stick Results (for diabetic youth)
- Chronic Care Information (i.e. Pulmonary Function test), as applicable
- Pregnancy Test, as applicable
- Physical Activity Restrictions

2. These elements including the vital signs may be conducted and recorded by a nurse, but this must be done prior to or on the same day that the CPA is performed by the Physician, PA or ARNP. The nurse should weigh the youth, minimally clothed and without shoes, using a calibrated scale. All youth with a Snellen deficit of 20/40 or more (OD/OS/OU) will have a referral to an optometrist or ophthalmologist for follow up care.
3. The nurse shall document the date and results of the most recent tuberculosis skin test (TST/PPD). Results of the PPD test must be recorded in millimeters. Documentation for follow up care must be available for test results of 10mm induration or more and for 5mm induration or more for the HIV positive youth. (Please refer to Chapter 3, Admission Process.)

4. If the youth is a diabetic, the nurse shall record a blood glucose via finger stick, (preferably fasting), and a urine dipstick, or automated urine screen conducted on the same day, and prior to, the physical examination. If the youth is a diabetic, she/he should be asked the last approximate date she/he was seen for a comprehensive eye exam by an ophthalmologist, and this should be noted for the clinician.

5. All girls over the age of 12 and all those who are sexually active or those who request testing, should receive a qualitative urine pregnancy screening test, with the youth’s verbal consent.

6. A gynecological examination should be performed on all symptomatic sexually active females. The examination and tests shall include a wet mount, (in CLIA licensed facilities), and Sexually Transmitted Infection testing (GC/Chlamydia cultures or urine-based testing). For females who are not sexually active, but who are at least 18 years or older, a gynecological exam is clinically recommended. Unless warranted by a clinical condition requiring a specialty consultation, the routine examination shall be performed by the health care provider responsible for the Comprehensive Physical Assessment. Given the extensive trauma history in this population, all pelvic exams shall only occur with the female youth’s full verbal consent.

7. HIV testing shall be a routine part of pre-natal care. All Pregnant youth shall have an HIV test unless, after counseling by the Physician, PA or ARNP as to the risks of transmission of HIV to the fetus, she refuses HIV testing. When this occurs, she must sign a waiver to decline the test.

8. Audiology testing for youth who do not pass basic hearing tests or complain of diminished hearing.

9. Any additional components may be added to the examination at the practitioner’s clinical discretion.

10. Any significant change in a youth’s condition from that which is indicated on the existing current CPA warrants the completion of a new one.

Note: The standard Comprehensive Physical Assessment form shall be used by all practitioners. If the CPA is performed by a community practitioner, (Physician, PA or ARNP) all efforts are to be made to provide them with the standard CPA form for documentation. If this cannot be accomplished then the DHA or their Physician Designee or PA or ARNP must augment that assessment to ensure that all of the CPA’s required components are clearly documented on the alternate form.
B. DOCUMENTATION

1. Clear and legible documentation is expected on all forms, progress notes and orders.

2. All sections of the exam should have either an “O” or an “X” beside them, with the following additional clarifications:

   a. An “X” requires further detail in the comment section to elaborate on the abnormality.

   b. Documentation of Tanner Stage is recommended but at the discretion of the clinician. If Tanner Staging is not performed, the clinician should so indicate by writing “Deferred by Clinician” or “Refused by youth.”

   c. When a complete pelvic examination (including a PAP smear for asymptomatic females) is routinely conducted off-site, that should be noted by the comment “Standard Referral” or “Off Site Referral.” The youth’s name shall then be placed on the Sick Call/Referral Log to insure a prompt referral.

   d. Examination of the anus is within the discretion of the clinician. If the clinician feels that this is not necessary, the clinician should write “Deferred by Clinician.”

   e. If the youth refuses any part of the exam (specifically the genital exam), the clinician should indicate by writing, “Youth Refused.” The term “Deferred” alone is not specific. The expectation is that if the clinician feels that by history, this exam is clinically indicated, they will make all efforts to explain the importance of the exam to the youth and notate this on the CPA. At no time shall a youth be forced to undergo any part of the exam. A youth who refuses any segment of the exam should initial next to that section of the CPA. If the refusal of the exam poses a substantial risk to the youth then the parent/guardian AND Designated Health Authority or Physician Designee, AND Program Director or Superintendent shall be notified.

C. SEXUALLY TRANSMITTED DISEASE EVALUATION

1. All sexually active males and females should be clinically screened and evaluated for sexually transmitted diseases, by both cause and/or symptoms on admission. A youth that reports signs or symptoms consistent with an STD, or reports engaging in unprotected intercourse shall be referred to the DHA or Physician Designee, PA or ARNP for evaluation and screening with testing.

2. The DHA, Physician Designee, PA, or ARNP shall then decide based on the evaluation which tests to perform to prevent the advancement of the infection and to decrease the risk of future transmission. The testing should include GC/Chlamydia and be timely in nature.
3. The *Sexually Transmitted Disease* screening form is a recommended means of determining which youth is at risk for STD’s and would warrant testing. In this population, it is recommended to test all youth for GC/Chlamydia.

4. Diseases warranting screening, based on youth’s history, include the following:

- Neisseria Gonorrhea
- Chlamydia
- Trichomonas
- Candidiasis (females)
- Bacterial Vaginitis (females)
- Mucopurulent Cervicitis (females)
- RPR (if that test is reactive without history of treatment for syphilis, a confirmatory test should be performed)

5. Youth that warrant follow up testing based on symptoms or screening shall be scheduled for a medical evaluation on the next available Physician, ARNP, or PA visit to the facility. If the youth is due to be released prior to being seen, the nursing staff should schedule follow up care with the local county health department or an appropriate community healthcare provider. Instructions should be provided to the youth for any appointment scheduled within the community. Any community appointments should be documented within the nursing progress notes and communicated to the youth, and parent or guardian, via the *Health Discharge Summary form*.

**D. LABORATORY RESULTS**

1. The results of any laboratory tests should be filed in the Individual Health Care Record in the section reserved for laboratory tests. When applicable, the results of tests should be noted on the Infectious and Communicable Disease (ICD) form.

2. The Sexually Transmitted Disease screening form described above should be conducted if the sexually active youth has been out of the physical custody of the Department for over 30 days, and/or symptoms are present.

3. Clinical screening, evaluation, treatment, and reporting requirements of all youth must be conducted in compliance with the standards promulgated by the Florida Department of Health, Division of Disease Control, and Bureau of STD. Treatment must comply with the current Center for Disease Control and Prevention (CDC) STD Treatment Guidelines.

4. The Designated Health Authority or Physician Designee, PA or ARNP shall determine what laboratory analysis is clinically indicated on intake for the youth. All youth admitted to a detention center and/or residential commitment program must have on file in the Individual Health Care Record laboratory section, a complete thyroid profile (e.g. if diagnosed with thyroid disease, or if sub-clinical disease is suspected, or if there is a history of an elevated TSH, or if the youth is receiving medications known to have an
effect on the thyroid). Other laboratory testing, including that for pregnant girls, youth with chronic conditions, and youth who are receiving medications that require serum levels at specific intervals or metabolic profiles due to the medications, should be conducted at the order of the individual who is conducting the Comprehensive Physical Assessment.

5. Ultrasounds and other testing required for pregnant females are to be ordered along with appropriate referrals to OB/GYN, as indicated. All available testing reports are to be maintained in the IHCR under the Laboratory results section.

IV. MEDICAL GRADES

A. The initial assignment of a medical grade is made at the time of the first Comprehensive Physical Assessment. The medical grade is to be updated/changed whenever the youth’s health status changes to such an extent that it is warranted.

B. Based on a change in health status, only the Physician, ARNP or PA shall change the Medical Grades to a higher or lower grade. Registered Nurses and Licensed Practical nurses may only increase a Medical Grade (e.g., from 2 to 3). They are not permitted to decrease grades. Documentation of the changes should be reflected in the progress notes as well as the DJJ Problem List Indexes, MAR and Practitioner’s orders.

C. All youth with Medical Grade 3-5 shall be placed on the Facility Medical Alert System.

(MEDICAL GRADE CLASSIFICATION SYSTEM Follows)
## MEDICAL GRADE CLASSIFICATION SYSTEM

<table>
<thead>
<tr>
<th>MEDICAL GRADE</th>
<th>MEDICAL NEED</th>
<th>CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>LOW</td>
<td>☑ Youth has no identified chronic health conditions; And ☑ Youth has no serious, chronic infectious, communicable disease; ☑ Youth has no periodic monitoring requirements; And ☑ Youth is not being treated with prescription medications. (Youth may be prescribed or receiving over-the-counter medications)</td>
</tr>
<tr>
<td>2</td>
<td>MEDIUM</td>
<td>☑ Youth has only one chronic condition, which has not required medical/nursing intervention within the last 12 months (except for routine periodic evaluations at the intervals required by the Department);* And ☑ Youth has no serious, chronic, infectious communicable disease; (Youth may or may not be prescribed oral medications).</td>
</tr>
<tr>
<td>3</td>
<td>HIGH</td>
<td>☑ Youth has been diagnosed with two or more chronic conditions (regardless of the actual or expected need for medical/nursing intervention); And/or ☑ Youth has been diagnosed with a serious chronic, infectious communicable disease; (e.g. Tuberculosis) And/or ☑ Youth requires nursing/medical intervention and/or evaluation no more frequently than once every 30 days*; (Youth may or may not be prescribed oral medications).</td>
</tr>
<tr>
<td>4</td>
<td>HIGH</td>
<td>☑ Youth is physically disabled (visual, hearing, mobility); And/or ☑ Youth is prescribed parenteral medications (medications which are administered by injection, such as insulin); And/or ☑ Youth requires nursing/medical intervention and/or evaluation at a frequency greater than once every 30 days*; And/or ☑ Youth is pregnant; or is within six weeks post-birth; And/or ☑ Youth is receiving anti-tuberculosis medications.</td>
</tr>
<tr>
<td>5</td>
<td>HIGH</td>
<td>☑ Youth is prescribed any medication for diagnosed mental and/or emotional disorders.</td>
</tr>
</tbody>
</table>

* The administration of each dosage of routine prescription medication does not constitute a “required medical/nursing intervention” for purposes of this classification system. The term, “nursing/medical intervention and/or evaluation” refers to ordered encounters between youth and nursing or medical staff (or those reasonably anticipated to be needed, based on the status of the youth) for evaluation (e.g., blood pressure checks, laboratory testing) or treatment (e.g., dressing changes, colostomy care, respiratory treatments), and the like;

Note: If a youth’s status is such that more than one grade is possible (for example, he has stable asthma which has not required any intervention for over 12 months [medical grade of 2] and he is receiving an antidepressant for depression [medical grade of 5], assign the higher grade.
V. TIME FRAMES FOR THE INITIAL COMPREHENSIVE PHYSICAL ASSESSMENT IN DETENTION CENTERS

A. MEDICAL GRADE 1

The facility Designated Health Authority or Physician Designee and Superintendent must ensure that youth who enter the physical custody of a detention center have documentation of a Comprehensive Physical Assessment or receive a CPA performed by a licensed Physician or Advanced Registered Nurse Practitioner or Physician Assistant as soon as possible, but no later than (7) seven calendar days from the date of admission. These youth must have no known acute or chronic conditions or communicable diseases; not be prescribed medications, not be pregnant, and have no acute problems identified in the Facility Entry Physical Health Screening.

B. MEDICAL GRADING 2, 3, 4, & 5

The facility Designated Health Authority, or Physician Designee, Superintendent or designee shall ensure that youth who enter the physical custody of a secure detention center and who report or exhibit signs of, an acute or chronic condition, or are prescribed medications, or have a communicable disease (and who do not have a current CPA on file) receive a Comprehensive Physical Assessment performed by a licensed Physician or Advanced Registered Nurse Practitioner or Physician Assistant no more than seven (7) calendar days from the date of admission.

C. USE OF PRIOR COMPREHENSIVE PHYSICAL ASSESSMENTS

1. If a CPA was performed on a youth during a prior admission (either to a detention center or a residential commitment program) and is considered “current”, that CPA should be reviewed as the youth is examined and signed off as reviewed, but not necessarily duplicated or repeated by the Physician, PA or ARNP unless, in the clinician’s professional opinion, a new CPA is necessary. (See this Chapter, Section VII for an explanation of the time frames for a CPA to be considered current.) If the Physician, PA or ARNP reviews the existing CPA, he/she must then sign and date the CPA in the space designated for the reviewer.

2. If there is a current CPA on file, and the youth has had a change in condition, the clinician should conduct a focused medical evaluation of the youth that is documented in the progress notes of the Individual Health Care Record (IHCR).

3. A focused medical evaluation does not require completion of a new Comprehensive Physical Assessment form. However, it does require that all of the components of the physical assessment are conducted. A focused medical evaluation is documented as a note which contains the relevant information (e.g. subjective, objective, assessment, and plan) in the youth’s Individual Health Care Record.
4. If there is a significant change in more than one component of the physical exam on the current CPA, then a new one should be completed.

5. The facility Designated Health Authority or Physician Designee and superintendent or designee must ensure that ALL youth in detention who are adjudicated, committed, and are to be placed in a residential commitment program, but are released pending placement, receive or have documentation of a current CPA completed prior to release from detention.

VI. TIME FRAMES FOR THE INITIAL COMPREHENSIVE PHYSICAL ASSESSMENT IN RESIDENTIAL COMMITMENT PROGRAMS

A. MEDICAL GRADE 1

The facility Designated Health Authority or Physician Designee and Program Director or Superintendent must ensure that youth who enter the physical custody of a residential commitment program have documentation of a CPA or receive a CPA performed by a Physician, Physician Assistant or Advanced Registered Nurse Practitioner as soon as possible but no more than seven (7) calendar days from the date of admission. These youth must have no known acute or chronic conditions or communicable diseases; no prescribed medications; not be pregnant and have no acute problems identified in the Facility Entry Physical Health Screening.

B. MEDICAL GRADES 2, 3, 4 & 5

The facility Designated Health Authority or Physician Designee and Program Director or Superintendent must ensure that youth who enter the physical custody of a residential commitment program and who report, or exhibit signs of, an acute or chronic condition, or are prescribed medications or have a communicable disease, (and who do not have a current CPA on file) receive a Comprehensive Physical Assessment performed by a Physician or Advanced Registered Nurse Practitioner or Physician Assistant no more than seven (7) calendar days from the date of admission.

C. USE OF PRIOR COMPREHENSIVE PHYSICAL ASSESSMENTS

1. If a CPA was performed on a youth during a prior admission (either to a detention center or a residential commitment program) and is considered “current”, that CPA should be reviewed as the youth is examined and signed off as reviewed, but not necessarily duplicated or repeated by the Physician, PA or ARNP unless, in the clinician’s professional opinion, a new CPA is necessary. (See this Chapter, Section VII for an explanation of the time frames for a CPA to be considered “current”.) If the Physician, PA or ARNP reviews the existing CPA, he/she must then sign and date the CPA in the space designated for the reviewer.
2. If there is a current CPA on file, and the youth has had a change in condition, the clinician should conduct a focused medical evaluation of the youth that is documented in the progress notes of the Individual Health Care Record.

3. A focused medical evaluation does not require completion of a new Comprehensive Physical Assessment form. However, it does require that all of the pertinent components of the physical assessment are conducted. When conducted on-site, a focused medical evaluation is documented as SOAP (subjective, objective, assessment and plan) note in the youth’s Individual Health Care Record. If conducted off-site, it is documented on the Summary of Off-Site Care form, and placed in the IHCR in reverse chronological order (most recent page on top).

4. If there is a significant change in more than one component of the physical exam on the current CPA, then a new one should be completed.

5. The Program Director or Superintendent or their designee must ensure that any youth in their residential commitment program or facility who does not have a current CPA on file, receive a CPA within the above-defined time frames. Every reasonable effort should be made to obtain the CPA from the sending/transferring detention center or probation officer where applicable.

VII. DURATION OF “CURRENT” COMPREHENSIVE PHYSICAL ASSESSMENTS

A. A current CPA is one that has been performed within one (1) year for youth with Medical Grades of 2, 3, 4, or 5 and within two (2) years for youth with a Medical Grade of 1. This holds true, only if there have not been any interim changes (new conditions, new medications, etc.)

B. While in the continuous physical custody of the Department, if a youth’s medical classification changes from a Medical Grade of 2, 3, 4 or 5 to 1 during the year after his or her CPA was conducted, the date of the next CPA shall be two (2) years from the date of the prior CPA. If a youth’s Medical Grade of 1 changes to a higher grade during the year after his CPA was conducted, the date of the next CPA shall be one (1) year from the date of the prior CPA. Residential facilities should maintain an ongoing roster or appointment schedules for the next scheduled CPAs.

NOTE: Nothing prohibits a practitioner from performing another CPA despite the existence of one that is “current”.

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OCTOBER 2006
(REVISED 4/15/2010)
VIII. STAFF DUTIES AND RESPONSIBILITIES

Juvenile Probation Officers, detention, and residential commitment program staff, shall all work collaboratively to ensure that Health-Related Histories and Comprehensive Physical Assessments are obtained in a timely and cost-effective manner.

A. JUVENILE PROBATION OFFICER: The JPO is responsible for:

1. Ensuring that those youth, who are committed to a residential facility directly from the community, have a Health-Related History and Comprehensive Physical Assessment performed and documented.

2. Providing the Department’s standard Health-Related History and Comprehensive Physical Assessment forms to the community or contracted Physician, PA or ARNP. OR, providing the forms to the parent/guardian responsible for taking the youth to the appointment.

3. Obtaining the completed documentation and ensuring that it is forwarded to the youth’s current facility or included in the Commitment Packet, whichever is applicable, for eventual inclusion in the IHCR.

   Note: The youth’s parent or guardian should accompany the youth to the medical appointment with the forms and return them to the JPO once completed. The JPO may choose to provide several copies of the blank HRH and CPA forms to frequently utilized health care providers.

B. DETENTION HEALTH CARE STAFF: This staff is responsible for ensuring that the Health Related History and Comprehensive Physical Assessment are conducted within Departmentally-specified timeframes after a youth is admitted to secure detention and then filing the HRH and CPA in the Individual Health Care Record.

C. RESIDENTIAL COMMITMENT PROGRAM HEALTH CARE STAFF: This staff is responsible for ensuring that the HRH and CPA are repeated at the appropriate intervals and filed in the Individual Health Care Record. If a youth arrives without these forms, depending on the youth’s prior location, the residential staff shall contact either the detention center or the JPO and JPO Supervisor (when the youth came from the community).

IX. FILING OF HEALTH RELATED HISTORY AND COMPREHENSIVE PHYSICAL ASSESSMENT

The Health-Related History and Comprehensive Physical Assessment shall be filed in the designated section of the Core Health Profile in the Individual Health Care Record. When a youth receives a subsequent Health-Related History and/or CPA, the prior HRH or CPA is moved from the Core Health Profile section and re-filed in the Miscellaneous section of the Individual Health Care Record reserved for Prior Medical/Physical Histories and Assessments.
I. INTRODUCTION

Sick Call is a critical component of the continuum of health care services provided to all youth in the custody of the Department. Each DJJ facility must have in place procedures that ensure access to regularly scheduled Sick Call to address all health-related complaints of a non-emergent nature.

This service shall meet the same standard of care that a youth would receive while in the community. Because the youth are in a confined setting, it is imperative that their health care needs are met in a timely and comprehensive manner. The Department’s expectation is that all youth are oriented to the Sick Call system on admission and have unfettered access to the facility health care providers. In light of the many different types and sizes of facilities, the Sick Call process should be adapted in order to function accordingly, but the basic service must always exist. Thus, detention centers and residential commitment programs shall develop Facility Operating Procedures that assure the comprehensive provision of sick call care. Access to proper Sick Call shall never be denied to any youth.

II. COMPONENTS OF SICK CALL

A. FACILITY RESPONSIBILITIES

1. Sick Call is the component of health care that responds to a youth’s complaints of illness or injury of a non-emergent nature but which require a professional nursing assessment and possibly, a nursing intervention. Facility Operating Procedures must clearly outline an effective system for youth to access Sick Call. There shall be regularly scheduled hours in each facility for a youth to be evaluated by a licensed nurse who can provide the appropriate response to the complaint or arrange a referral to an off-site health care provider with whom the facility has an agreement to provide treatment. Every facility shall incorporate into their procedures a means by which Sick call requests are triaged promptly and screened for urgency, such that emergency conditions are not inappropriately delayed for the next regularly scheduled sick call session.

2. For those times of day where licensed health care staff are not on site, the facility must have a procedure whereby the shift supervisor reviews all sick call requests for issues requiring immediate attention. This should occur promptly, but no longer than four (4) hours after request is submitted. The direct care staff shall be trained to always immediately report any youth who appears distressed to their supervisor and/or the onsite health care staff.
Note: For the purposes of this manual, issues requiring immediate attention are those where a youth complains of pain, bleeding, shortness of breath, a recent injury, etc. This list is not all-inclusive, thus the Superintendent or Program Director and DHA or Physician Designee shall develop facility-operating procedures that define the instances that require immediate attention.

3. Complaints of severe pain (including dental pain) with which any staff member is unfamiliar, or cannot determine the severity, shall be treated as emergencies and require immediate referral to a licensed health care professional who possesses the knowledge and expertise to address the complaint. This shall be the on-site Nurse, ARNP, Physician Assistant or Physician. Sick Call must include procedures for ANY and ALL staff to contact Emergency Medical Services (EMS) by calling “911” immediately under any circumstances where a youth’s condition warrants immediate attention or evaluation.

B. STAFFING REQUIREMENTS

Only a licensed nurse may conduct Sick Call. Neither Certified Nursing Assistants (CNAs), nor facility staff persons may perform any version of the Sick Call process.

C. TREATMENT PROTOCOLS

The facility Designated Health Authority shall review and approve Treatment Protocols for the on-site licensed nursing staff to utilize when administering care in response to commonly encountered complaints. These protocols must be within the scope of practice and level of expertise and training of the nurse(s) conducting Sick Call. When Licensed Practical Nurses are utilized for a clinical assessment during the sick call process, specified and limited nursing protocols shall be established and approved by the facility’s Designated Health Authority.

These protocols should include the following components, at a minimum:

- Complaint
- Associated signs and symptoms
- Criteria for type of treatment
- Treatment to be rendered

Note: When utilizing treatment protocols, nursing staff shall ensure that a youth’s signs and symptoms follow what is outlined in the protocol while remembering to treat the individual youth. If there is ever a question, the Designated Health Authority or Physician Designee, PA or ARNP shall be contacted.
III. FREQUENCY OF REQUIRED SICK CALL

A. REQUIRED FREQUENCY BASED ON OPERATING CAPACITY

The table below provides the *minimum* required frequency of regularly scheduled Sick Call for detention centers and residential commitment programs (all types, restrictiveness levels, and models).

<table>
<thead>
<tr>
<th>Operating Capacity</th>
<th>Required Frequency of Sick Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-25</td>
<td>3 times per week</td>
</tr>
<tr>
<td>26-50</td>
<td>4 times per week</td>
</tr>
<tr>
<td>51+</td>
<td>5 times per week</td>
</tr>
</tbody>
</table>

The requirement for a schedule of fixed hours and days for Sick Call does not preclude a facility from also having procedures in place to address youth complaints as they arise. If health care staff is available on-site, they shall be responsible for assessing a youth and if health care staff is not present then there shall be procedures in place whereby a designated staff person knows how to access the on-call health care staff and/or off-site services (emergent and non-emergent) promptly. In all cases, Sick Call procedures shall include the appropriate notification and referral processes, as well as documentation requirements in accordance with this manual.

B. YOUTH IN RESTRICTED HOUSING

1. For youth in restricted housing of any kind (for example, confinement, seclusion, room restriction, secure observation, etc.) provisions shall be made to ensure that communication of sick call needs, nursing triage and a clinical assessment are available. Due to the potential for exacerbation or worsening of symptoms for youth in restricted housing, a system must be in place through which these patients are routinely questioned, on at least a daily basis, about any health-related complaints, with treatment and/or referrals as warranted.

2. Nursing staff is required to make a daily visit and a detailed narrative entry in the chronological progress notes of the Individual Health Care Record for each youth who is treated while in restricted housing.

3. This entry shall evidence that a thorough inquiry was made regarding the patient’s health status and whether or not a nursing assessment was conducted. Using a log format is acceptable if it is detailed, dated and includes categories that address the health status of the youth. If the youth has a specific Sick Call complaint, the usual procedures for Sick Call shall be conducted and documented.
IV. YOUTH ACCESS TO SICK CALL

A. A process shall be in place for all youth to have timely access to sick call care and treatment. The process by which youth indicate their respective need for Sick Call may vary as long as access is not denied. The timely, effective access to Sick Call is accomplished through the collaborative efforts of the direct care staff and the nursing staff using the most current and approved system in place for communication. This method of communication would be specific to the detention center and residential commitment program. In all instances, the confidentiality of the youth’s sick call information shall be maintained.

B. Youth are to be provided a Sick Call Request form and a pencil when requesting to see a nurse (forms may also be available on living unit). For youth who need assistance completing the form, a staff person shall be available. The staff person must make the youth aware that this then gives them access to the youth’s personal information. The staff person shall maintain the youth’s confidentiality.

1. DETENTION FACILITIES

   All facilities shall utilize the Detention Facilities Management System (the system in place at the time of this printing) to allow staff to enter the Sick Call requests generated by the youth. This entry must then generate a Notice to the nurse for her timely review. Every facility shall have a backup procedure for notification to the nurse in situations where the computerized system is unavailable.

2. RESIDENTIAL COMMITMENT PROGRAMS

   ➢ The completed Sick Call Request form shall be placed in a secure location inaccessible to youth (e.g. locked box, or in a sealed envelope) to then be provided to the nurse.

   ➢ A list of youth who have requested to be seen at the next Sick Call should be generated and provided to the nurse.

   ➢ The program’s Facility Operating Procedure (FOP) must outline the process by which youth are brought to Sick Call (by living unit, individually, etc).

3. SPECIAL CONSIDERATIONS FOR ALL FACILITIES

   ➢ Youth who appear to be in pain or have symptoms indicative of a possible infectious illness (for example, they are coughing, complaining of fever, or have gastrointestinal complaints), shall be seen in a manner most conducive to preventing spread of the possibly contagious illness to other youth.

   ➢ Youth who appear to have symptoms of childhood illnesses that may spread rapidly shall be seen separately.
When a staff person feels that a youth needs to be seen as early as possible in Sick Call, the staff has the authority and responsibility to notify the nurse.

When a staff person believes that a youth needs to be seen in Sick Call, but the youth has not made a request, the staff person has the authority and responsibility to notify the nurse in order for the nurse to come to the living unit and assess the youth, or to have the youth brought to Sick Call.

V. SICK CALL DOCUMENTATION

A. DOCUMENTATION PROCESS

1. Detention facilities shall utilize the established Detention Facilities Management System (DFMS) to coordinate and document the Sick Call process. A copy of the completed electronic Sick Call Request form shall be placed in the youth’s Individual Health Care Record.

2. For other facilities and programs, documentation of the sick call encounter can be accomplished using the Sick Call Request form or by a comprehensive narrative Progress note referencing the Sick Call Request form and utilizing the SOAP (Subjective, Objective, Assessment and Plan) documentation format. When the Sick Call Request form is used, it is filed chronologically with the Progress notes in the Individual Health Care Record to facilitate ease of tracking the youth’s health care encounters.

3. If information is documented in another section of the Individual Health Care Record such as a weight flow sheet, the nurse may refer to this in the notes i.e. “see flow sheet.”

4. When the youth is evaluated and treated by the facility’s Physician, PA or ARNP the SOAP format in the Chronological Progress notes should be utilized to provide documentation for the Individual Health Care Record.

B. STANDARD DOCUMENTATION REQUIREMENTS

The Sick Call Request form requires the inclusion of the following information on the form and which contains the relevant information (e.g. the subjective complaint, objective findings, an assessment and a plan), in the youth’s Individual Health Care Record. If a section is not applicable, this may be indicated by “N/A.”

☑ Date and time of the encounter;
☑ Youth’s complaint;
☑ Nursing history and assessment (including vital signs, weight* [if applicable]);
☑ Treatment or other interventions rendered;
☑ Plans for future treatment or follow-up;
Education and instructions given to the youth;
Instructions given to staff;
Legibly printed name (first, last), credentials and position of the nurse rendering care and the DJJ facility or program;
Signature (legible, first name, last name) of the nurse rendering care.

The following components should also be included, as applicable:

- A notation if the patient was placed on Medical Alert;
- Documentation if the DHA or other provider was notified and a description of the communication;
- Documentation if the program director was notified;
- Documentation if the parent was notified by telephone (or what attempts were made);
- Documentation if a Parental Notification of Health Related Care form was mailed.

*Note: Youth that are not on a routine weight regimen shall be weighed during sick call. The purpose is to ensure that a youth is weighed at regular intervals, but no more frequently than once per month, unless otherwise ordered by the Physician, ARNP or PA.*

VI. SICK CALL INDEX

A. The Sick Call Index provides a rapidly accessible and concise history of the patient’s Sick Call complaints. Sick Call complaints shall be listed on this standard form, which should be filed in the section reserved for the Core Health Profile in the Individual Health Care Record. This form is designed to avoid the occurrence of repeatedly unresolved Sick Call complaints.

B. Youth identified on the Sick Call index as having the same complaint and seen by the nurse three times within a two-week period shall be referred to the Physician, ARNP or PA. If the ARNP or PA is unclear of the youth’s diagnosis then this warrants evaluation by the facility Physician.

VII. MEDICATION ADMINISTRATION DURING SICK CALL

(REFER TO CHAPTER 11: MEDICATION MANAGEMENT)

A. Medication Administration Process

1. All medications (including over-the-counter medications) administered to a youth to treat his or her symptoms during Sick Call shall be placed on the standard Medication Administration Record (MAR).
2. When the Nurse administers over-the-counter medication (OTC) or treatments based on the assessment results, and according to physician approved nursing care protocols, the nurse shall ensure that:

- Medication, as documented on the Medication Administration Record (MAR), is part of a pre-approved protocol.

- If the OTC is given subsequent to a verbal/telephone order, the administration of the OTC is to be recorded on the MAR with the notation “per verbal order.”

- The confirmation of verbal orders from the Physician, ARNP or PA (shall be noted in the IHCR or on the Practitioner’s Order sheet (for those facilities that utilize this form). For example: “Tylenol 325mg one tablet now”. Nurses’ signature: noted/date/time according to nursing documentation procedures. This notation shall signify verification of transcription and implementation of the practitioner’s order(s) onto the MAR.

- The physician shall provide a signature on all verbal orders during the next scheduled visit to the facility.

- If subsequent doses of an OTC have been ordered or are a part of the Physician’s protocol, these may be administered as part of routine medication administration and do not require another Sick Call encounter, unless the patient’s condition so warrants.

Note: Any medications administered outside of scheduled sick call shall be documented accordingly on the MAR as well.

VIII. SICK CALL LOG: (REFER TO CHAPTER 9 FOR USE OF THE EMERGENCY CARE LOG)

An aggregate log must be in place at each facility. Detention facilities shall utilize the sick call log generated by the DFMS system. Residential commitment programs shall utilize the Sick Call/Referral log which documents, by date, each youth and his/her sick call complaints as stated, the nature of the complaint as determined by the licensed nurse, a brief description of the treatment rendered, any referrals offsite or to the hospital and if the youth was placed on the referral list for the Physician, ARNP, or PA.

IX. NOTIFICATION OF PARENT/GUARDIAN

The parent/guardian must be notified regarding certain specific Sick Call complaints. Under the following circumstances, all attempts shall be made to notify the parent/guardian preliminarily by phone with a subsequent Parental Notification of Health Related Care by regular mail:
A. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever a non-psychotropic medication is prescribed or changed by a Physician, PA or ARNP. (Refer to Chapter 11, Medication Management.)

Note: Psychotropic medications require the use of the Clinical Psychotropic Progress Note (CPPN). (Refer to Chapter 12, Psychotropic Medication Management.)

B. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever a youth has a chronic mental or physical health condition and a licensed health care practitioner has determined that a significant change has occurred in the chronic health condition of that youth. **This shall not include those limited conditions to which, by statute, a youth can legally consent to screening, evaluation and/or treatment without the parent/guardian’s knowledge or consent (and which are to be protected from disclosure to the parent/guardian).**

C. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever a youth has the same medical complaint in Sick Call, three (3) or more times during a two-week period.

D. A Parental Notification of Health-Related Care must be sent to the parent/guardian on any occasion in which the youth’s oral temperature equals or exceeds 102 degrees orally upon two sequential checks in one day, or the oral temperature equals or exceeds 102 degrees on two consecutive morning checks. An attempt should also be made to notify the parent by telephone.

E. A Parental Notification of Health-Related Care must be sent via certified mail to the parent/guardian if the parent/guardian has specifically prohibited certain types of care, or medication or requested that they be notified prior to the provision of certain types of care.

✓ Written permission from the parent/guardian must be obtained prior to the initiation of a treatment, which the parent has previously specifically prohibited. This may be in the form of a letter obtained from the parent/guardian, or facility staff may check the box on the bottom of the Parental Notification form, indicating that the parent is to sign the form and return it to the facility if the parent/guardian agrees to the care. Telephone consent should be attempted and documented. The Department’s regional general counsel should be notified if treatment is necessary and parent/guardian is unwilling or unable to consent.

F. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever the youth is taken off-site for medical treatment (for example, to a dentist, an emergency room, hospital or an off-site specialist). Exceptions include situations in which the reason for the transfer and treatment are related to the conditions which, by statute, a youth may consent to without parental knowledge or consent (assessment and treatment for sexually transmitted diseases, assessment/treatment for HIV/AIDS, family planning services and those gynecological services that, in the opinion of the health care
provider, are necessary for the health and well-being of the youth). In these situations, the youth must provide consent for the Department to notify the parent.

G. Telephone notification is required as soon as possible. When feasible, in the case of an upcoming appointment, telephone notification and mailing of the Parental Notification should be accomplished prior to the scheduled appointment date.

H. The written notice shall be sent regardless of the telephone notification.

I. In the case of a pregnant female, although statutorily the consent or notification of the parent or guardian is not explicitly required, the youth should be encouraged to allow this to occur. However, because of the Department’s unique responsibility for the health and safety of the youth and the unborn child, if the youth refuses, the facility superintendent, program director or designee shall consult with the regional general counsel’s office.

J. Written parental notification is required for the administration of all over-the-counter medications (OTCs) not specifically listed and consented for on the AET. These shall be administered per approved protocols or an order (unless the parent has prohibited the administration of OTCs on the Authority for Evaluation and Treatment in which case over-the-counter medications will not be administered).

K. Written parental notification is required if health care or facility staff determines that the parent or guardian requires notification, regardless of the reason.

L. Mailing of a Parental Notification of Health-Related Care is not required in the following situations:

- Youth who return for on-site follow-up of a sick call complaint at the instruction/direction of a Physician, ARNP, PA or RN where the condition is resolving;
- Youth who report to sick call for complaints, which are of such a nature that they are statutorily protected from disclosure to parents/guardians (e.g., evaluation/treatment of sexually transmitted illnesses/diseases);
- Youth who present to sick care for hygiene-related requests (e.g. nail trimming).
- Treatment or services which are court ordered.

M. All copies of the Parental Notification of Health-Related Care sent to the parent/guardian, and the returned form with the parent’s signature must be filed in the Individual Health Care Record in the section reserved for parental notices, directly behind the Authority for Evaluation and Treatment, in reverse chronological order (most recent Parental Notification on top in that section).
X. WHEN PARENTAL NOTIFICATION OF CARE CANNOT BE ACCOMPLISHED BY TELEPHONE OR MAIL

When parental notification cannot be accomplished through telephone contact or by mail, the DJJ facility superintendent, program director or his/her designee must contact the youth’s juvenile probation officer (JPO) and request that the JPO visit the parent or legal guardian for the purpose of providing the necessary parental notification. The JPO must document all efforts to provide this parental notification.

XI. PARENT NOTIFICATION WHEN THE YOUTH’S ILLNESS, INJURY OR SUICIDE ATTEMPT REQUIRES EMERGENCY MEDICAL SERVICES OR IS LIFE THREATENING

When the youth’s illness or injury requires emergency medical services or is life threatening (after necessary medical treatment is obtained for the youth) the facility superintendent or program director must make every effort to immediately notify the parent/legal guardian. If the parent or legal guardian cannot be contacted, the following steps must be taken:

A. Use alternative contact methods as documented in the youth’s record. Such alternative methods may include, but are not limited to, contact via the parent’s or legal guardian’s work address, pager/cell phone or electronic notification or contact via a relative or neighbor.

B. Contact the youth’s juvenile probation officer to request assistance with notification. In the case where the youth’s family lives in close proximity to the JPO’s work location or area, request that the JPO drive by the parent’s or legal guardian’s home, place of work, school or other known location outside of the home.

C. Contact law enforcement to request assistance in locating the parent or legal guardian.

D. In all cases, the facility superintendent or program director must document all efforts to contact the parent or legal guardian.

XII. EXCEPTIONS TO PARENTAL NOTIFICATION

A. Complaints that are of the type which are statutorily protected from disclosure to parents/guardians (e.g., evaluation/treatment for sexually transmitted diseases).

B. Repeated Sick Call request utilized by the youth for assistance with personal hygiene needs (e.g., nail trimming.).

XIII. FILING REQUIREMENTS (REFER TO CHAPTER 15: INDIVIDUAL HEALTH CARE RECORD)

Parental notification: A copy of the Parental Notification of Health Related Care form that is sent to the parent/guardian is to be filed in reverse chronological order behind the AET section of the Individual Health Care Record.
XIV. NOTIFICATION OF DESIGNATED HEALTH AUTHORITY AND PROGRAM DIRECTOR

A. Each detention center and residential commitment program shall ensure that a system is in place to regularly and effectively communicate a youth’s medical status and information from the nursing staff to the Designated Health Authority or Physician Designee and the facility Superintendent or Program Director. The circumstances warranting notification include, but are not limited to:

- The complaint is related to a chronic condition and the practitioner determines the youth’s condition is worsening.

- The youth has a temperature of 102 degrees or above (oral) upon two sequential checks in one day (AM/PM), or has a temperature of 102 degrees or above on two consecutive morning checks.

- The youth presents repeatedly for pain of the same generalized nature or type.

- The youth’s daily activities must be limited due to the nature of his/her condition (e.g. observation for abdominal pain).

- The practitioner determines that notification is necessary due to the nature of the complaint.

- The superintendent or program director determines that notification is required.

  Note: If the youth’s Sick Call complaint is related to side effects from a psychotropic medication then the notification shall include the facility Psychiatrist or Psychiatric ARNP.

B. There shall be a formalized procedure that allows for regularly scheduled meetings, at least weekly, between the Superintendent or Program Director, or their designee, and the health care staff to review the important medical issues pertaining to youth at the facility. There should never be a situation in which the Superintendent or Program Director is unaware of ongoing medical concerns about any youth in their facility.
I. INTRODUCTION

The Designated Health Authority, at each facility is responsible for ensuring that there is a system in place that affords every youth the immediate availability of medical care and services, a physician consultative referral process, and the medical management for each youth in need of additional specialized consultative medical care and services. A facility ARNP or P.A. may share the clinical responsibilities with the Designated Health Authority or physician designee, however if at any time the condition or complaint is non-emergent, but beyond the scope of his/her training, then the youth MUST be referred to the facility DHA or physician designee or a specialized physician, for a consultative medical evaluation. Each DJJ facility must have procedures in place that ensure access to on-call (by telephone or pager) and scheduled physician services for these types of conditions or complaints.

Additionally, specialized physician consultative services shall be provided for youth requiring medical or dental treatment when the DHA or designee, PA or ARNP deems that the medical or dental care required is outside his, or her, scope of practice.

Each facility may utilize community health care providers, as needed, to obtain necessary medical consultative referrals for youth requiring specialized medical care. In smaller programs, the arrangement for the preliminary physician referral may be accomplished with a community pediatrician, family practitioner or Internist.

II. PHYSICIAN ON-CALL

A. Every detention and residential commitment program shall have the Designated Health Authority or designee) available on-call (by telephone or pager) twenty-four hours a day, seven days a week to address staff and nursing concerns.

B. The Physician on-call service ensures immediate telephonic access to a Physician, or designee. The existence of the on-call physician shall never prevent health care and non-health care staff from immediately contacting Emergency Medical Services (EMS) by calling “911” whenever a youth’s condition warrants (unconsciousness, bleeding, severe pain, etc.). The on-call information shall be clearly posted and readily available to health care and non-health care staff.

C. For small facilities and those located in remote areas that primarily use an offsite physician for medical services, there must be clear facility operating procedures
outlining the use of the Emergency Room when concerns or issues arise about a youth's condition for the nursing or non-health care staff.

D. Pursuant to F.L. HB 699, effective July 1, 2006, a Physician that supervises any satellite clinic, separate from his or her primary place of practice, shall post in each facility a current schedule of the regular hours that the Physician is present in the medical clinic and the hours that the clinic is open when the Physician is not present.

E. The on-call schedule shall be made available to all licensed health care and non-health care staff.

III. FACILITY PHYSICIAN REFERRAL

Referral to the Facility Designated Health Authority or physician designee is a critical component of sick call, episodic care, chronic medical care and medication management.

The Licensed nurse shall be responsible for youth clinical assessment, evaluation, and implementation of on-call medical access procedures when providing care and services on-site at a facility. The licensed nurse shall triage all youth sick call, chronic and episodic complaints to determine the need for immediate consultative referral to the DHA or designee, PA or ARNP.

When a youth reports complaints of severe pain, distress, or unfamiliar complaints of which a non-health care staff member cannot determine the severity, this should be treated as an emergency and must immediately be referred to a licensed health care professional that has the knowledge and expertise to address the complaint. If there is no one onsite to perform this immediate evaluation then emergency medical services shall be accessed.

The ARNP or P.A. shall immediately notify the DHA (physician) when he or she cannot determine the nature and/or severity of a youth’s medical or clinical condition. The Designated Health Authority has the final authority for determining the next medical course of action. A youth that has received medical evaluation and treatment by the ARNP or P.A. repeatedly for the same complaint that is still unresolved after two medical evaluations shall be referred immediately to a physician (on-site, off-site or Emergency Room).

The DHA or designee, PA or ARNP can determine when the youth requires a routine non-emergent referral to a Physician specialist for medical care and treatment.

The arrangements with any off-site licensed health care providers must include facility procedures that ensure an effective exchange of youth’s medical information when a youth is taken to a hospital, clinic, or private office for a medical complaint.

The Licensed nurse shall be responsible for youth clinical assessment, evaluation, and implementation of on-call medical access procedures when providing care and services on-site at a facility. The licensed nurse shall triage all youth sick call, chronic and episodic complaints to determine the need for immediate consultative referral to the DHA or designee, PA or ARNP.
IV. PHYSICIAN SERVICES

The Facility Superintendent or Program Director shall be responsible for establishing facility operating procedures that include, but are not limited to, the following components:

- Delivery of physician on-call medical services to meet the emergency, immediate, episodic, and chronic medical needs of the youth.
- Physician’s consultative referral addressing all components of emergency care, sick call, episodic care, first aid, chronic medical care and medication management.
- Regularly scheduled hours, in which medical and clinical complaints are identified, assessed, and (if treatment is warranted) either treated on-site or taken to the off-site provider with which the facility has an arrangement to treat.
- An effective system for youth to access a licensed health care professional.
- Treatment protocols (approved by the Designated Health Authority for on-site licensed nursing staff to follow in administering care in response to commonly encountered complaints. Such procedures are to be within the scope of practice of the staff member responding to the youth’s health care needs.
- An effective system of medical referral and follow-up when the youth’s complaint requires an assessment by a licensed health care professional with whom the facility has an agreement, such as the DHA, and off-site physician, an Advanced Registered Nurse Practitioner (ARNP), a Physician Assistant (PA) dentist, psychiatrist, specialized physician or hospital.

V. YOUTH ACCESS

A. All youth shall have access to necessary medical and dental care. The timely, effective access to medical care shall be accomplished through the collaborative efforts of the DJJ direct care staff, supervisors, facility management staff and the facility’s licensed health care professionals. The process by which a youth’s respective needs for medical care and services are accessed may vary, as long as access is not denied.

B. DJJ facility staff members and contracted health care providers shall access routine and specialized medical care and services as needed for youth residing within detention centers and residential commitment programs. Each DJJ facility shall collaborate with professional community health care providers to obtain necessary emergency and specialized medical care and services.

C. Provisions must be made to ensure that on-call medical care and service are available to youth in restricted housing of any kind (for example, confinement, seclusion, room restriction). Due to the potential for exacerbation or worsening of symptoms of patients in restricted housing, a system must be in place through which these patients are routinely observed and questioned, on at least a daily basis, about any health-related complaints. If a youth has a known active medical condition, then observation may need to be as frequent as every 2 hours.
VI. SPECIALTY MEDICAL SERVICES

A. Many times a youth, with complex medical conditions, requires routine medical care and treatment by a specialized physician’s with specific expertise in a particular area of medical specialty. It may be necessary for some youth with multiple medical conditions to be under the medical care and treatment of several medical specialists.

1. In certain situations, a youth may enter a facility or program having an existing relationship with a specialist, in which case all attempts must be made to continue those services (facility location permitting) with that specialist or to procure those services from a local specialist.

2. Under no circumstances shall a youth have necessary specialty services discontinued. In remote locations, this may necessitate frequent communication between the specialist and the facility DHA or designee, PA or ARNP for guidance on proper treatment if the youth is unable to be transported to a local specialist.

3. Alternately, a youth may develop or manifest a medical condition (acute or chronic) that is beyond the scope of practice of the DHA or designee. In this case the youth shall be referred out to a local specialist. This shall be recorded on the Sick Call/Referral Log and tracked accordingly.

4. A youth that has been receiving medical care and treatment by a specialized medical provider shall continue to receive the required specialized medical care (periodic evaluations and requisite follow-up) until the specialist determines that the youth no longer requires specialized care and services.

5. The Superintendent or Program Director, in conjunction with the facility DHA shall ensure that specialized medical care and services are accessed.

B. Common Specialists

In order to provide clarification, the following is a brief list of specialists (not all inclusive):

1. **Cardiologist:** This specialist treats youth with conditions related to the heart such as, hypertension, congenital heart disease, etc.

2. **Dentist:** A dental consultation should be provided when a youth is symptomatic with dental pain related to dental caries, impacted teeth or abnormal soft tissue examination of the oral cavity.

3. **Endocrinologist:** An Endocrinologist specializes in hormonal conditions and treats youth with Diabetes, hyper or hypo-thyroidism, etc.

4. **Gastroenterologist:** This specialist treats youth with stomach and intestinal conditions, e.g., inflammatory bowel disease, gall stones, colitis, etc.
5. **Hematologist:** This specialist treats youth with blood disorders such as Sickle Cell disease, hemophilia, etc.

6. **Neurologist:** This specialist treats youth with seizure disorders or neurological impairments.

7. **Obstetrician/Gynecologist:** Any female youth that is pregnant upon admission requires regular prenatal care from an OB/GYN and shall be referred on admission. The local health department may also provide prenatal care. Post-natal care shall be provided in accordance with the Obstetrician/Gynecologist's recommendations. All female youth routinely require at least a 6-week appointment after delivery.

8. **Optometrist:** An Optometry consultation shall be provided when a youth demonstrates abnormal visual acuity on the Comprehensive Physical Assessment.

9. **Ophthalmologist:** An Ophthalmologist treats youth with medical conditions and/or trauma to the eyes or who has a history of diseases, which requires routine medical evaluation, and treatment of the eyes (i.e. glaucoma, diabetes etc.).

10. **Orthopedic Surgeon:** This specialist treats youth with fractures, back injuries, chronic musculoskeletal conditions, etc.

11. **Rheumatologist:** This specialist treats youth with conditions affecting the joints e.g. Juvenile Rheumatoid Arthritis.
I. INTRODUCTION

A. Youth in the physical custody of a DJJ facility who have chronic conditions will receive periodic evaluations. Periodic evaluations are a mandatory component of care and can occur several times during a youth’s stay at a facility, depending on the length of stay and changes in the youth’s condition. The periodic evaluation is an updated focused medical assessment by a Physician, PA or ARNP, that includes laboratory and other diagnostic or monitoring tests as warranted, in accordance with medical practice standards. This does not mean that laboratory testing or other diagnostic testing are mandatory as part of each periodic evaluation, but only as clinically indicated. The purpose of the periodic evaluation is to ensure that youth with chronic conditions, that require ongoing treatment, or who experience changes in condition or treatment regimen, are adequately monitored. The treatment regimen is subsequently adjusted in accordance with the youth’s health status.

B. A chronic condition is any illness, disability or condition that is permanent or persists longer than three months. It generally does not resolve or go away. It is important to note that some chronic conditions are not always obvious. That is, a youth with a chronic condition may not appear to be ill, or may appear to have periods of only mild illness. Chronic conditions typically require regular periodic monitoring and/or treatment by a Physician, ARNP or PA and/or a medical specialist, even if the youth’s condition appears stable. Subtle chronic conditions include those such as scoliosis or sub-clinical thyroid disease. Examples of more obvious chronic conditions or illnesses include diabetes, asthma, tuberculosis, cancer, AIDS, or Hepatitis B. Chronic condition also includes those specific conditions for which there are treatment regimens requiring periodic monitoring. Examples of this type of chronic condition include anti-tuberculosis medication regimens or regimens with medications which have the potential for serious side effects. Additionally, the periodic evaluation is the category of care through which prenatal health care is provided to pregnant youth.

A periodic evaluation by a Physician, PA or ARNP must be conducted for youth who:

- Have chronic conditions (not necessarily requiring prescription medications);
- Have communicable diseases;
- Are prescribed medications on an on-going basis for any reason;
- Are undergoing treatment for a physical health condition;
- Have been classified as a Medical Grade 2, 3, 4 or 5;
II. FREQUENCY OF EVALUATIONS

A. The frequency of the periodic evaluation is determined by the youth’s condition, clinical needs and clinically appropriate medical standards. However, in no case is the interval between periodic evaluations by a Physician, PA, or ARNP to exceed (3) three months.

B. In the case of conditions for which more frequent monitoring is required (e.g. monitoring for side-effects to anti-tuberculosis medication, follow-up after initiation of antiretroviral medications, adjustment of insulin dosage or for monitoring of responses to psychotropic medications) the periodic evaluation shall be conducted at a frequency which is in accordance with accepted clinical standards and practice but in no case shall it exceed three months. All youth receiving anti-tuberculosis medications prophylactically (as a result of the conversion of a Tuberculosis skin test from negative to positive) shall receive a periodic evaluation at the frequency recommended by the prescribing clinician, that is, after monthly periodic evaluations for the first two months following initiation of treatment.

C. Intermittent evaluations by nursing personnel (for example, for medication administration) shall not take the place of the periodic evaluation. Intermittent evaluations by nursing personnel shall include evaluation of the youth’s weight once per month. However, if a Physician, ARNP or PA evaluates the youth for a different condition during the three month interval, and the evaluation includes an assessment of the status of the chronic condition, another periodic evaluation during that three month period will not be required unless clinically indicated.

D. A periodic evaluation is always required prior to renewing a prescription for a medication that has expired.

E. Pregnancy during adolescence is inherently a high-risk condition. Thus, prenatal care should begin as early as possible in the pregnancy with an Obstetrician. Unless otherwise determined by the obstetrician, until the eighth month, periodic evaluations should be scheduled every two-to-four weeks. Pregnant youth should receive a periodic evaluation every two weeks in the eighth month, and weekly thereafter. Documentation of the periodic evaluation on a pregnant youth may be made on the outside practitioner’s form, if desired, and then filed in the Individual Health Care Record, after review to determine if laboratory tests or other orders are to be initiated.

III. SCHEDULING AND TRACKING YOUTH WITH CHRONIC CONDITIONS

A. Each DJJ facility must develop a health-related schedule or calendar on which periodic evaluations are noted. The establishment of a Chronic Physical Health Conditions Roster can facilitate a review of those youth requiring periodic evaluations. This roster is typically a list of youth names placed under the specified chronic disease or conditions.
The date of the next evaluation can be entered next to the youth’s name. Due to the nature of the information on these lists, youth information shall be kept confidential and stored in a secure manner.

B. Periodic evaluations must also be conducted at the appropriate intervals for youth housed in restricted housing (such as confinement). If a youth is due for a periodic evaluation and that youth is housed in restricted housing, the periodic evaluation cannot be delayed until after the youth returns to the general population of the facility.

C. The suggested form *Chronic Physical Health Conditions Roster* can be used to track and follow, on a monthly basis, those youth who have chronic conditions to ensure that their care is not overlooked.

IV. DOCUMENTATION

A. ON-SITE EVALUATIONS

If conducted on-site, the periodic evaluation must be documented in the chronological progress notes in the Individual Health Care Record and must conform to professional clinical standards (SOAP format). The documentation of the periodic evaluation provided by the Physician, PA or ARNP must be suitable to facilitate the revision of the Problem List, Medical Grade Classifications and Medical Alerts as well as for treatment planning purposes.

B. OFF-SITE EVALUATIONS

If conducted off-site, the outcome of the periodic evaluation shall be documented on the *Summary of Off-Site Care* form, and filed in the Individual Health Care Record in the chronological progress notes, in reverse chronological order. Orders resulting from the periodic evaluation must be followed, actions recorded and a system in place that provides for regular review to determine that follow up is in place and timely.

C. The Department recommends the use of the *Treatment Flow Sheets* and the *Treatment Plan Form* for general and specific chronic conditions to ensure that thorough periodic monitoring of all vital signs, body systems, diagnostic and laboratory tests, etc., are being performed.

V. ORDERS RESULTING FROM PERIODIC EVALUATIONS

A. ON-SITE EVALUATIONS

1. If treatment orders are made at the time of the periodic evaluation, these orders should be written in the progress notes, or on the *Practitioner’s Order Form* or on or on whatever form a facility uses to track/flag practitioner orders in the Individual Health Care Record. Orders may be written in the chronological progress notes only, if the orders are clearly distinguished from the remainder of the entry and
flagged for the nursing staff. If this option is chosen by a facility, it must be followed consistently.

2. If prescription medications are ordered, a copy of the prescription should be made for filing in the Individual Health Care Record (with the exception of prescriptions for controlled substances). Changes in medical classification or in medical alert status may be written as orders as well.

B. Off-Site Evaluations

1. If treatment orders are made at the time of an off-site periodic evaluation, the examining clinician shall document the findings and orders on the Summary of Off-Site Care. The DJJ staff member accompanying the youth to the off-site periodic evaluation should remind the clinician of the need to be specific about treatment orders and prescriptions, and also to note on the documentation any changes in the youth’s medical classification or medical alert status.

2. Copies of any prescriptions written shall be filed in the Individual Health Care Record (except for controlled substances).

3. The youth should be scheduled for any additional tests, laboratory work, and electrocardiograms (EKGs), if applicable. The facility Superintendent/Program Director or their designee shall ensure that all follow up appointments and tests are accomplished by developing an effective tracking mechanism. The ordering clinician should FAX a copy of any lab results to the DJJ facility so that the Designated Health Authority or Physician Designee may acknowledge and communicate with the specialist regarding the treatment regimen. The Designated Health Authority, Physician Designee, PA, ARNP must sign and date the faxed material to indicate that it was reviewed.

4. A licensed nurse may call the Designated Health Authority and read the test results as long as this is in the facility operating procedures. The telephone call must include the date and time of the call, brief details of the conversation, further action/orders required by the DHA or any other events relative to the conversation.

5. The chart documentation must be thorough and include changing the Medical Grade, revising the Problem List, making additions to the MAR and documenting scheduled appointments if these or other items were part of the telephone/verbal orders transcribed. There must be a mechanism in place to ensure that a periodic review of the IHCR occurs and that all follow up appointments and orders transpire.
CHAPTER 9
EPISODIC CARE

I. INTRODUCTION

Episodic care is the health care component intended to provide medical services in response to unexpected illnesses, accidents or conditions that require immediate attention or an immediate professional assessment to determine their severity. Although some instances of episodic care are easily recognized because of their severity, this term also refers to health care provided in response to unexpected injuries or accidents, which do not necessarily require transfer to a hospital or emergency room (for example, a sprained ankle). Episodic care also includes responses to those complaints that can result in severe pain or suffering, even if the youth’s life does not appear to be in danger. This includes, but is not limited to:

- Severe physical pain;
- Acute dental injury;
- Conditions in which the severity of the illness, or injury, is unknown.

Twenty-four hour episodic care (first aid and emergency care) is a mandatory clinical component required by the Department. Every DJJ facility must provide episodic care to include: basic first aid procedures and interventions, an appropriate process for emergency transfer when indicated, procedures to ensure that facility health care staff follow-up when the youth returns to the facility and a Protective Action Response (PAR) Medical Review. Health care professionals, Para-professionals and non-health care staff may all provide episodic care. If a licensed nurse is on duty, the nurse shall conduct and/or oversee the care.

Every facility health care and non-health care staff person shall know that they have the right and responsibility to immediately call 9-1-1 at any time a youth’s condition appears compromised.

II. STAFF TRAINING REQUIREMENTS

A. FIRST AID AND CPR CERTIFICATIONS

1. All non-health care staff that has direct contact with youth must maintain current certifications in First Aid and Basic Cardiopulmonary Resuscitation (CPR) with Automated External Defibrillator (AED) training (when an AED is on site).

2. All facility licensed health care staff must maintain at a minimum, current certification in Basic Cardiopulmonary Resuscitation (with AED training, as applicable). Nursing staff is not required to maintain First Aid Certification since that instruction is included in a nurses training.
3. First Aid/CPR recertification must be provided at the required intervals.

4. AED training is required for all facilities with AED’s. Any facility that has an AED shall have at least two staff members on each shift certified in the use of the AED. The Department recommends that all staff be certified.

5. The DJJ facility Superintendent or Program Director in conjunction with the Designated Health Authority or Physician Designee are responsible for verifying with organizations such as the American Red Cross or American Heart Association the current standards and requirements.

6. Training records and proof of certification must be maintained at each facility.

B. EMERGENCY DRILLS

1. All health care and non-health care staff must act quickly and effectively when faced with youth and/or staff emergencies. Emergency drills help to ensure a proper response. Thus, each facility Superintendent or Program Director in conjunction with the DHA or Physician Designee must ensure that emergency drills are conducted for each shift, on at minimum a quarterly basis. These drills are not the same as institutional emergency or disaster preparedness drills. The drills should be announced and unannounced and simulate an episodic care event that calls for immediate First Aid and/or administration of CPR techniques and the initiation of the emergency procedures to follow when a life-threatening emergency does occur. Not all drills must include CPR, but those techniques MUST be practiced on a regular basis.

Suggested simulated events that may be used for emergency drills include:

- Cardiopulmonary Arrest
- Unconsciousness (youth found down)
- Choking Episode
- Uncontrolled Bleeding
- Seizures
- Sudden Mental Status Changes
- Chest Pain
- Shortness of Breath
- Open Head Injury
- Fractures or Potential Fractures
- Suicide Attempt

2. These drills do not need to be elaborate and do not require licensed health care professionals. However, if licensed health care staff are available onsite then facilitation of these drills should be one of their responsibilities. Direct care staff must always be active participants.
3. All staff responding to a youth’s emergency event shall be at the scene of the event location and render assistance to the youth within three minutes. The designated person “in charge” shall assure that the event site is cleared and secure from all youth and unnecessary personnel. The focus should be on calling “911” and initiating CPR immediately.

4. The health care staff rendering care to a youth during an emergency drill shall be responsible for concluding the event. When health care staff is not present at an actual event or drill the designated person “in charge” of the emergency event shall be responsible for concluding the event.

5. Each facility shall establish documentation procedures for actual emergency medical events and/or simulated emergency medical drills. This documentation shall include all of the following:

- Type of emergency medical event/ Type of simulated scenario (e.g., seizures, unconscious youth, etc.);
- Time the event or drill commenced;
- Actual time “911” called;
- Name of supervisor/health care provider in “charge”;
- Health care provider response time;
- Direct care staff response time;
- Type of medical care rendered at the actual event or drill;
- Name of person concluding actual event or drill;
- Time event or drill concluded;
- Actual event or drill deficient practices and plan for rectification.

6. These drills are to be documented and critiqued in detail in order to determine areas in which additional training is needed. Documentation of the critiques and the follow-up corrective action/education, if any, shall be maintained at the facility.

III. FIRST AID KITS AND AUTOMATED EXTERNAL DEFIBRILLATORS (AEDs)

A. FIRST AID KITS

1. Each facility shall maintain locked and secure first aid kits located at designated and staff accessible locations throughout the facility. Locations are to be determined by the Designated Health Authority or Physician Designee in conjunction with the facility superintendent or program director. Determination of the location of the first aid kits should be made based on facility size, use, traffic pattern, extent and availability of on-site licensed health care professionals, etc. If necessary, instead of being locked in a cabinet, DJJ facilities should consider other approved methods, such as, placing them in breakaway containers that are secured. A first aid kit must also be readily accessible to staff who are responsible for monitoring youth who are housed in restricted housing of any kind.
2. Because of the potential security risk of certain items contained in first aid kits (for example, elastic wraps and scissors), location of the kits should be secure and inaccessible to youth. When possible, blunt-nosed scissors should be used. Items such as the knife-for-life and wire cutters should not be in the first aid kits. An exception to this rule is that these items may be kept in those first aid kits maintained in vehicles used for transportation of youth.

3. Specific contents of the kit shall be determined by the Designated Health Authority or Physician Designee and should reflect the particular needs of the facility. For example, a wilderness program will require first aid supplies beyond that of a program situated in an urban facility. It is suggested, but not required, that decisions regarding the contents of first aid kits be based on recognized national standards, such as those published by the American Academy of Pediatrics or the American Red Cross.

4. First aid kits must have the proper contents for the area of the facility in which they are to be used and must be organized and arranged for efficiency. They are not to contain oral or injectable medications of any sort. Exceptions to this prohibition include wilderness programs or other programs in which quick access to Epi-pen and similar drugs such as bee sting kits and oral or injectable antihistamines, inhalers or other youth-specific emergency medications, must be readily accessed by staff.

5. A system should be in place that ensures that the first aid kits are restocked after use and inventoried on a regular basis. “Inventoried" means that staff is aware of items that are due to expire and need to be replaced by current items. It also means that the emergency kits are in the designated places. It is suggested that first aid kits be resealed with breakaway tabs after each use and restocking in order to facilitate quick access while also ensuring a means of readily identifying that a kit has been opened. All staff should be educated about the proper use of the contents of first aid kits, regardless of what contents have been decided upon by the Designated Health Authority.

6. Suggested Basic Contents for First Aid Kits:

- Sterile gauze pads
- One-inch tape (hypo-allergenic)
- Elastic bandage
- Scissors
- Eye rinse solution
- Disposable gloves
- Antibacterial ointment
- Band-Aids
- Aromatic spirits of ammonia
- One-way CPR barrier mask
- Small Biohazard Waste Disposal Bag
▪ Sterile Saline for cleansing wounds
▪ Antibacterial hand washing materials

*Note:* The Ammonia ampules are to be used only for the purpose for which they were intended and by personnel trained in First Aid.

**B. AUTOMATED EXTERNAL DEFIBRILLATORS**

1. The use of an AED has been demonstrated to assist in the life-saving efforts for those individuals suffering from sudden cardiac arrest from ventricular fibrillation prior to EMS arrival. Thus, the Department strongly recommends that all facilities have at least one AED.

2. The AED should be placed in its locked, wall-mounted case in an area that is easily staff accessible.

3. Established procedures must ensure that the batteries, pads, etc. are replaced at the requisite intervals.

**IV. ADVANCED FIRST AID EQUIPMENT AND SUPPLIES**

Based on the type of on-site health care staff and the youth population, each DJJ facility should determine the need for advanced first aid equipment, such as a portable oxygen tank, a pulse oximeter (highly recommended), oral airways, suction equipment, etc. Each facility should consider having a portable oxygen tank and the appropriate equipment necessary to administer oxygen in the event of a medical emergency. Decisions regarding this equipment should be made based on the following:

- Availability and authorization of staff who are proficient in the use of this equipment
- Existence of advanced emergency treatment protocols
- Likelihood of the need for such equipment
- Response time of local emergency medical services (EMS)

For those DJJ facilities which frequently have youth in custody who may require specified emergency medication to counteract severe side effects to prescription medication; or youth who have life-threatening allergies, consideration should be given to the need for maintaining a limited non-youth specific and youth-specific inventory of required medications. Examples include: (1) Glucagon or equivalent and, (2) the Epi-pen. In order to maintain such supplies, both a system for the safe and secure storage, as well as appropriate training for health and non-health care staff, must be in place.

**V. ACCESS TO EPISODIC CARE**

During orientation to the facility or program, all youth must be informed of the 24-hour availability of episodic care (first aid and emergency care) and methods of access to emergency care. It is to be emphasized that if they have a significant injury, illness or change in condition
(or notice another youth in distress) they are to immediately notify the direct care and/or health care staff.

VI. ON-SITE FIRST AID AND EMERGENCY CARE

A. PROVISION OF EMERGENCY CARE

Both health care and direct care staff has an obligation to protect the health and safety of the youth at all times. Thus, on-site First Aid and/or Emergency Care shall be provided to ALL youth who are in need (when a youth’s health is compromised or life is in jeopardy), in the most effective and efficient manner possible. If any direct care staff is unsure as to whether a situation is an emergency or warrants emergency medical attention, they shall immediately notify the on-site licensed health care staff. If this person is not on-site or is otherwise not immediately available then Emergency Medical Services shall be summoned by calling “911” while Cardiopulmonary Resuscitation (CPR) is started (as appropriate to the type of injury or illness). Similarly, if the licensed health care staff on-site is uncertain as to the condition of the youth, 911 shall be summoned immediately. No staff person should be faulted for acting too quickly or accessing EMS for a situation that was ultimately less critical that it appeared. Delays in calling 911, for whatever the reason, are unacceptable and place valuable lives in jeopardy unnecessarily.

B. EMERGENCY TREATMENT PROCEDURES

All facility clinical emergency procedures, guidelines and instructions must be reviewed and approved annually and as needed by the Designated Health Authority. At a minimum, the following procedures and/or guidelines should be in place:

1. An emergency procedure for life-threatening emergencies, rapid communication, notification of emergency medical services (EMS) by calling 911, preparation of relevant information from the Individual Health Care Record, parental notification process and security procedures for the rest of the juvenile population.

2. In the event that a serious suicide attempt occurs, the procedures should include the planned, quick access to tools used for cutting or removing items from around a youth’s neck, measures for reduction in constriction around the neck while extraction and release is occurring and measures to safely initiate CPR with minimum risk of further injury. For the purpose of this manual, a serious suicide attempt is one whereby a youth is unconscious, has stopped breathing, is noted to have a change in facial or tongue color, has profuse bleeding, etc.

3. Emergency procedures, (appropriate for the layperson and the licensed health care professionals to follow), for the following examples of life-threatening emergencies:
   - Arterial bleeding
   - Burns
Florida Department of Juvenile Justice  
Health Services Manual

- Choking
- Chemical splash in the eye
- Strangulation
- Foreign object in the eye
- Neck injury
- Head injury
- Poisoning
- Actual or potential broken or fractured limb
- Seizure
- Respiratory and/or cardiac arrest
- Asthma attack
- Shock
- Anaphylaxis: severe allergic reaction

4. These procedures need not be written by the DJJ facility although they may be adjusted for the facility’s needs, if approved by the Designated Health Authority. Standard, published first aid guidelines and procedures for the layperson may be used for the listed situations.

5. In addition to emergency procedures, each DJJ facility must have procedures for first aid encounters, to include documentation on an *Episodic (First Aid/Emergency) Care Log*.

6. A list of emergency telephone numbers and cell-phones numbers, including the number of the statewide Poison Information Center (1-800-282-3171) for example, must be posted or located so that it is accessible to all staff, on all shifts. This list should not be in a location accessible to juveniles.

7. Facilities that frequently have in custody, youth on psychotropic medications should have in place a list of the common severe side effects to the various classifications of psychotropic medications. This list should be posted where it is accessible to the individual(s) responsible for administering the medications. These facilities should also have arrangements with licensed receiving facilities and hospitals in the event that life-threatening events occur as the result of ingestion, consumption, over-dosage, or any other adverse event related to a medication, particularly psychotropic medications.

C. EPI-PEN (EPINEPHRINE AUTO INJECTOR)

1. The Epi-pen is a disposable, pre-filled, automatic epinephrine injection device that is used during (anaphylactic) allergic emergencies. It contains a single dose of (latex-free) Epinephrine that is injected into the outer thigh. This medication is used for allergic emergencies that may occur from:

- Insect stings or bites
- Foods
2. A youth with allergies may experience mild to severe allergic reactions. Anaphylaxis (severe allergic reaction) is a life-threatening event. Anaphylaxis symptoms include, but are not limited to:

- Urticaria (hives)
- Erythema (severe redness)
- Pruritus (itching)
- Dizziness
- Edema (swelling)
- Flushed Appearance
- Sweating
- Weakness
- Pulse Variations
- Rapidly Falling Blood Pressure
- Anxiety
- Shock
- Difficulty Breathing

3. A youth having such a severe allergic reaction that it requires the use of an Epi-pen is having a true medical emergency and EMS must be called immediately.

4. The Designated Health Authority or Physician Designee, PA or ARNP shall assure that a medical evaluation and individualized physician’s order (when appropriate) are written for an Epi-pen when a youth is identified as having allergies that could result in an anaphylactic reaction. All DJJ facilities shall have an Epi-pen available for each youth identified as having this severe of an allergic reaction.

5. A youth’s Epi-pen shall be nearby and ready for use at all times. The facility shall store the Epi-pen at the recommended storage temperature (77-86 degrees Fahrenheit). The Epi-pen must be protected from light. Do not store Epi-pen in the refrigerator. Each facility shall be responsible for establishing emergency procedures for the procurement, usage, and storage of the Epi-pen.

6. When a youth is at a facility and may require the use of an Epi-Pen, all health care and direct care staff (at the Supervisory level) shall be appropriately trained on the administration of the Epi-pen and shall administer the Epi-pen when indicated. An appropriately trained RN can train other health care staff and non-health care staff on the use of the Epi-pen.
D. DOCUMENTATION REQUIREMENTS FOR NON-HEALTH CARE STAFF

1. All on-site episodic care must be documented legibly in ink in the chronological progress notes in the Individual Health Care Record. The entry in the notes must be clearly designated by one of the notation(s) “First Aid,” or “Emergency Care.”

2. Staff members who are not licensed health care professionals who provide episodic care (first aid and/or emergency care) are authorized to provide care only which is within their training. The documentation of on-site care provided by a staff member who is not a health care professional is not expected to meet the standards of a licensed health care professional.

3. Facilities without health care staff on site shall utilize an Episodic (First Aid/Emergency) Care Log and progress note to document episodic care. The non-health care staff member rendering care to a youth must document the care that was rendered on the Episodic (First Aid/Emergency) Care Log and the chronological progress note. A youth identified as receiving episodic care by a non-health care staff person must have a follow-up evaluation by a licensed health care staff person the next time this person is on-site, or sooner, if warranted.

4. Progress note documentation must contain the following information:
   ☑ Date and time of the episodic care (first aid and/or emergency encounter)
   ☑ The nature of the complaint (e.g., “cut finger”, “bee sting”, “swallowed poison”, “overdose of medication”, “stopped breathing”, etc)
   ☑ The findings of the person rendering care (documented in keeping with whether or not the individual rendering care is a licensed health care professional)
   ☑ Treatment rendered (again, commensurate with the individual rendering care)
   ☑ Referral to hospital or another off-site facility (as applicable);
   ☑ Education and instructions given to the youth, if applicable
   ☑ Plans for follow-up and future treatment, (to MD, PA, ARNP) if applicable
   ☑ Placement on the facility’s medical alert roster, if applicable
   ☑ Parental notification (e.g., telephone, written notice, name of person contacted)
   ☑ Legibly printed name (first name, last name), credentials and position of the staff member rendering care; (or name stamp, if available)
   ☑ Official signature
   ☑ DJJ facility name

5. If an error is made in any form of health care documentation that error should be indicated by one line drawn through the error and the word “ERROR” printed above it. Obscuring the error through use of whiteout or other means is prohibited.
E. DOCUMENTATION REQUIREMENTS FOR LICENSED HEALTH CARE PERSONNEL

If on-site episodic care (first aid and/or emergency care) is provided by a licensed health care professional, documentation shall be in such a manner that conforms with professional standards and can be used to communicate pertinent information to other health care professionals. Although problem oriented charting may be used, (e.g., formats which include “Subjective, Objective, Assessment, Plan” [SOAP]) it must be sufficiently detailed, and include all elements of a professional nursing note. The nursing professional may use standard narrative charting, as long as it is sufficiently detailed and contains, at a minimum, all of the elements listed above, (Section VI. D.).

F. ON-SITE EPISODIC (FIRST AID/EMERGENCY) CARE LOG

In addition to the detailed entry about a youth requiring episodic care into the Individual Health Care Record, a log must be in place at each DJJ facility that documents in aggregate by date, in chronological order, episodic care complaints. This log must include the date, the youth’s name, a brief description of the nature of the complaint and disposition of the emergency complaint (all transfers for off-site emergency evaluation and/or treatment should be noted). This log may be typed, computer-generated or maintained by hand. If manually maintained, the entries must be in ink and must be legible. This log is maintained at the facility, and does not take the place of documentation in the Individual Health Care Record. Entry into this log shall be made at the time care is rendered by the same individual who provides the care.

Unlike the youth’s Individual Health Care Record, the Episodic (First Aid/Emergency) Care Log remains (permanently) at the facility, and a designated individual shall be responsible for its maintenance, location and accessibility.

A suggested format for this log is included in the Forms Appendix. This is a suggested format only. A facility may utilize any other type of format as long as it contains these components. These logs shall be kept in the facility for a minimum of three years.

VII. OFF-SITE EMERGENCY SERVICES

A. ARRANGEMENTS WITH HOSPITALS

1. Each DJJ facility shall have an arrangement with a licensed general hospital to provide emergency services on a 24-hour per day basis. Arrangements with facilities should be made ahead of time. They should include consideration of the anticipated needs of the DJJ facility and other discussions about procedures between the two entities. This shall ensure that an effective exchange of medical information necessary for continuity of care will occur whenever a youth is transferred to a hospital, for emergency medical or dental care.

Note: In many cases, the only documentation able to be procured by a detention center or residential commitment program is an acknowledgement that all local
ambulances and emergency arrivals will be accepted at the facility. This documentation will suffice.

2. Ideally, all the health care providers, with whom the facility has arrangement(s), shall agree to provide the DJJ facility with information about the off-site care rendered (assessment findings, diagnosis, treatment and recommendations for follow-up). It is recommended that the Departmental form Summary of Off-Site Care accompany the youth to the off-site provider, to be filled in and returned to the facility for filing in the youth’s Individual Health Care Record. The most recent copy of the Authority for Evaluation and Treatment Form should also accompany the youth. The off-site provider may retain a copy of both forms.

3. Any other discharge instructions or standardized forms routinely used by the off-site provider and given to facility staff should also be filed in the youth’s Individual Health Care Record. Upon the youth’s return, the documents sent back to the DJJ facility MUST be reviewed in order to ascertain if there are orders for referrals, lab work, exercise restrictions, alerts or follow-up appointments. Referrals must be entered on the Sick Call/Referral Log or the facility’s referral tracking log. Pertinent information about the referral (i.e. Physician to whom the youth is referred, date and time of appointment and other information) must be documented within the progress note. The youth’s parent or guardian should be notified via the Parental Notification of Health Related Care form that the youth has a pending appointment in the event that this youth is discharged before the date of this appointment.

4. The Designated Health Authority or Physician Designee, PA or ARNP shall initial all orders/information sent back with the youth to the facility, including radiological reports and other tests that may arrive in the ensuing days. Reports of “wet reads” if sent must be reviewed and initialed; preliminarily, the review may be telephonic.

5. Release of this information by the treating facility to the DJJ facility is authorized both as part of the Departmental Authority for Evaluation and Treatment and through the HIPAA exemption which allows for the release of a DJJ youth’s personal health information between outside practitioners and DJJ staff for the purpose of serving a youth’s medical needs. (Refer to Chapter 4, Consent and Notification Requirements).

B. DOCUMENTATION OF OFF-SITE CARE

1. All DJJ facilities shall have procedures in place to facilitate documentation by off-site health care providers. It is the policy of the Department that off-site providers have access to health-related information contained in the Individual Health Care Record to the extent necessary to provide safe and effective health care services. Establishing the method of providing copies of the necessary health-related information to offsite providers is ultimately the responsibility of the DJJ facility. Relaying brief verbal information over the phone to hospital staff is not sufficient, although this should be included in the facility’s process if desired. At minimum, a copy of the Authority for Evaluation and Treatment, Physician’s Orders, Health-
Related History, Comprehensive Physical Assessment, Progress Notes, (or a brief relevant transfer note), Laboratory/X-ray Reports (when applicable), and the Medication Administration Record must be delivered to the off-site facility in order to allow the health care professionals to provide necessary care.

2. In the event of a life-threatening emergency in which there is no time to gather these documents prior to the arrival of the Emergency Medical Services (EMS), arrangements should be made for the copies of documents to be taken to the hospital as soon as possible after the youth is transported. A copy of the treating facility’s findings, interventions and recommendations for follow-up shall be made a part of the youth’s Individual Health Care Record. The treating facility should be provided with the standardized form, Summary of Off-Site Care, which at a minimum, must be returned to the facility and filed in the Individual Health Care Record. This form or an appropriate discharge summary should be filled out by the treating facility and returned with the youth. The Summary of Off-Site Care (and any other documents sent by the off-site treating facility) is to be filed in the Off-Site Care section of the Individual Health Care Record, most recent document on top.

3. Procedures shall be in place at each facility that ensure that youth who have required treatment at an off-site facility for first aid or emergency care receive appropriate monitoring and follow-up. This may include such provisions as automatic placement on the facility’s medical alert roster for a minimum of 24 hours. A designated individual, preferably a licensed nurse, must ensure that all hospital instructions and consultations/referrals, follow-up appointments, laboratory or diagnostic studies, etc. by the hospital, are made and documented within the nursing progress notes and/or Practitioner’s Orders. The Designated Health Authority, or Physician Designee must also sign and date all of the findings, instructions etc., that were sent with the youth from the outside facility.

VIII. NOTIFICATION REQUIREMENTS

A. NOTIFICATION OF PARENT AND OR GUARDIAN WHEN THE YOUTH’S ILLNESS, INJURY OR SUICIDE ATTEMPT REQUIRES EMERGENCY MEDICAL SERVICES OR IS LIFE THREATENING

When the youth’s illness, injury or suicide attempt requires emergency medical services, hospitalization or is life-threatening (after necessary medical treatment is obtained for the youth) the licensed nurse, facility superintendent or program director must make every effort to immediately notify the parent/legal guardian by telephone. If the parent or legal guardian cannot be contacted, the following steps must be taken:

- Use alternative contact methods as documented in the youth’s record. Such alternative methods may include, but are not limited to, contact via the parent’s or legal guardian’s work address, pager/cell phone or electronic notification or contact via a relative or neighbor.
Contact with the youth’s Juvenile Probation Officer to request assistance with notification. In the cases where the youth’s family lives in close proximity to the JPO’s work location or area, request that the JPO drive by the parent or legal guardian’s home, place of work, school or other known location outside of the home.

Contact law enforcement to request assistance in locating the parent or legal guardian.

In all cases, the facility nurse, superintendent or program director must document in the chronological progress notes of the youth’s Individual Health Care Record all efforts to contact the parent or legal guardian.

B. For other non-critical hospitalizations, emergency room visits, etc. all attempts shall be made to contact the parent or guardian by phone. The Parental Notification of Health-Related Care form should be sent by regular mail at the earliest possible time, but no later than 2 days after the transfer. If a health care event occurs that warrants that this form is sent, a copy of the completed form that is mailed to the parents should be filed directly behind the Authority for Evaluation and Treatment.

C. Written notification of a youth’s emergency treatment at an off-site hospital or clinic shall always be sent, with the exception of the death of a child. In no case shall a written notice be sent in the event that the youth has died. The facility Superintendent, Program Director, or appropriate designee shall notify the parent or guardian in person (not over the phone) and arrangements should be made for grief counseling. If the distance for personal notification is too great, the facility Superintendent or Program Director is to arrange with the JPO and/or the local DJJ management that is proximate to the family of the child, for personal contact.

D. NOTIFICATION OF DESIGNATED HEALTH AUTHORITY

1. The Designated Health Authority or Physician Designee shall be informed if a youth requires emergency transfer off-site for evaluation, treatment and/or hospitalization. During life-threatening circumstances (e.g. cardiac arrest, respiratory arrest, anaphylactic reaction or profuse bleeding, etc.) notification to the Designated Health Authority shall be during or after the youth receives necessary medical treatment and is transported to the ER. Immediate EMS notification, response and transport of the youth are the primary objectives.

2. The staff member who notifies the Designated Health Authority shall include in the chronological progress notes an entry that includes the date, time and manner of notification (telephone, etc.) and the person notified.
IX. EPISODIC CARE SUBSEQUENT TO A PROTECTIVE ACTION RESPONSE (PAR)

PAR is the Department approved verbal and physical intervention techniques and application of mechanical restraints used in accordance with the DJJ Rule 63H – 1.001 – 1.016, the Protective Action Response Escalation Matrix, and PAR training curricula.

A. THE POST-PAR INTERVIEW

Each facility must ensure that the Superintendent, Program Director or designee conducts a Post-PAR interview within 30 minutes after the incident, for any youth that experiences a Level 2 or Level 3 PAR response. This interview shall include, but not be limited to, a review of the following components:

- Verbalized physical complaints (e.g. pain, headache, unable to see);
- Any visible injuries (e.g. swelling, redness, bruising, bleeding);
- Severe agitation and restlessness;
- Medical or clinical concerns expressed by youth;
- Ability/inability to answer questions appropriately (e.g. name, day, date);
- Orientation/disorientation to environment (e.g. unfamiliar with surroundings);
- An assessment of level of alertness (e.g. lethargic);
- Shortness of breath;
- Unconsciousness.

Any of these findings on interview, warrant a PAR Medical Review.

B. THE PAR MEDICAL REVIEW

1. If the Post-PAR Interview indicates the need for a PAR medical review then the youth shall be referred to the on-site licensed health care professional (nurse, ARNP, PA or Physician) who shall be responsible for performing a clinical assessment for any youth exhibiting potential or actual injuries following a PAR incident.

2. When there is no licensed health care staff on-site, the facility Superintendent or Program Director shall transfer a youth exhibiting possible injuries following a PAR incident, to the hospital emergency room for a medical evaluation to determine if any injuries or complications occurred because of the PAR incident.

C. THE POST-PAR DOCUMENTATION

1. The Post-PAR interview and PAR Medical Review shall be documented on the progress note in the youth’s Individual Health Care Record. The youth interview information must be entitled; Post-PAR Interview and the Medical evaluation shall be entitled PAR Medical Review.
The documentation must include the following components:

- Date and Time of PAR Interview and or medical review (as applicable);
- Findings of the PAR interview and/or medical review (as applicable);
- Signature and Title of individual conducting interview and/or medical review;
- Descriptions of injuries or complications;
- Medical treatment provided.

The individual performing the Post-PAR interview will also sign and date the PAR Report.

2. If an offsite medical review is conducted, the relevant sections of the youth’s Individual Health Care Record and Medication Administration Record shall accompany the youth to the review.

3. When a youth returns to the facility from an off-site medical review, the top of each page returned by the reviewer must be dated and labeled with “PAR Medical Review.” The documents will then be placed in reverse chronological order in the Progress Notes in the youth’s Individual Health Care Record.

4. The facility Superintendent or Program Director must review the PAR Incident report, Post-PAR interview and the PAR Medical Review.

*Note: These requirements are based on the PAR Rule 63H – 1.001 – 1.016.*
DEPARTMENT OF JUVENILE JUSTICE
HEALTH SERVICES MANUAL

CHAPTER TEN
GIRLS’ HEALTH

OCTOBER 2006
I. INTRODUCTION

This chapter discusses the unique and complex health care needs of delinquent girls. Girls entering Department of Juvenile Justice facilities and programs often have serious unmet health care needs, especially girls who are runaways, living in poverty or have limited access to health care. Girls and young women's health care needs are very different from boys. Female-specific disorders related to reproductive and gynecological issues pose unique health risks for girls. Incarcerated girls and young women also have high rates of infectious and communicable disease, sexually transmitted diseases, genitourinary disorders and injuries.

Extensive research indicates high rates of physical and sexual abuse among girls involved in the juvenile justice system. The range of health care needs of abused girls and young women often include mental health and substance abuse problems and physical health problems including neurological problems, gastrointestinal problems and gynecological problems. The particular health care service needs of abused girls are an important factor in considering the health care needs of girls involved in the juvenile justice system.

The delivery of health care services for females must differ from males in order to meet the female’s individual physical and emotional needs. By providing gender specific health care services, which address the life experiences, issues and needs of delinquent girls, the Department is directly addressing a fundamental aspect of providing necessary and appropriate health care services to these youths.

The goal of delivery of gender-specific health care to girls is to incorporate into the Department’s continuum of services, health care services that reflect an understanding of female development and the specific issues of the adolescent female.

The health care needs of teen girls are heightened due to girl's maturation and development occurring two years earlier than boys and society’s gender role expectations for girls and women. There is a connection between women’s roles in greater society, societal barriers to healthy female growth and development, and the specific treatment issues of girls. It is essential that staff guide girls to an awareness of these issues and how to constructively address them in their lives. It is important that staff understand the adolescent girl’s growth and development process and the medical and mental health issues that are related to adolescent girls, particularly within the context of the girl’s culture and ethnicity.

II. BASIC PRINCIPLES

Each DJJ facility and program that serves girls must ensure youth access to a full range of gender responsive health care services which address female growth and development,
sexuality, reproductive health, trauma related to physical abuse, sexual abuse, neglect and
witnessing violence, sexually transmitted diseases, drug/alcohol abuse, and teenage
pregnancy.

All facilities and programs that serve girls shall provide gender responsive health care services,
which promote wellness, resiliency and positive outcomes for girls. Gender responsive health
care must include the following components:

- Well-trained, staff that are knowledgeable about adolescent growth and development,
  health-related issues, risk and protective factors and cultural characteristics of delinquent
girls.
- Individualized treatment plans to address the health care issues and needs of each youth.

DJJ facilities and programs serving girls shall provide comprehensive gender responsive health
care services that are efficient and effective.

III. GIRLS GENDER SPECIFIC COMPONENTS

Gender responsive services for girls include the following essential components:

A. GROWTH AND DEVELOPMENT

During the teen years (between 13 to 18 years), adolescent girls experience changes in
their physical development at a rate of speed unparalleled to the male adolescent. During this time, a girl will see the greatest amount of growth in height and weight and puberty changes.

Adolescent girls require an increased focus on specific growth and development issues to provide effective health care during puberty. Sexual and other physical maturation that occurs during puberty results from rapid hormonal changes. Each girl is different and some girls progress through these changes more rapidly, resulting in early maturation. Early maturing girls tend to suffer more from depression, anxiety, and eating disorders.

A girl’s Health Related History and/or Comprehensive Physical Assessment should
include the following health information that focuses on a female’s growth and development issues. This would serve to facilitate the identification of risk factors or presence of medical and mental health issues related to anxiety, depression, eating disorders, drug and alcohol abuse, suicide and pregnancy:

- Recent weight loss or gain;
- Oversensitivity about weight;
- Recent attempts to lose weight;
- Eating patterns;
- Average hours of sleep each night (average required hours 9-10 hours per night);
B. **MEDICAL CARE AND SERVICES**

The Designated Health Authority or Physician Designee, PA or ARNP shall be responsible for ensuring that appropriate gender responsive and age-related health care and services are provided in addition to routine medical care and services to all youth within the DJJ continuum of health care.

Each female should receive individualized gender responsive medical care and services that includes, but is not limited to, the following:

- Gynecological and menstrual conditions;
- Medication management;
- STD testing and medical treatment;
- Contraceptive management;
- Specialized nutritional management: (pregnancy, anorexia, obesity, anemia);
- Alcohol and drug abuse medical management;
- Specialized female adolescent complex medical management: (anorexia, bulimia);
- Prenatal and postnatal care for pregnant girls;
- Standard well-child check-ups, immunizations, and sick baby care for any infants in residential programs with their mothers;
- Aftercare Planning (i.e. medical foster home which includes health insurance coverage such as Medicaid, Kid Care, or private insurance; safe housing; child care);
- Education about girls’ health (sexual identity, sexually transmitted diseases, contraception, reproduction, nutrition, pregnancy, parenting, self-worth);
- Childbirth education, parenting skill education, family planning, infant care education; and
- Hygiene and grooming needs that are culturally appropriate.

Each facility serving girls must develop gender responsive treatment plans, which are individualized to address the needs of each adolescent female.

### IV. GENDER RESPONSIVE MEDICAL SERVICES

#### A. PREGNANCY

1. **Pregnancy Screening and Testing**

   Teenage pregnancy can result in serious health risks and social problems for teenage girls. Teen pregnancy is closely linked to poverty and failure to complete
school. Additionally, medical complications are partnered with alcohol use, drug abuse, and sexually transmitted diseases.

Each female youth shall be screened for pregnancy at the time of admission into a detention center and/or residential commitment program. This screening shall include any history of pre-existing medical conditions, medication therapy, alcohol use or substance abuse. The Designated Health Authority shall be notified and provided with screening information within twelve hours of determining a newly admitted youth is pregnant.

Any female identified as pregnant at the time of admission to a DJJ facility or program who confirms consumption of alcohol at any time during her pregnancy is eligible for Florida’s Healthy Start services http://www.healthystartflorida.com. These services should be utilized as a collaborative effort to reduce barriers to treatment, provide support for abstinence and assist the youth in getting needed health care upon return to the community.

Any youth that identifies her menstrual cycle as more than two weeks late shall have a urine or blood pregnancy test performed. Over-the-counter home pregnancy tests are not always accurate and should be avoided.

If the youth is identified as being pregnant, the Designated Health Authority or Physician Designee, PA or ARNP shall be immediately notified and medication held until explicit instructions are given regarding continuation of the current medication regimen.

2. Consent and Notification Issues for Pregnant Youth

Pursuant to Section 743.065, F.S., a minor pregnant female may independently make health care decisions regarding her medical care related to her pregnancy. Thus, in the case of a pregnant female, although statutorily the consent or notification of the parent or guardian is not explicitly required, the youth should be encouraged to allow for parental notification when medical issues arise. Because of the Department’s unique responsibility for the health and safety of the youth and the unborn child, if the youth refuses, the facility Superintendent, Program Director or designee shall consult with the regional general counsel’s office. Adolescent girls often need and seek the support and assistance of their family during pregnancy and after the birth of their child.

3. Prenatal Health Care in the DJJ Facility or Program

Pregnant girls and girls who are parents shall receive health care services and health education consistent with standard health care protocols for pregnant and postpartum adolescents and parents of young children.

The Department’s facilities and programs serving pregnant girls must provide the necessary medical, mental health and prenatal services to facilitate a healthy
pregnancy. Department programs and providers must collaborate with the Department of Health and the Department of Children and Family Services in an effort to meet the needs of the pregnant female and infant while in the care of the department and during the transitional phase back into the community.

Each DJJ facility and program serving girls shall be responsible for ensuring that facility procedures are in place to provide necessary and appropriate health care services to the pregnant youth and youth who are parents. Necessary and appropriate services and procedures shall include, but are not limited to, the following components:

- DHA recommended prenatal, postnatal, and neonatal (as applicable) medical care;
- Coordination of routine health care services (e.g., physician appointments, childbirth education, lactation consultations, postpartum examinations, and well-baby care);
- Nutrition;
- Mental health services to address mental health issues during pregnancy and promote mother-infant bonding and attachment; and
- Aftercare planning, including community referrals.

The Designated Health Authority or Physician Designee shall be responsible for establishing procedures for the early identification of pregnancy in the adolescent female and the medical management oversight for provision of specialized prenatal, postnatal, and neonatal (as applicable) medical care for the pregnant female, adolescent parent and infant. Collaboration with community health care providers shall be utilized when necessary to obtain prenatal, postnatal, and neonatal specialized health care services.

Prenatal care shall begin immediately upon determination that the youth is pregnant. An appointment shall be made with an Obstetrician and/or Perinatologist. The Department of Health may be utilized to obtain these specialized medical services. Prenatal vitamins may be initiated prior to the Obstetrician and/or Perinatologist's initial medical evaluation.

The Designated Health Authority or Physician Designee, PA or ARNP shall provide a routine, focused medical oversight evaluation of the youth’s pregnancy progress every thirty days. This medical oversight evaluation is in addition to the youth’s routine specialized obstetrical care. The Designated Health Authority shall collaborate with the Obstetrician and/or Perinatologist in the oversight and management of the youth’s pregnancy.

4. Complications of Pregnancy: Signs and Symptoms

The licensed professional health care staff and trained non-licensed health care staff shall provide routine daily monitoring and observation for indications of danger signs associated with medical complications related to the female’s pregnancy. These danger signs include, but are not limited to, the following:
Chills and fever;
Severe headache;
Dizziness;
Dim or blurred vision;
Facial and body swelling;
Heavy pain under ribs that won’t go away;
Sharp pains in the stomach or side that won’t go away;
Bright red vaginal bleeding;
Leaking fluid from vagina (slow leak or sudden gush);
Pain when passing urine;
Constant back pain that will not go away;
Signs of pre-term labor: contractions 10 minutes apart;
Cramps like a period;
Vaginal discharge: watery, mucus or blood;
Low dull backache;
Pelvic pressure.

The pregnant youth shall be thoroughly evaluated by a health care professional when there are any complaints of illness or injury. If the pregnant youth is experiencing medical complications related to her pregnancy, the Designated Health Authority shall be immediately notified. When this person is on the facility premises the youth shall receive an immediate medical evaluation.

Licensed health care staff or facility direct care staff shall immediately call 911 when the pregnant youth is in need of emergency services.

5. Housing Needs for Pregnant Youth

Bunk beds (the upper bunk) for pregnant and postpartum mothers can pose a hazard for falling. Preferably, a standard bed with adequate mattress support should be provided to the pregnant youth for the safety of the mother and baby during pregnancy. The pregnant female should be encouraged to sleep on her side at all times. She should avoid sleeping on her back or stomach to prevent fetal injury and growth retardation.

6. Testing for Sexually Transmitted Diseases

Medical providers screen pregnant women and girls for sexually transmitted diseases (STD’s) to improve the identification, management and treatment of STDs during pregnancy. Pursuant to Section 384.31, F.S., the Department of Health revised Florida Administrative Code (F.A.C.) 64D-3 to reflect the following STD testing requirements for pregnant women and girls:

- Testing for the following STD’s should occur:
  - Chlamydia,
  - Gonorrhea,
• HIV,
• Syphilis,
• Hepatitis B;

- The youth shall be informed of the specific STD’s she will be tested for during the screening;
- HIV testing shall be a routine part of pre-natal care. All Pregnant youth shall have an HIV test unless, after counseling by the Physician, PA or ARNP as to the risks of transmission of HIV to the fetus, she refuses testing. When this occurs, she must sign a waiver (refusal) to decline the test. This shall be filed in the IHCR.
- The youth may refuse testing for one or more of the above STD’s, should she choose to do so. The refusal should be documented in the IHCR.

Sexually transmitted diseases shall be medically treated and reported in accordance with the established Florida Department of Health standards. (Refer to Chapter 14-8 and website www.doh.state.fl.us)

7. Nutrition Related to Pregnancy

The licensed health care professional staff shall provide routine monitoring of the pregnant female’s nutritional and weight status during the course of her pregnancy. Any pregnant female that experiences severe vomiting because of “morning sickness” shall be monitored closely for evidence of dehydration. Adjustments shall be made to her dietary intake to promote improvement with her nutrition and hydration status. These adjustments shall include eating small meals several times a day and providing a diet high in complex carbohydrates (such as whole wheat bread, pasta, bananas) to facilitate the reduction in the severity of nausea and vomiting.

Each facility shall provide nutritious foods in sufficient quantities that meet the standards of the minimum daily allowances for pregnant and lactating adolescents. Scheduled meals shall be rich in vitamin C, iron and folic acid and be supplemented with nutritious snacks (i.e. fresh fruit, cheese with crackers) during waking hours. Lactating youth may need additional snacks and/or drinks during the night when breastfeeding her infant. The food provided to pregnant and lactating youth should not be limited (except in rare cases of obesity). Pursuant to the Department of Health and Human Services recommendations and individual energy needs, a pregnant youth shall receive 2300-2800 calories per day. The Institute of Medicine of the National Academy of Sciences recommends an additional daily energy intake of 340 calories per day over pre-pregnancy energy needs during the second trimester of pregnancy, and an additional 450 calories per day increase over the pre-pregnancy energy needs during the third trimester of pregnancy. The American Dietetic Association recommends an additional 500 calories a day for breastfeeding.

Each facility shall establish relationships with local health departments, hospitals,
or universities that employ registered dieticians and nutritionist to obtain information on the proper diet for pregnant and lactating adolescents.

Pregnant girls and girls who are parents shall receive services that promote mother and infant bonding and attachment and a healthy parent-child relationship.

8. Medical Conditions and Pregnancy

Certain medical conditions may complicate a youth’s pregnancy. Each facility shall develop an individualized medical treatment plan to meet the needs of each pregnant girl with a chronic medical condition. A medical condition that necessitates a specialized treatment plan includes, but is not limited to, the following:

- Diabetes: Pre-existing and/or Gestational;
- High Blood Pressure;
- Infectious Disease: (i.e. STD, UTI, URI, HIV, Food Poisoning, etc.);
- Alcohol and/or Drug Use during Pregnancy;
- Psychotropic Medication Therapy;
- Cardiac Medical Conditions (i.e. Cardiac Insufficiency, Anomalies, etc.);
- Respiratory Medical Conditions: (i.e. Asthma, Cystic Fibrosis, etc.);
- Ectopic Pregnancy;
- Pre-eclampsia.

Community medical specialists shall be utilized when necessary for the management of girls with chronic conditions or complex needs.

9. Guidelines for Vaccinating Pregnant Youth (Refer to Chapter 4: Consent and Notification Requirements)

As a youth must be fully vaccinated, (unless contraindicated for religious or medical reasons), in order to attend school, the process of determining a youth’s immunization history and status should begin at the time of admission to the facility. Department of Juvenile Justice facilities have a thirty-day grace period from the time of admission, to obtain and verify records and subsequently provide necessary vaccinations (with parent/guardian consent). Refer to Chapter 4: Consent and Parental Notification for further information on parental consent and what is necessary when a parent or guardian is unavailable to provide consent.

Generally, live-virus vaccines are contraindicated for pregnant girls due to the theoretical risk of transmission of the vaccine virus to the fetus. No evidence exists of risk from vaccinating pregnant women with inactivated virus or bacterial vaccines or toxoids. To ensure the health of pregnant and non-pregnant youth cared for by the Department, pregnant girls should be vaccinated in accordance
with the Florida Department of Health and the Centers for Disease Control and Prevention’s standards (unless religious or medical reasons deem vaccination unacceptable). The following list serves as a guide to the appropriate vaccinations for pregnant youth:

- Hepatitis B;
- Influenza (Inactivated);
- Tetanus-Diptheria (Td);
- Meningococcal (MPSV4);
- Rabies (When indicated.)

On-line resources for vaccinating pregnant girls are available on the U.S. Department of Health and Human Services Centers for Disease Control and Prevention website at [http://www.cdc.gov/nip/publications/preg_guide.htm](http://www.cdc.gov/nip/publications/preg_guide.htm) and the Florida Department of Health website at [www.doh.state.fl.us](http://www.doh.state.fl.us).

10. Prenatal, Post-partum and Parenting Education

Each pregnant adolescent should be provided prenatal, postpartum and parenting education that includes topics directly related to health care issues and medical risk for pregnant adolescents/teens. These topics include, but are not limited to, the following:

- Alcohol and drug usage;
- Smoking;
- Nutrition;
- Sexually transmitted diseases;
- Contraception;
- Prenatal care;
- Birthing process;
- Post-partum care;
- Basic baby care (feeding, diapering, bathing);
- Child/Infant development;
- Parenting skills.

The Department of Health and Human Services Girl’s Health website at [www.girlshealth.gov](http://www.girlshealth.gov) and Florida Department of Health (www.doh.state.fl.us) should be utilized to provide the adolescent female education in contraception, reproduction, prenatal, postnatal, neonatal care and parenting.

All youth education shall be documented in the Individual Health Care Record on the Health Education Record.

11. After Care Planning

To reduce the risk of recidivism and increase the potential for positive outcomes, DJJ facilities shall plan for the release of teen parents and their children into the best possible environments and circumstances that will afford opportunities for
success. Facilities shall provide collaboration with existing community agencies and organizations to provide pregnant girls and girls who are parents with goal-setting activities, extensive planning, guidance and follow-up community support.

Referrals to the statewide Healthy Start Programs may be made during the prenatal or infancy period. Referrals to Healthy Families, available in some zip code areas, must be made during pregnancy or shortly after the birth of the baby. While it is best to enroll participants in Healthy Families during pregnancy or within the first two weeks after the birth, enrollment remains open until the child is three months of age. Each school district in Florida has some type of Teenage Parent Programs to support the educational, health, and Social Service needs of teen parents as they return to home communities.

B. GYNECOLOGICAL AND UROLOGICAL CONDITIONS

Adolescence is a time of many changes. As girls grow into young women, become physically, and sexually mature, they need additional care from health care practitioners trained to address these issues. Since many delinquent girls have experienced sexual abuse and trauma, gynecological examination takes special care and sensitivity. Victims of sexual abuse often experience feelings of discomfort, shame and vulnerability and trauma-related symptoms such as fear of having their body touched or flashbacks during gynecological examination. Health care professionals must be cognizant of trauma-related symptoms and provide care that is responsive and sensitive to the abused girl.

Routine medical care must be geared towards promoting good health screening for health problems in adolescent girls, and helping open the line of communication about health care between the physician, parents and the adolescent female. Adolescents who are sexually active will need additional services, including a pelvic examination and testing for sexually transmitted diseases. Many of the conditions that affect gynecological, reproductive and sexual health may be detected early, which, in most cases, provides for a more positive prognosis and successful treatment.

The Designated Health Authority shall be responsible for developing and implementing facility procedures for recognizing urologic and gynecologic medical conditions, and for medical management of specialized medical care and services.

These medical conditions shall include, but are not limited to, the following:

- Abnormal Pap Smear;
- Vaginitis;
- Vulvitis;
- Amenorrhea;
- Dysmenorrhea;
- Premenstrual Syndrome (PMS);
- Sexually Transmitted Diseases;
- Urinary Tract Infections.
The Designated Health Authority shall be responsible for overseeing the development of facility operating procedures that provide for the routine monitoring and observation of medical conditions, which include, but are not limited to, the following:

- Pregnancy;
- Eating disorders: anorexia, bulimia, and obesity;
- Thyroid disorders;
- Ovulation abnormalities;
- Chronic Disease (e.g., Diabetes, Sickle Cell Anemia, Epilepsy);
- Premenstrual syndrome.

The licensed health care professional shall be responsible for routine monitoring and observation for significant changes in a girl’s menstrual cycle, appetite, weight, mood, energy level, and sleep patterns. The DHA or Physician Designee, PA or ARNP shall be notified immediately when a girl complains of vaginal discharge, abdominal, pelvic, or back pain.

1. PREMENSTRUAL SYNDROME (PMS)

   Most females experience some unpleasant or uncomfortable symptoms during their menstrual cycle. Some females experience symptoms that are so severe that the symptoms temporarily disturb normal functioning.

   The licensed health care staff is responsible for routine monitoring and observation of signs and symptoms of severe premenstrual syndrome. The DHA or Physician Designee, PA or ARNP shall be notified when any youth experiences severe symptoms of Premenstrual Syndrome. These symptoms include, but are not limited to, the following:

   - Insomnia;
   - Confusion;
   - Depression;
   - Agitation;
   - Paranoia;
   - Nausea/Vomiting;
   - Edema: Fluid Retention;
   - Oliguria: Diminished Urine Output;
   - Visual Disturbances;
   - Syncope;
   - Vertigo;
   - Numbness/Tingling of Extremities;
   - Decreased Coordination.

   The licensed health care staff and non-professional staff shall promote behaviors and activities that reduce the occurrence of severe PMS symptoms as recommended by the Designated Health Authority. These behaviors and activities may include the following:
Increased nutritional intake of whole grains, vegetables and fruit while decreasing intake of salt, sugar, and caffeine;
provide increased time for sleep and allow for periodic rest time;
stress management;
increased exercise time and/or specialized regimen; and
medication management.

2. Sexually Transmitted Diseases (STD's)

The prevalence of sexually transmitted diseases (STD's) is high among girls entering Department of Juvenile Justice facilities and programs. Sexually Transmitted diseases (STD's) are infectious diseases transmitted through unprotected sexual intercourse. Each year there are approximately 9.5 million new cases of STD's in the United States that effect young people between the age of 15 and 24 years of age. While some sexually transmitted diseases are treatable and can be fully cured, others are incurable and can be life threatening.

Genital Chlamydia and Gonococcal infections can lead to pelvic inflammatory disease, Ectopic pregnancy, infertility, or chronic pelvic pain in adolescent girls/women. These infections are associated with an increased risk for human immunodeficiency virus infection (HIV). Screening and treating girls for Chlamydia and gonorrhea may prevent some of these complications and prevent transmission to members of the community upon release back into the community setting. Most girls/women with Chlamydia or Gonorrhea are asymptomatic, increasing the importance of screening and testing for STD's upon admission to a Departmental facility and upon evidence of any signs or symptoms of these diseases.

The Designated Health Authority shall be responsible for developing and implementing facility procedures for the screening, testing, evaluation, and treatment of sexually transmitted diseases.

The licensed health care professional shall be responsible for routinely screening each girl for signs and symptoms of sexually transmitted diseases at the time of the girl's admission to a detention center or residential commitment facility. The DHA, or Physician Designee, PA or ARNP shall conduct testing and medical evaluations for any girl exhibiting signs and symptoms of sexually transmitted diseases.

Medical testing for Chlamydia and Gonorrhea may be conducted at the local county health department or at the Departmental facility or program. If the testing is conducted at the DJJ facility or program, the urine assay screen shall be utilized for testing of Chlamydia and Gonorrhea.

Sexually transmitted diseases shall be medically treated and reported in accordance with the established Florida Department of Health standards. (Refer to Chapter 14-8 and website www.doh.state.fl.us)
C. EATING DISORDERS

1. ANOREXIA NERVOSA

Anorexia nervosa is the third most common chronic illness among adolescent girls. This potentially life-threatening eating disorder is characterized by an intense fear of gaining weight, a distorted body image, restrictive intake or binging and purging with an initial onset of amenorrhea for three months. Anorexia Nervosa affects up to 4% of all adolescent girls in the United States. However, the true prevalence of this disorder may be higher because it goes undiagnosed in up to 50% of cases. The onset is most frequent during the adolescent years (bimodal distribution with peaks at 14.5 and 18 years), a period during which the majority of physical and psychosocial growth occurs. Critical hormonal and growth-related changes occur during this period, and deprivation of nutritional substrates that are essential for growth and development can hinder these physiologic processes. Cardiovascular events and suicide are important causes of death for youth with this disorder.

The Designated Health Authority or Physician Designee shall establish and implement facility protocols for the medical management of youth with anorexia nervosa. These protocols shall include, but are not limited to, medical management of the following medical abnormalities and complications related to anorexia:

- Hematological Disorders;
- Endocrine Abnormalities;
- Bone density loss;
- Cardiovascular disorders (e.g. Bradycardia and Hypotension);
- Amenorrhea;
- Anemia;
- Hypothermia;
- Leukopenia.

Many medical complications result from physiologic adaptation to self-imposed starvation and malnourishment.

The licensed health care professional and non-health care staff shall be responsible for monitoring each girl for signs and symptoms of anorexia nervosa.

These symptoms include:

- Gradual or sudden reduction in caloric intake;
- Excessive intake: Binging with immediate visits to the bathroom after each meal for purging;
- Obsession with excessive body weight;
- Distorted body image recognized through conversation with youth;
- Gradual excessive weight loss;
- Excessive exercise regimens.
The Designated Health Authority or Physician Designee, PA or ARNP and Designated Mental Health Authority shall be notified immediately of any girl exhibiting signs and symptoms of anorexia nervosa.

Each youth diagnosed with anorexia nervosa shall be referred to a licensed mental health professional for appropriate mental health services.

D. STAFF EDUCATION

Education and training on gender specific health care issues of the adolescent female should be provided to licensed health care staff, clinical staff and direct care staff working in DJJ facilities and programs which serve girls.

A licensed nurse should provide in-service education on girls’ health care annually to all non-health care staff involved in the supervision or treatment of girls. This in-service training shall include training on monitoring, observation, and emergency care of the pregnant female.

A record of the in-service training shall be maintained in accordance with Departmental training policy and procedures.
I. INTRODUCTION

The Department is committed to ensuring that all medications and pharmaceutical products are procured, dispensed, administered and stored safely, accurately and in accordance with state, federal and industry regulations. Thus, an effective medication management system is a mandatory component at every DJJ facility.

Given the inherent need to avoid medication errors under all circumstances, there must be strict adherence to the policy on medication management. Through comprehensive Facility Operating Procedures, all DJJ Facilities must meet the requirements for safe and secure storage, inventory, and disposal. This shall include the adherence to prescriber’s orders, the monitoring of side effects and appropriate disposition upon a youth’s release or transfer. Failure to identify a youth’s prescribed medication regimen, and/or provide the medication can result in the deterioration of a youth’s physical or mental health. It must be noted that children and adolescents are more prone to medication errors related to inappropriate medication dosage, frequency and adverse effects, due to their smaller size and incompletely developed mechanisms for medication metabolism, clearance, etc.

Note: In addition to the potential adverse effects on a youth’s health, failure to provide necessary medication in a correctional setting (including the failure to provide an accurate assessment prior to discontinuing or changing a currently prescribed medication) has repeatedly resulted in litigation, class action suits and prolonged consent decrees.

A. All State and contracted dispensers (when applicable), prescribers, and staff who administer medications, must practice according to their respective statutes and the Florida Administrative Code.

B. Providers for the privately operated residential commitment programs shall share the above-mentioned responsibility with their Program Directors.

C. All contracted and subcontracted pharmaceutical vendors must adhere to this general policy as well as other Federal and State regulatory requirements.
II. VERIFICATION AND PROCUREMENT OF EXISTING MEDICATIONS

A. VERIFICATION OF MEDICATIONS PRESCRIBED PRIOR TO ADMISSION

1. Under no circumstances may personnel in a DJJ facility stop an appropriately prescribed medication that the youth is receiving upon admission. A duly licensed Physician, PA or ARNP must make all changes in medication regimens subsequent to an appropriate assessment. This provision applies to all classifications of medications, including medications prescribed for physical health conditions, those for psychological and/or psychiatric conditions and medications specifically prescribed for pain relief, inclusive of narcotics and other controlled substances. All DJJ facilities and programs must develop Facility Operating Procedures to address this component of the medication management process.

2. Upon admission to a DJJ facility, the youth and parent or guardian (if available), shall be interviewed about the youth’s current medications. This shall be conducted as part of the Medical and Mental Health Assessment Screening (Detention) or the Facility Entry Physical Health Screening (Residential Commitment Programs). Medication verification shall also occur during the completion of the Health-Related History, and/or the Comprehensive Physical Assessment.

3. If a youth returns to a facility or program after a court appearance or other activity that would not prompt a change in medications, then current medications do not need to be reviewed.

4. Only medications from a licensed pharmacy, with a current, patient-specific label intact on the original medication container may be accepted into a DJJ facility. Prior to medication administration, all of the following requirements must be met:

   ✓ The youth reports that he or she is taking an oral prescribed medication, AND
   ✓ Either the youth or the parent or guardian of the youth has brought the valid, patient-specific medication container to the facility, AND
   ✓ There are no doubts about the substance in the medication container, AND
   ✓ The medication is properly labeled.

Proper labeling includes, but is not limited to, the following:

✓ Name of youth
✓ Name and address of the pharmacy
✓ Date of dispensing
✓ Name of prescribing health care professional
✓ Directions for use (route and number of times to be taken daily)
✓ Expiration date
✓ Warning statements, if applicable
5. The type of packaging may vary (e.g. patient-specific individual containers or patient-specific blister packs), as long as the label on the container meets the requirements defined above.

6. When the above defined verification process is successfully completed, the licensed nurse must call to obtain an order from the DHA or Physician Designee, PA or ARNP to resume the specified medications. This telephone order must be documented in the youth’s Individual Health Care Record and co-signed when the ordering Practitioner is next on-site. The medication will subsequently be administered according to the instructions on the label.

7. For situations when youth are admitted to a facility or program and licensed nurses are not on duty (e.g. at night) then there must be a nursing protocol developed by the Designated Health Authority permitting the trained non-health care staff person to verify the medications (as described above) and assist the youth with self-administration. A telephone order must then be obtained (from the DHA or Physician Designee, PA or ARNP) and documented by the incoming nurse on the next shift. This protocol should only apply to critical medications (e.g. psychotropics, seizure medications, diabetes medications, etc.) for which a missed dose would compromise the youth’s health. The protocol shall list which specific medications to which this would apply.

8. If there is doubt about the authenticity of a prescription medication brought with the youth to the facility, verification of the prescription/contents shall be accomplished by:
   - Calling the pharmacy that dispensed the medication
   - Calling the outside provider who prescribed the medication

9. The need for any further verification requires the notification of the Designated Health Authority or Physician Designee, PA or ARNP who then must evaluate the youth. This is of particular importance if a youth is on a medication for a chronic condition (e.g. seizure disorder or diabetes) for which a dose should not be missed.

10. Documentation of prescription verification must occur in the chronological Progress Notes in the Individual Health Care Record.

11. Pursuant to Chapter 499, F.S. documentation shall be provided with each receipt of prescription medications and maintained for at least two years.

B. COORDINATION AND COMMUNICATION WITH COMMUNITY PRACTITIONERS/PREScribers

1. If a youth was receiving medications or medical services prior to admission to a DJJ facility, the licensed health care staff should make every effort to contact the community provider to determine the effectiveness of the currently prescribed medications, and document in the youth’s record that an attempt to contact the provider was made.
2. Although input from the community health care practitioner is critical in certain cases, (e.g. the Endocrinologist treating a diabetic youth), facility health care staff shall assume final responsibility for delivery and management of the medications. The degree of input and involvement of a given community practitioner shall be determined on a case-by-case basis between the outside practitioner and the facility DHA or Physician Designee, PA or ARNP.

3. Any continuation or renewal of medications from community practitioners shall only take place after a complete and timely evaluation by the facility DHA or Physician Designee, PA or ARNP.

4. Contact with the practitioner treating the youth prior to admission shall be documented in the youth's Individual Health Care Record.

5. This same type of communication shall occur between the Psychiatrist or psychiatric ARNP and the outside psychiatric practitioner.

6. All off-site prescribing practitioners should relay to the facility all necessary information on side effects and/or precautions.

7. If a prescription is written by an off-site practitioner, that information should be included on the Summary of Off-Site Care form. A copy of this prescription should then be affixed to the form (except for narcotics).

C. CRITERIA FOR DESIGNATED HEALTH AUTHORITY, PHYSICIAN, PA OR ARNP ASSESSMENT

1. Each detention center and residential commitment program shall have a system in place for communicating timely (less than 24 hours) notification to the Designated Health Authority or Physician Designee, PA or ARNP when a youth with a medication has been admitted into the DJJ facility.

The criteria for this mandatory notification and evaluation are as follows:

☑ The youth is currently prescribed a medication, which must be administered intramuscularly, subcutaneously, or intravenously.
☑ The youth is admitted without a prescription medication that he/she reports taking.
☑ There is reasonable doubt about the need, appropriateness or effectiveness of the medication.
☑ The youth or parent expresses a concern about the medication.
☑ Staff at the facility is uncertain as to the status of the medication.
☑ Any other situation that appears to require a medication evaluation
Note: In any instance where concern for the youth's medical status exists, an evaluation by the Designated Health Authority, Physician Designee, PA, or ARNP is warranted regardless of the status of the prescription.

2. The Designated Health Authority or Physician Designee, ARNP or PA must still see all youth presenting for admission to a detention center or residential commitment program who have a verified prescription medication within 7 calendar days, as outlined in Chapter 5: Health Related History and Comprehensive Physical Assessments. An evaluation of the previously prescribed medication regimen shall be a part of the Comprehensive Physical Assessment.

3. If the facility DHA or Physician Designee, PA or ARNP decides that alteration in the medication regimen is clinically indicated (including changes in dosage), a detailed entry in the chronological Progress Notes must be made which explains the rationale for the change. This entry must document any discussions between the youth, parents and/or original prescribing practitioner. In the event that an off-site Physician, PA or ARNP decides that an alteration is clinically indicated, a detailed explanation shall be provided on the Summary of Off-Site Care Form. Written parental notification must occur in all instances where a medication regimen is altered. (Please refer to Section IV. B., Consent Requirements for Medications.)

4. The Designated Health Authority or Physician Designee, PA or ARNP must place an order on the Practitioner Order Form or other designated area in the Progress Notes indicating which medications are to be continued, discontinued or otherwise changed.

D. MEDICATIONS UNABLE TO BE VERIFIED

1. The parent or guardian shall be notified by telephone to pick up any medication that is not successfully verified. An explanation as to why the medication cannot be used shall be provided to the parent along with notification that the medication will be held for a period of two weeks for parental pick-up after which time the medication will be destroyed. The facility shall document in the nursing progress note all parental telephone conversation(s). A disposal log shall be maintained for all destroyed medication. All medication shall be stored securely until retrieved or destroyed.

2. In instances where it appears that the substance in the container may be contraband (i.e. not a youth-specific prescription medication) disposition of the substance should be in accordance with the facility’s procedures for disposing of contraband and/or controlled substances. For departmental policy on contraband, removal from secure detention centers or residential commitment programs, refer to the respective Branch manual. Properly prescribed controlled substances, including narcotics, are not to be construed as contraband.
III. TRANSFER OF MEDICATIONS BETWEEN FACILITIES

A. MEDICATION TRANSPORT PROCESS

1. All youth who are transported shall have the required medical and mental health transfer packet, which shall consist of the Individual Health Care Record and all required medications.

2. Depending on the purpose of the transport (short or long-term), each detention center and residential commitment program must provide, at a minimum, the following information to the transporting staff for delivery with the youth:

- Photo of Youth
- Expanded Face Sheet
- Authority for Evaluation and Treatment and Parental Notifications
- Medication
- Medication Administration Record
- Suicide Risk Form
- Mental/Medical Health Alert(s)

3. If it is known that a youth is NOT returning to the originating facility then the entire IHCR must accompany the youth along with the above items.

4. The Superintendent, Program Director or designee shall be informed if the required documentation is not provided at the time of transport.

5. A youth currently receiving medications, who is transferred to another DJJ facility, shall receive all required doses during the transport process and arrive with all necessary medications. Each DJJ detention center and residential commitment program shall develop procedures to ensure that a youth’s medication regimen is provided and maintained during transfer to another DJJ facility. Components of these procedures shall include, but not be limited to:

- Verification of all current prescription medication prior to transport;
- Alternative measures for procurement of prescription medications stored in bulk at the current facility;
- Secure transport of prescription medication(s) (including narcotics) to receiving facility;
- Oversight and assistance with youth self-administration of the required medications at the scheduled time(s);
- Receivership of transferred prescriptive medications.

6. When a youth’s medication has been dispensed by a community pharmacy, the entire prescription container is transferred in the youth’s transport packet with the transporter, and shall be given directly to staff at the receiving facility.
7. In the event that the transferring facility does not have a youth’s prescription medication on hand to transfer to the receiving facility, (e.g. in the case of a bulk supply) the transferring facility shall make the necessary arrangements to procure a limited supply of the medication via a community pharmacy in order that the youth will have a supply of medications en route and upon admission to the receiving facility.

B. CONFIRMATION OF TRANSPORTED MEDICATIONS

1. Prescription medications that have been deemed verified and confirmed by a DJJ facility and which have remained exclusively in the control of the DJJ facility do not require re-verification or confirmation by the facility to which the youth is transferred.

2. The receiving facility must confirm that no medications were lost en route by comparing the medications listed on the youth’s MAR with those arriving with the youth.

3. Formal verification and/or confirmation may always be conducted at the facility’s discretion if there is concern that the medication has not been in the strict control of DJJ personnel or if there is doubt about the regimen.

4. Only designated and trained staff members on each shift have the responsibility for receipt and control of medications.

C. FACILITIES WITH BULK PHARMACIES

For larger facilities that utilize bulk pharmacies and dispense on-site, the transfer of youth-specific medications must be accomplished by using a community pharmacy. The transferring facility must procure a limited supply of the medication from the community pharmacy so that the youth will have a complete supply of patient-specific medications while en route and upon admission to the receiving facility.

D. TRANSFER OF THE MEDICATION ADMINISTRATION RECORD AND PHYSICIAN ORDERS

1. The Medication Administration Record and the Practitioner’s Order Form (or the Progress Notes with the Physician, PA or ARNP’s Orders) must be included in the youth’s transport package. When possible, the nurses between the two facilities should discuss a youth and his/her medications prior to transport. However, when this cannot occur, the above documentation will serve as notification.

2. When a youth is transferred between facilities, a legible copy of the current MAR or the original current MAR must be included in the transfer of the IHCR temporarily filed directly behind the Health Discharge Summary/Transfer Note. The MAR from the transferring facility must show the current medication regimen and the time of the last dosage prior to transfer. All subsequent doses received during transport shall also be recorded there. The objective of requiring that the current, ongoing MAR be
sent in this fashion is to avoid multiple rewrites of ongoing orders, to clearly indicate the timing of the last dosage, as well as the current medication regimen.

3. A copy of all prescription(s) shall be filed in the Individual Health Care Record, either attached to the Practitioner Order Form or attached to the Summary of Off-Site Care (when the prescription has been written by an off-site provider). A copy of the prescription is acceptable as is a duplicate hand written copy or the Pharmacy receipt tab.

Note: All controlled substances (narcotics) must be verified by reviewing the Physician, PA or ARNP’s orders in the record. The original prescription for a controlled substance shall be submitted to the pharmacy for procurement of medication. Prescriptions for controlled substances cannot be copied.

4. At the receiving facility, the Physician, PA or ARNP must place an order on the Practitioner Order Form indicating which medications are to be continued, discontinued or otherwise changed.

IV. CONSENT REQUIREMENTS FOR MEDICATIONS

A. Medications Prescribed Prior to Admission

The Departmental form, the Authority for Evaluation and Treatment (AET), when properly executed and signed by the parent or guardian, provides consent to give a youth medications. This consent serves as the parent/guardian’s permission to:

- Continue the administration of ALL current medications for which the youth has a verified prescription at the time of admission to a facility.

- Renew and refill current medications prescribed prior to admission, for the life of the prescription(s) as long as there are no changes in the total dosage or route.

Note: Prescription renewals still require an automatic medical evaluation by the DHA or Physician Designee, PA or ARNP to assess the youth’s status while on the medication.

B. New Medications Prescribed Subsequent to Admission or Changes to Existing Medications (Not Inclusive of Psychotropic Medications. For these Requirements Refer to Chapter 12)

1. After a youth has been admitted, parents or guardians shall receive a notification whenever one of the following three actions are taken by a prescriber (Physician, Dentist, PA, or ARNP):

- Makes a significant change in the dosage of prescription medication(s), (which the youth was currently prescribed at the time of entering the physical custody of
A “significant change” in dosage of a medication is any increase or decrease in dosage beyond a small increment or beyond the normal dosage for youth of similar age; or

- Prescribes or otherwise orders a prescription medication which the youth was not currently prescribed at the time of entering the physical custody of the Department; or

- Discontinues those prescription medication(s), which the youth was prescribed at the time of entering the physical custody of the Department or discontinues medications, which the youth has been prescribed since entering the physical custody of the Department.

2. The purpose of this notification is:

- To advise the parent or guardian of the health care professional’s recommendations;

- To instruct the parent, or guardian to notify the facility/program if they would like to request additional information;

- To allow the parent or guardian to notify the facility/program of concerns or objections to a medication.

3. The health care staff should make all reasonable efforts to initially inform the parent/guardian verbally (in person or by phone). All contact attempts and/or actual telephone conversations shall be documented in the chronological Progress Notes in the Individual Health Care Record by the person attempting and/or making contact with the parent/guardian. A staff member should witness all telephone call attempts and conversations.

   Note: Smaller programs (25 youth or less) may utilize ancillary, non-health care staff to notify parents/guardians as long as the DHA or Physician Designee, PA or ARNP is available for parental questions.

4. Parental notification shall then be provided in writing (even if verbal notification was accomplished) on the standardized form, Parental Notification of Health-Related Care: Medication Management. Written notification shall be mailed as soon as possible, but no later than two calendar days after the facility/program receives the Physician, PA or ARNP’s medication orders. The written notice may be mailed via regular mail except in the case of psychotropic medications, which require certified mail with return receipt requested.

   The form allows for the prescribing practitioner to request written parental consent prior to administering or changing a medication if they so choose. In this situation,
the administration of the medication shall not begin until the parent/guardian is given a reasonable time period to provide consent.

5. If parental notification is sent, the Authority for Evaluation and Treatment serves as consent to administer the medication unless the parent or guardian notifies the Facility or Program that he or she objects to the medication. When the medication is non-critical, the parent or guardian should be allowed time to contact the facility to register an objection.

6. If a medication requires an immediate modification or commencement then the medication shall be initiated.

7. Again, once a youth has entered the physical custody of a DJJ facility, the AET cannot be used as the authorization to begin newly prescribed medication(s), to make significant changes to the dosage of existing medication(s), or to discontinue current prescription medication(s) without the notification of the parent/guardian.

8. Copies of all notification(s) (and parental responses) will be filed in the youth’s Individual Health Care Record behind the AET.

C. OVER-THE-COUNTER MEDICATIONS (OTCs)

1. Written parental notification is required for the administration of any over-the-counter medications (OTCs) not already listed and consented for on the AET (Acetaminophen [Tylenol], Ibuprophen [Motrin], Pepto Bismol, Milk of Magnesia, Maalox, and Triple Antibiotic Ointment). They shall be administered per approved protocols or Practitioner’s Order, unless the parent has prohibited the administration of OTCs by way of the AET.

2. In these circumstances, the parent/guardian shall be provided a one-time notification by the DJJ facility. The parent or guardian shall be given time to notify the facility if they object to the administration of the additional specified OTCs.

3. All OTCs are to be administered under the following circumstances:

☑ Pursuant to specified protocols for Sick Call, from an expanded formulary, to be administered by a Registered Nurse, or a Licensed Practical Nurse, (with the manner of supervision outlined on the facility operating procedures).

☑ Pursuant to specified protocols (pre-approved by the Designated Health Authority) and administered by trained non-health care staff, from a limited, secured supply of medication that shall be located in the shift supervisor’s office or Master Control room with the appropriate safeguards.
D. **Psychotropic Medications**

*Please see Chapter 12 for complete information regarding consent requirements for Psychotropic Medications*

In all cases, parental or guardian consent shall be obtained prior to the initiation of new psychotropic medications and/or changes in a psychotropic medication regimen. Neither the Designated Health Authority or Physician Designee, PA or ARNP, nor the facility Psychiatrist shall have the authority to initiate prescriptive orders for psychotropic medications without parental consent. If circumstances warrant the immediate administration of psychotropic medications due to a psychiatric emergency then involuntary commitment shall occur.

E. **Parental Objection to Medications**

1. If the parent or guardian objects to the administration of a medication, either upon receipt of the *Parental Notification of Health Related Care: Medication Management* form or at any other time, the prescribing practitioner shall be notified immediately in order to determine the safest manner in which to stop the medication(s). The health care staff shall then stop the medication according to those practitioner’s orders. If it is not feasible to notify the practitioner who originally prescribed the medication, the facility Designated Health Authority or Physician Designee or Psychiatrist or psychiatric ARNP (for Psychotropic medications) shall be notified for further instructions.

2. The regional general counsel’s office is to be contacted if a parent objects, at any time, or is unable to be contacted regarding a medication deemed medically necessary by the prescribing practitioner. In these situations, the prescriber should make all reasonable attempts to explain the need for the medication to the parent or guardian. A court order would then only be obtained if the parental objection were believed to be detrimental to a youth’s mental or physical condition. It is recommended that a responsible individual at each facility be designated to contact the department’s regional general counsel for this purpose.

F. **Filing of Parental Notification**

A copy of the *Parental Notification of Health-Related Care: Medication Management* form shall be filed in the core health profile, directly behind the *Authority for Evaluation and Treatment* with the most recent Parental Notification on top.

V. **Accountability and Storage of Medications and Sharps**

*Including Narcotics and Psychotropics*

Each facility shall have a procedure by which prescription medications are obtained or received, verified and safely stored with measures that ensure accountability. Each shift, a designated staff person shall be assigned the responsibility of receiving, verifying, and
securing medications. This shall be the responsibility of licensed health care professionals when they are on duty.

A. RECEIPT OF MEDICATIONS INTO DETENTION CENTERS

1. Each detention center shall generate a Medication Receipt form or utilize the Prescription Medication Verification Checklist that includes, but is not limited to, the following components:

- Youth name
- Date
- Prescribing Physician
- Name of each medication
- Strength of each medication
- Prescribing order (from label) for each medication
- Number of medications (tablets, inhaler, ointment etc) received
- Parent signature, if accompanying child
- Staff member signature
- Copy of Parental picture ID, as available

2. All medications received shall immediately be collected and placed in a bag that is labeled with a youth’s identifying information, and then secured in the designated area for medication storage.

3. The youth’s parent or guardian, if available, shall be given a copy of the form as a receipt acknowledging that the facility has received and counted the medication(s). The original form shall be a part of the Individual Health Care Record.

B. RECEIPT OF MEDICATION FROM PHARMACIES OR PHARMACY VENDORS

1. A system shall be in place to track prescription medications ordered from pharmacies to ensure timely delivery. The prescribing practitioner or Designated Health Authority or Physician Designee, PA or ARNP shall be notified when a prescribed medication has not been received from the pharmacy within 24 hours of the order request.

2. Each facility shall have access to an alternate back-up pharmacy from which medications can be procured in the event that the usual pharmacy is unable to dispense medications in a timely manner.

C. STORAGE OF MEDICATIONS AND SHARPS

1. All medications shall be identified and secured in the locked area designated for storage of medications.

2. All non-controlled medications (prescribed and over-the-counter) shall be stored in a separate, secure, locked area that is inaccessible to youth (when unaccompanied by
an authorized staff member). This area must be clean, organized, free from temperature extremes, moisture, etc., and thus suitable for medication storage.

3. The location of, and storage mechanisms for, over-the-counter medications will vary according to the size of the facility and whether or not protocols allow staff to administer these medications, at times other than sick call, for specified minor complaints.

4. A limited supply of DHA approved over-the-counter medications (limited to Tylenol, Motrin, Antacids) ordered by the Physician for minor complaints, which do not warrant a sick call visit, may be stored in a secured central location with the shift supervisor or master control unit to facilitate trained staff members ability to administer these medications to youth upon request. The OTCs shall not be stored on the living units.

5. All controlled substances, such as narcotics, shall be kept in a medication storage area that secures them behind a double-lock system. A double lock system consists of two separate locks where there is an external lock securing a separate storage area which has another individual internal lock. A cabinet with two external locks does not meet the requirement of a double-locked system.

6. A medication cart with two separate external and internal locking devices is acceptable for the storage of controlled and non-controlled medications.

7. Each facility shall develop procedures for the storage of medications and sharps that include the following components:
   - Separate storage of different medication forms (i.e. injectable, topical medications, drops, liquids) pursuant to pharmacy regulations;
   - Refrigerated medications in a location separate from food storage;
   - Non-controlled prescription medication;
   - Over-the-counter medications;
   - Controlled Medications (Narcotics, Psychotropics);
   - Secure storage of sharps such as needles, syringes, scissors, suture removal kits, etc.;
   - Clearly designated youth-specific sections.

8. For smaller programs with fewer medications, a metal, fire-safe box (with a secure outer locking device) may be adapted to store each youth’s medications in a separate compartment. This box can then be locked in a cabinet with an exterior lock located in an area specifically designated as the medication administration area.

9. A locked filing cabinet may be designated solely for the storage of non-controlled medications. With this system, a separate file is created for each youth who is receiving medications. Each file is labeled with the youth’s name and allergies.
filing cabinet is placed in an area that is locked, inaccessible to unaccompanied youth and suitable for medication administration.

10. A rolling tool cart may also be adapted for the individual storage of multiple youths’ medications. With locks installed, this cart shall then be locked in a secure area.

VI. INVENTORY PROCEDURES FOR SHARPS

A. Any medical equipment classified as sharps (e.g. syringes, needles, scissors, suture removal kits, etc.) shall be secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed of.

B. The smallest number of necessary syringes, needles, phlebotomy equipment, suture kits, and all other potentially dangerous sharps and other devices shall be kept in the area where they are to be used. This is called “the working inventory.”

C. The stocked supply shall be securely stored.

D. There are no exceptions to the requirement that a perpetual inventory and a weekly inventory of all sharps (stocked and working supplies) shall be conducted. In larger programs where the working inventory is frequently utilized, a shift-to-shift inventory is highly recommended. The Designated Health Authority and the facility superintendent or program director shall be notified when any discrepancies are found in the perpetual or weekly inventory counts.

VII. INVENTORY PROCEDURES FOR MEDICATIONS

A. GENERAL REQUIREMENTS

Each facility shall develop procedures for the daily perpetual inventory of prescription and over-the-counter medications, as well as the shift-to-shift inventory of controlled substances. “Perpetual inventory” shall be defined as an inventory that begins with a known total quantity of medications, where the number of remaining tablets/pills/liquid is decreased each time a dosage is given.

Facility procedures for the inventory process shall include, but not be limited to the following components:

- A perpetual daily running inventory of medication utilization for all prescription and over-the-counter medications;
- Daily shift-to-shift inventory counting of controlled substances;
- Weekly inventory counts for all opened over-the-counter medications; and
- Reporting criteria and procedures for inventory discrepancies.

B. PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS
1. The dose-by-dose daily administration and documentation of a medication shall be the perpetual inventory process for the daily distribution of non-controlled prescription medications and over-the-counter medications. Documentation of each individual dosage of medication administered to youth shall be maintained on the youth's Medication Administration Record (MAR). Facilities shall utilize the Department Standardized MAR or their Pharmacy vendor has pre-printed Medication Administration Record to demonstrate the distribution and utilization of medications.

2. Although it is not required to count these medications, the licensed nurse shall be responsible for monitoring the routine distribution of prescription and over-the-counter medication and reporting, to the Superintendent or Program Director and DHA or Physician Designee, any notable discrepancies with medications.

3. Trained, non-health care staff that assist with the self-administration of over-the-counter medications at times other than the routine medication pass, and thus do not have immediate access to the Medication Administration Record shall include the following information on an aggregate log so that the licensed nurse can transcribe information onto the youth’s individual Medication Administration Record:

- Name of youth;
- Date and time medication provided;
- Reason for medication;
- Dosage of medication; and
- Amount of medication given;
- Staff member’s signature.

4. In instances where a non-health care staff person (e.g., a shift supervisor or direct care staff) is assisting with the medication process for prescribed medications, both the staff member distributing the medication and the youth to whom the medication is distributed shall initial the MAR with each dose. When a licensed health care staff member is administering the medication, the youth’s initialing of the MAR is optional but not required. (Refer also to this Chapter, Section XIII, E. Note.)

5. The licensed nurse shall perform the weekly inventory count for all open bulk supplies of over-the-counter medications. This process shall include the documentation of the weekly counting of each tablet in an open bottle of over-the-counter medication. This includes the inventories of larger formularies of OTC’s that are administered by health care staff during Sick Call and the limited inventories of approved OTCs that are stored in a central locked location, such as Master Control, for minor complaints.

D. CONTROLLED SUBSTANCES

1. Each facility shall develop procedures for the receipt, storage, inventory and, where applicable, disposal of all controlled substances. All substances defined as
“Controlled” in Ch. 893.03, F.S. (2005) (“Drug Abuse Prevention and Control”) shall be double locked, with daily perpetual inventories and running balances maintained.

2. If a controlled substance is administered to a youth as ordered through a prescription, the number of pills, tablets or dosages remaining after each administered dosage must be documented on the youth’s individualized Controlled Medication Inventory Record that is received with the medicine from the pharmacy. Additionally, the administration of the medication shall be documented on the MAR in the youth’s Individual Health Care Record.

3. Pursuant to Pharmacy regulatory requirements, a shift-to-shift inventory count of each narcotic shall be performed and documented on the youth’s individualized Controlled Medication Inventory Record. Strict control and accountability of the running balance for each narcotic shall be maintained. Supervisory level non-health care staff trained in the delivery and oversight of medication self-administration may perform these duties.

4. The DHA or Physician Designee, Superintendent, or Program Director shall be notified immediately for any discrepancies with the daily controlled substance inventory count.

E. BULK SUPPLIES OF MEDICATIONS

1. Bulk supplies of medications are stocks or inventories of prescription medications that are not patient-specific (i.e. they have not been dispensed by a pharmacist for an individual youth). Unless a facility has obtained a Modified Class II B Institutional Pharmacy permit, bulk supplies of any prescription medication, including controlled substances, are prohibited.

2. Facilities that do choose to store any bulk medications on-site are responsible for the secure, appropriate storage of these medications, proper invoicing and accountability for inventories, ensuring that no expired or contaminated medications are on the premises and that correct disposal measures are in place.

3. Exceptions to the requirement of a Modified Class IIB Institutional Pharmacy Permit for bulk storage of specific medications and pharmaceuticals include the following:

   ☑ Vaccination serum is allowed only if immunizations are administered on-site, if appropriate inventories are maintained and if the facility stores the medications under the required conditions (temperature, humidity, etc.).

   ☑ Pharmaceuticals required for tuberculosis skin testing are allowed only if the skin testing is performed on-site.

   ☑ Epinephrine (Epi-pen or Epi-pen Jr.), or Albuterol inhalers commonly administered in response to severe allergic reactions or anaphylaxis. The supply
may be maintained as long as licensed health care staff or laypersons proficient in the use of this medication are employed on-site. The suggested method for maintaining this type of medication is not in bulk. Instead, when a youth is admitted with a known history of severe allergic reactions, the Designated Health Authority or Physician Designee, PA or ARNP shall write an individual prescription for the Epi-pen or inhaler so that it is maintained as a patient-specific medication. Emergency drugs of this sort (Epi-pen, inhalers, etc) must be immediately available to the applicable youth at all times.

☑ Glucagon: A Limited bulk supply of injectable Glucagon, would be administered for emergency treatment of insulin-induced hypoglycemia (insulin shock). The supply may be maintained as long as licensed health care staff or laypersons proficient in the use of this medication are employed on-site. As with Epi-pen, it is recommended that, if a youth is admitted with diabetes and/or the potential need for emergency Glucagon or similar drugs, a prescription be obtained and procured as a patient-specific supply of the medication.

☑ Kwell (lindane) or other ectoparasiticide/ovicide. Bulk supply on site is acceptable. Note: Medications for the treatment of sexually transmitted diseases (STDs) shall be patient specific in accordance with a DHA, Physician Designee, ARNP or PA order and shall not be kept in bulk supply.

4. If a facility has not obtained a Modified Class II B Institutional Pharmacy Permit then the above listed medications may only be procured in bulk if the DHA orders the medications in his or her name utilizing his or her DEA Number. The invoice from the distributor must be addressed to the DHA by name for delivery to the facility. The DHA is then responsible for the storage and proper distribution of the bulk supply of prescription medications.

5. A youth-specific order must then be written for any prescription medication that is to be obtained from the bulk supply.

6. All medication invoices must be kept in the facility for a period of two (2) years.

VIII. MEDICATION ADMINISTRATION BY LICENSED HEALTH CARE STAFF

A. Medication Administration shall occur as scheduled in a comprehensive, accurate and organized manner in all facilities and programs.

B. Each facility must have operating procedures to ensure that the Five Rights of Medication Administration are verified for every individual youth.

These five rights are specifically defined as:
1. Right Youth: Verify youth arm band with youth picture on MAR.

2. Right Medication: Verify Physician’s order on MAR with prescription label on medication bottle. They must match exactly.

3. Right Route: Verify that the route on the prescription bottle corresponds to the route identified on the MAR (by mouth, topically, etc.).

4. Right Dosage: Compare dosage on MAR with prescription label on the medication. They must match exactly.

5. Right Time: Check time that medication is to be delivered on the MAR. Medication must be delivered within one hour of scheduled delivery time.

C. The facility operating procedures developed must include, at a minimum, the following concepts for the licensed health care staff person.

1. Medication delivery and supervision as the sole responsibility during the time of administration;

2. Clean and organized working space;

3. Control of medication containers and cart;

4. Structured process for youth to approach licensed staff person individually;

5. Verification of Five Rights and correct MAR;

6. Verification of allergy and alert status;

7. Inquiry as to side effects;

8. Proper documentation on MAR.

D. A system must be in place to ensure that youth housed in restricted housing (e.g. secure observation) receive all prescribed medications as ordered and on time.

IX. YOUTH SELF-ADMINISTRATION OF ORAL MEDICATIONS ASSISTED BY TRAINED NON-HEALTH CARE STAFF (UNLICENSED ASSISTIVE PERSONNEL)

A. GENERAL MEDICATION ADMINISTRATION REQUIREMENTS

1. Florida Chapter 64B9-14 FAC (Delegation to Unlicensed Assistive Personnel) provides the authority for the licensed nurse to delegate unlicensed trained staff (the Unlicensed Assistive Personnel) to serve as assistant to the Registered Nurse or Licensed Practical Nurse with the delivery, supervision, and oversight of youth
who perform self-administration of medication(s). Unlicensed Assistive Personnel are persons who do not hold licensure from the Division of Health Quality Assurance of the Department of Health but who have been trained and assigned to function in an assistive role to registered nurses or licensed practical nurses in the provision of patient care services through regular assignments or delegated tasks or activities and under the supervision of a nurse. The nurse must supervise this trained staff member’s duties by periodically performing direct observation of skills, inspecting the Medication Administration Record(s) and the required documentation assigned to the staff member.

2. If a sufficient number of licensed nurses are not available, on-site to administer oral prescription medications or OTC’s, then the nurse shall delegate the delivery, supervision, and oversight of youth who are performing self-administration of medications to the trained non-health care staff (Unlicensed Assistive Personnel). All facilities or programs must have operating procedures in place that include the nurse’s delegation process as well as the training of non-health care staff who will perform these duties.

3. Each facility shall develop a training curriculum to demonstrate unlicensed staff members’ competency and validation of his or her ability to assist with the delivery, supervision, and oversight of the youth’s self-administration of medication as defined in this chapter. Additionally, the licensed nurse’s delegation process must be defined in the training curriculum. The delegation process shall include all of the following components:

- Communication process between the nurse and staff member identifying his or her assigned task;
- The desired outcome for the completion of the delivery, supervision, and oversight process;
- The limits of medical and clinical authority;
- Required time frames for the nurses’ delegation of duties;
- Specific supervision to be performed;
- Verification of staff’s understanding of assigned duty,
- Verification of the licensed nurse’s monitoring process,
- Verification of the licensed nurse’s supervisory activity.

4. Only a registered nurse shall perform the validation to ascertain an unlicensed staff member’s competency.

5. Appropriate assignment of staff responsibilities and implementation of procedures to be followed are imperative. Non-health care staff should not be expected to detect medication-related problems beyond the scope of the layperson.

6. All prescription and OTC medications shall be administered by licensed nursing staff when they are on duty.
B. THE ASSISTED SELF-ADMINISTRATION PROCESS

1. The self-administration of medications by a youth is a highly structured process in which a staff member facilitates the delivery of medication to a youth so that he or she can self-administer them under the staff's supervision.

2. The youth are provided their specific oral medications, then closely supervised and guided by a trained staff member while taking the medication in the absence of licensed health care staff. This concept is not to be confused with the actual medication administration performed by licensed health care staff.

3. Each facility must have operating procedures to ensure that it includes the Five Rights of Medication Administration.

   These five rights shall be specifically defined as:

   - Right Youth: Verify youth arm band with youth picture on MAR.
   - Right Medication: Verify Physician’s order on MAR with prescription label on medication bottle. They must match exactly.
   - Right Route: Verify that the route on the prescription bottle corresponds to the route identified on the MAR (by mouth topically, etc.).
   - Right Dosage: Compare dosage on MAR with prescription label on the medication. They must match exactly.
   - Right Time: Check time that medication is to be delivered on the MAR. Medication must be delivered within one hour of scheduled delivery time.

4. The facility operating procedures developed must include, at a minimum, the following concepts of medication delivery and supervision for the non-health care staff:

   a. The staff member who is assigned this responsibility shall have as his or her primary focus the duty of medication delivery and supervision during the time medications are distributed to the youth. The designated staff member shall not be required to conduct or supervise any facility activities during this time. Should an unexpected situation arise whereby the staff member must temporarily attend to another issue, that person should secure the medication administration area. After the issue has been resolved, the staff should then resume medication administration.

   b. The staff member shall assist one youth at a time with medication.
c. The staff member shall wash his or her hands, prior to commencing the process.

d. The staff member shall remove the prescription container from the storage area and hold the container.

e. The staff member shall maintain control of the medication container at all times.

f. Individual youth will approach the area for medication administration when called by the staff member.

g. The staff member shall compare the youth with the photograph attached to the MAR and shall confirm the youth’s identity verbally.

h. The youth and staff member identify and verify the medication he/she is to take by checking the label and comparing the label to the Medication Administration Record. The staff member shall not permit youth to take any medication that has a discrepancy between the medication prescription label and the MAR.

i. The staff member confirms the allergy status of the youth and questions the youth about any current perceived side effects or adverse reactions to the medication. Specific inquiry must be made when the youth is prescribed anti-tuberculosis medications or when requested by the Designated Health Authority or Designated Mental Health Authority.

j. While the youth observes, the staff member shall remove the medication from the container and will hand the youth the exact amount of ordered medication. When the medication is a liquid, the staff member will pour the exact volume of liquid ordered into a measured container and hand it to the youth.

k. The staff member will directly observe that the youth actually swallows the medication.

l. A youth shall be asked to verify whether medication has been swallowed, by opening his mouth and sticking out his tongue, for all of the following situations:

- When there is doubt that the medication has been swallowed
- The youth is on a Mental Health Alert
- As required by the DHA/DMHA
- When the youth has been known to hold medications in his or her mouth
m. Both the youth and the staff member shall initial that the dosage was given.

n. The staff member shall assist youth with the medication within one hour of the scheduled time of the ordered medication.

o. A system must be in place to ensure that youth housed in restricted housing (e.g. secure observation) receive all prescribed medications as ordered and on time.

C. PRESCRIPTION MEDICATIONS

Trained non-health care staff shall only assist youth with the self-administration of oral prescribed medication(s). These medications must be in the original packaging or container from the pharmacy that filled the medication. The current, correct pharmacy-generated label must be intact on the prescription container. A non-health care staff member may not access a bulk (non-patient-specific) supply of prescription medications.

D. OVER-THE-COUNTER MEDICATIONS (OTC)

1. Trained, non-health care staff may only assist in the self-administration of oral over-the-counter medications that are on the facility formulary, pursuant to established nursing protocols. This formulary as well as the protocols must be reviewed and approved annually by the facility Designated Health Authority, and is specifically for the treatment of commonly encountered, self-limiting conditions.

2. These OTC’s may only be administered from the facility’s approved and secure OTC inventory. A facility may choose to maintain three types of OTC’s securely stored in a shift supervisor’s office or in Master Control in order that trained staff members may assist in the self-administration of these medications, as a youth requests, for minor complaints. The full inventory may be a bulk supply but the supply stored outside of the Nurse’s clinic shall be the smallest number possible (based on population and request rates).

3. The OTC medications shall be inventoried weekly and an OTC log shall be maintained so that staff can document the youth’s name and medication administered, etc. (See Section VII, B.3.) for the nurse to transcribe on the MAR.

4. Wilderness Programs. An expanded formulary suitable for wilderness counselors who have the requisite training and experience, to utilize in the wilderness setting, camp setting, “packing out” (meaning camping away from the usual camp-site) or other such extended activities as endorsed by the department, such as day or extended hiking, canoe trips, etc. In order for this process to be utilized, the facility must have constant cell-phone and radio contact ability with an expert wilderness physician, and, if prolonged outdoor trips
are conducted, maps of the itinerary and a list of the nearest hospitals along the route me be available to staff.

E. **DOCUMENTATION ON THE MEDICATION ADMINISTRATION RECORD**

1. The trained staff member shall be provided with only the *MARs* of the youth receiving medications during his/her shift. At the end of the shift, the *MARs* shall be returned to the health care staff.

2. The trained, designated staff member providing medication to a youth shall document his or her initials on the *MAR* in the correct designated space associated with each medication, signifying that the medication was given in accordance with how it was prescribed. The youth shall also initial on the *Medication Administration Record* verifying that the medication was received.

3. Under no circumstances shall a non-licensed health care staff member make any entries on the *Medication Administration Record* other than his or her initials and the proper documentation of a youth’s refusal.

4. Only a licensed health care professional shall be responsible for the accurate transcription of Physician’s orders on the *Medication Administration Record*.

F. **COMMUNICATION BETWEEN HEALTH CARE PROFESSIONALS AND STAFF MEMBERS**

1. Each DJJ facility shall have procedures in place to facilitate routine periodic monitoring of the non-health care staff that participates in the assisted medication self-administration process. A licensed health care professional must be responsible for this monitoring. This monitoring shall include a routine review of the *MARs*, a review of the OTC logs for OTC’s maintained in the supervisor’s office or Master Control, and periodic checks of inventories.

2. If the facility does not have licensed health care staff, the Designated Health Authority or Physician Designee must perform a systematic periodic review of the medication administration process. At a minimum, this shall consist of a review twice per month (by the Designated Health Authority or Physician Designee, PA or ARNP) of the inventory of over-the-counter medications, of the *MARs* to insure initialing of dosages and of the OTC log(s) to determine whether there are unusual amounts of OTCs administered by non-health care staff.

3. At a minimum, the facility shall also develop mechanisms that provide non-health care staff who assist with the delivery of oral medication, in the absence of a licensed health care professional, with an available resource should questions or concerns arise. This can be accomplished through a variety of mechanisms. These include, but are not limited to, the following:
Methods and times when the Designated Health Authority or Physician Designee, PA or ARNP is available either on-site or by phone to answer questions.

Procedures through which a local pharmacy can be called.

4. At the change of shift, the outgoing, trained staff member responsible for administering medications shall discuss any problems in administration, treatment refusals, new arrivals that may have a medication need, etc, with the incoming responsible staff person or licensed health care staff. Any keys to the medication storage area are exchanged at this time.

X. PRE-POURING OF MEDICATIONS

1. Under no circumstances may a prescription medication be removed or pre-poured from its original packaging or prescription container and placed in another container for subsequent administration.

2. A licensed health care staff member can prepare medications only for **immediate** administration. In this situation, the following criteria shall be met:

   - Administration of prescription medication is within the scope of practice of the health care staff member.
   - The licensed health care staff member maintains direct and constant control over the medications.
   - The **same** staff member prepares and administers the medications.

3. A nurse may replenish a prescription medication on a one-time basis in facilities that operate Modified Class IIB Institutional Pharmacies. Each facility is responsible for complying with all federal and state laws, rules and regulations governing this practice.

XI. REFUSAL OR HOARDING OF MEDICATION

A. REFUSAL OF MEDICATIONS

1. Each facility may develop a Medication Refusal Form, or document in the Progress Notes of the Youth’s IHCR, all instances of refusal to include all of the following components:

   - Name of youth
   - Date
   - Time
   - Name of medication/treatment refused
Number of counseling attempts taken to get youth to accept medication/treatment
Person or persons notified: (i.e., shift supervisor, facility superintendent, program administrator, Designated Health Authority or Physician Designee, PA or ARNP)
Staff/health care provider signature
Youth signature

2. All instances of a youth’s refusal to take a dosage of a prescribed medication must be clearly documented on the MAR. This shall be done by documenting the abbreviation “R” for “Refused” in the appropriate block of time for the medication that was refused and a notation with an explanation written on the back of the MAR. The youth should be asked to initial the refusal. If the youth will not initial the refusal notation, this should simply be noted in this documentation.

3. Each DJJ facility shall have a procedure that defines the system in place for the periodic review of medication refusals by the Designated Health Authority, or Physician Designee, PA or ARNP and when applicable, the Designated Mental Health Authority.

4. Such systems must require notification to the DHA or prescribing Physician for review after the refusal of three consecutive dosages of a prescribed oral medication. This review may be conducted by telephone.

5. Refusals of prescribed injectable medications (for example, insulin) must be immediately made known to the Designated Health Authority or Physician Designee and, when applicable, the Designated Mental Health Authority. This notification may be conducted by telephone.

6. The facility DHA or Physician Designee, PA or ARNP should discontinue non-essential over the counter medications consistently refused by a youth, after an appropriate assessment of the youth. Reasons for the discontinuation must be documented in the chronological Progress Notes in the Individual Health Care Record.

THE FORCED (INVOLUNTARY) ADMINISTRATION OF MEDICATION IS NOT PERMITTED, UNDER ANY CIRCUMSTANCES.

Note: There shall be no emergency telephone orders or emergency treatment orders for medication therapy (e.g. psychotropic medications, etc.) Any youth that is felt to require an emergency medication orders by telephone or in person shall be transported to the hospital or to a Baker Act Facility for an emergency evaluation and treatment.

B. HOARDING OF MEDICATIONS

1. When a youth is suspected of (“cheeking”) or not swallowing his or her medication(s), the staff member may use a sterile, one-time-use disposable tongue blade to gently pull
the tongue and cheeks away from the gums to ensure that the medication has not been held. Standard (universal) precautions and hand washing must be observed at all times.

2. Licensed Health Care staff shall notify the DHA/DMHA when a youth is not swallowing medication. The Designated Health Authority or Physician Designee may provide a general authorization for all medications, when pharmacologically appropriate, to be crushed and sprinkled or mixed with applesauce on a case-by-case basis. When an order is obtained, medication can be crushed and sprinkled or mixed with applesauce to reduce the incidence of “cheeking.”

3. Licensed Health Care staff is responsible for notifying the Designated Health Authority or Physician Designee, PA or ARNP of a youth with swallowing difficulties or developmental disabilities, to obtain an order for the appropriate method to be used when providing oral medications. This method shall be noted on the MAR. The non-health care staff member shall provide medication method in accordance with Physician’s order.

XII. ADMINISTRATION OF PARENTERAL MEDICATIONS

A. Under no circumstances may any non-health care staff person or any health care staff person, who is not duly licensed by the laws of the State of Florida to administer parenteral medications, routinely administer any medication that is injected subcutaneously, intradermally, intramuscularly or intravenously. The exception to this is when a youth requires percutaneous injection of a pre-packaged medication (such as Epi-pen) in order to prevent or treat a severe allergic reaction and the staff member has been trained in the use of this product.

B. If a youth routinely self-administers his/her own parental medication(s) prior to admission to the DJJ facility and is proficient in the procedure and well informed about the techniques and precautions associated with the administration, the facility may allow the youth to continue self-administration with prior approval from the facility Superintendent or Program Director and the Designated Health Authority or Physician Designee.

C. Arrangements shall be made for that youth to report to the area designated for medication administration for self-administration under the supervision of the staff member who has control of the vial of medication. The Designated Health Authority shall approve all procedures for self-administration under these circumstances.

D. Standard (universal) precautions shall be followed in all instances of medication administration.

XIII. THE MEDICATION ADMINISTRATION RECORD (MAR)
(REFER ALSO TO CHAPTER 15: INDIVIDUAL HEALTH CARE RECORD)

The standard Department Medication Administration Record (MAR) also known as the Medication and Treatment Record for each youth receiving either prescription medications on a
routine basis or over-the-counter medications shall be maintained at every facility. The same form shall be used for all medications. Treatments (e.g., dressing changes) that have been ordered, vital signs (temperature, respiratory rate, heart rate and blood pressure), glucose finger sticks, etc., shall also be listed on this form.

**NOTE:** The Department’s standard MAR shall be required for those facilities that do not use a pharmacy vendor’s pre-printed MAR.

A. One form shall be used for each month. The current month’s MAR may be kept in the area where medications are stored and administered. The previous months MARs are filed in the youth’s Individual Health Care Record.

B. All pharmacy pre-printed forms shall include notation of the facility, the youth’s name, date of birth, allergies, medical grade, medical alerts, side effects or precautions and DJJID number. This information shall be added to any pre-printed form that is used which does not contain this basic information.

C. The youth’s photograph must be attached to the current MAR. The attachment can be either on the MAR or alongside the MAR as long as it is clearly fixed and visible at the time of medication administration.

D. Each medication shall be listed once. The MAR should list as many of the prescribed medications as possible. If more than one MAR is needed, the total number of pages should be written on the bottom of each page (for example, “page 1 of 3”).

E. Prescription medications and directions for use are entered exactly as on the prescription container. Both the youth and the staff member, (as applicable) shall initial each dosage under the appropriate date. If licensed nurses are administering the medication, the youth is not required to initial. However, the nurse has the option of requesting him/her to do so.

*Note: The Department recommends that all persons administering medications to youth, including licensed health care providers, have the youth initial the MAR on receipt of the medications. If the Designated Health Authority and the facility Superintendent or Program Director both deem that this process is not necessary in a given facility, then this must be documented in the Facility Operating Procedure. It is still MANDATORY that a youth sign or initial the MAR when a non-licensed health care provider or a non-health care staff person administers or assists in the self-administration process for medications.*

F. The back page of the MAR shall be used for PRN medications.

G. Major specific side effects, precautions or drug interactions should be placed on the front and the pharmacy generated list of side effects, should be attached to the form for reference purposes.
H. The full printed name, signature and title of each staff member who initials a dosage and the full printed name and signature of the youth shall be included at the bottom of the form.

I. The licensed health care professional shall be responsible for the accurate transcription of Physician’s orders on the Medication Administration Record.

J. Documentation on the MAR is required for any on-site administration of medications or pharmaceuticals which may occur under the following circumstances:

1. Routine administration of a youth’s prescribed medication;
2. Administration of any medication (prescribed or over-the-counter) during a sick call encounter;
3. Administration of over-the-counter medications independent of a formal sick call encounter (by health care and non-health care staff);
4. One time dosages of prescription medications administered by a physician or nurse;
5. On-site administration of immunizations;
6. Placement and interpretation of a Tuberculin Skin Test (TST)/PPD.

Note: With the exception of the routine administration of on-going prescription medications, immunizations and the placement of the TST, the other circumstances require a notation in the chronological progress note to document the nature of the complaint, findings and reason for the medication.

XIV. REQUIRED MEDICATION EVALUATIONS AND MONITORING

All youth who are prescribed medications for any chronic condition shall receive periodic evaluations by the DHA or Physician Designee or PA or ARNP or other off-site specialists that are regularly following the youth. These periodic evaluations shall not exceed three (3) months under any circumstances. A re-evaluation shall always occur prior to renewal of a medication prescription.

A. SERUM DRUG LEVEL MONITORING

1. Those classes of medications, which require serum drug level testing to ensure that they are therapeutic and not at toxic levels, shall have those tests drawn on admission if a recent baseline level is not otherwise available.

2. If a medication was prescribed prior to the youth’s entry into the custody of a DJJ facility, it is the responsibility of the Designated Health Authority or Physician
Designee, PA or ARNP to ensure that appropriate laboratory testing is ordered and scheduled.

3. The facility must have a system in place to ensure that all necessary serum drug level testing occurs, that laboratory results are conveyed to the prescriber, and subsequent timely adjustments are made to medication doses based on the orders of the prescribing practitioner.

4. The following is a list of medications for which additional laboratory monitoring is often necessary. This list neither replaces the independent clinical judgment of the prescriber, nor is it all-inclusive.

- Dilantin
- Digoxin
- Lithium
- Tegretol
- Theophylline (oral)
- Thyroid preparations
- Valproic Acid (Depakote)

B. ROUTINE MONITORING FOR ADVERSE SIDE EFFECTS

1. All medications shall be monitored routinely for adverse side effects. The Designated Health Authority or Physician Designee, PA or ARNP shall conduct this monitoring.

2. It is the responsibility of the health care staff to facilitate the scheduling of the follow-up visits for the youth to see their prescribing clinician, onsite or offsite, for the monitoring, laboratory testing and review of the results.

3. It is the responsibility of the prescribing Physician or PA or ARNP to order the appropriate laboratory tests, determine other monitoring requirements (e.g. EKGs) and be alert to precautions regarding potential drug interaction, at the time of prescription of any medication.

4. Relevant precautions or restrictions are to be communicated to the nursing and facility staff using the Medical Alert system as appropriate.

5. Nursing staff is to question each youth daily, prior to administering medications, about relevant side effects.

C. DOCUMENTATION OF MONITORING PRACTICES

1. Ongoing documentation of monitoring for side effects of all medications, including psychotropic medications, is required. The frequency and specificity of such monitoring, including the method of documentation and what level of staff member is
authorized and responsible to observe for side effects, shall be established by the Designated Health Authority or the Designated Mental Health Authority or as outlined in the Mental Health and Substance Abuse Services Manual (Revised 2006) and Chapter 12: Psychotropic Medications.

2. At a minimum, the nursing staff shall document weekly side effect monitoring on the MAR.

3. For documenting side effects of anti-tuberculosis medications, the health care staff may utilize standardized, published checklists (such as those utilized by local county health departments) that include potential side effects.

D. MEDICAL GRADE CLASSIFICATION CONSIDERATIONS

Medical Grade classification of youth who are prescribed certain categories of medications shall be as follows:

1. All youth who are prescribed any medication on an on-going basis which must be administered by intradermal, subcutaneous, or intramuscular routes shall be classified a Medical Grade 4, for the duration of treatment with the medication.

2. All youth who are prescribed medications used to prevent the development of active tuberculosis or to treat active tuberculosis ("anti-tuberculosis medications") shall be classified a Medical Grade 4, for the duration of treatment with the anti-tuberculosis medication.

3. All youth who are prescribed any medication classified as a psychotropic medications shall be classified a Medical Grade 5, for the duration of treatment with the psychotropic medication and shall be placed on the medical alert list. For purposes of this manual, the term “psychotropic medication” refers to any medication capable of affecting the mind, emotions and behavior that is used to treat mental illness.

XV. MEDICATION ERRORS

A. A process shall be in place to monitor for potential and actual adverse drug events secondary to medication errors. This shall include required reporting procedures pursuant to state guidelines and federal pharmacy rules. For the purposes of this manual, an actual adverse drug event is defined as an illness or injury resulting from a medical intervention related to a drug; and a potential adverse drug event is defined as any circumstance involving a drug that did not result in actual injury but could potentially have done so.

B. The purpose of this process is to identify factors leading to medication errors, identify trends, determine preventability and implement corrective actions. “Corrective action” does not mean disciplinary action of an employee. Although disciplinary action may be a
part of the corrective action regarding a particular medication error, the term “corrective action" typically refers to an analysis of the problem’s root cause with a subsequent adjustment in the system in order to prevent future mistakes from taking place.

C. Analyses of the events surrounding a medication error would best be recorded in an incident report specifically for this purpose. These reports shall be reviewed by the Designated Health Authority and Superintendent or Program Director to perform an analysis of any existing trends. As an example, the analysis may reflect that medications given in the morning are consistently administered late because the youth are in the classroom and staff is unavailable to accompany them to the medication administration area. Corrective action may involve establishing earlier times of medication administration, or arranging for one staff member to accompany the youth during a given time period for the administration of the medications.

D. Any error related to medications must be entered on the incident report, regardless of whether it resulted in harm to the youth. The report should document the following items:

- Name of youth;
- DJJ identification number of youth;
- Name of the prescribed medication;
- Prescribed dosage of the medication;
- Category of medication (for example, anti-tuberculosis, psychotropic, etc.);
- Actual medication given;
- Actual dosage given;
- If a medication was omitted, the date and time of the omission;
- Whether the error involved a medication prescribed by an off-site provider;
- Whether the error involved a newly admitted or transferred youth;
- Any adverse side effects to any medication;
- What action was taken, if any, for that particular youth;
- Whether or not the youth required professional medical attention as a result of the event;
- What action was taken, if any, to address the factors that resulted in the adverse drug event or potential adverse drug event;
- Persons notified of the error (must include the Designated Health Authority, Superintendent or Program Director and prescribing Physician, PA or ARNP).

E. Recording of actual adverse drug events and potential adverse drug events in this manner does not take the place of required Departmental incident reporting.

F. The Designated Health Authority or Physician Designee, and the facility superintendent or Program Director shall review the medication error reports every two weeks in order to identify trends and institute corrective action in the medication management system as applicable.
XVI. DESTRUCTION AND DISPOSAL OF MEDICATIONS

A. The Designated Health Authority or Physician Designee shall be responsible for assuring the proper destruction and disposal of medications in accordance with Chapter 64F-12 F.A.C. Regulations.

1. Each facility must establish a systematic process for the following:

   ☑ Inventory Accountability  
   ☑ Monitoring pharmaceutical expiration dates  
   ☑ Quarantine of unusable medication  
   ☑ Disposal of medications

2. A youth’s parent or guardian shall be provided any prescription medications when youth is released from a detention or residential commitment program.

3. Any medication not procured by a youth’s parent or guardian, after a youth’s discharge from a facility, shall be destroyed after 30 days.

B. EXPIRATION OF MEDICATIONS

1. The Registered Nurse or Licensed Practical Nurse shall be responsible for checking all prescription and over-the-counter medications for expiration dates monthly. Additionally, prescription medication expiration dates shall be examined during the routine medication administration process. Outdated medications shall never be administered to a youth.

2. All outdated medications will be removed and segregated from regular stock and placed in a designated secure locked quarantine area. Outdated medications shall be destroyed at least monthly.

3. Any non-expired pharmaceutical product that has been subjected to improper storage condition, contaminated in any way, adulterated, or deemed to be unusable for any reason shall be placed in the designated quarantine area and destroyed.

4. A secured designated quarantine medication storage area shall be clearly marked and designated separate and apart from usable medications.

C. INVENTORY ACCOUNTABILITY

1. Each facility shall document an inventory of all medication entering or leaving the quarantine storage area. This documentation can be maintained electronically or by utilizing a manual or separate log.

2. A physical inventory reference list of drugs quarantined shall be maintained. The inventory must reflect the following information:
D. DISPOSAL OF MEDICATION

1. Each facility shall establish a process for the proper disposal of medication.

2. A licensed health care professional shall be responsible for the disposal of medications. Controlled and non-controlled medications for disposal shall be inventoried prior to disposal and disposed of in the presence of a witness. The witness shall be a licensed health care professional or facility supervisor or designee.

3. All DJJ facilities must follow Federal Regulations ((CFR) Section 1307.21; (CFR) Section 1910.2030) and the Florida Department of Environmental Protection for the disposal of medications and bio-hazardous waste. According to Board of Pharmacy Administrative Rule 64B16-28.303, F.A.C., medications, by and large, are not considered hazardous waste. Therefore, the best method of medication disposal is through a Reverse Distributor. Second to that, all medications are to be disposed of by flushing, or through the sewer system. In the case of controlled medications (e.g. Narcotics), this must be done by a three-party witness, and must be destroyed beyond reclamation, per FAC 64B16, by a Pharmacist, Nursing Supervisor, and administrator or designee, and should be done via sewer. Medications should not be disposed of in regular trash at facilities or programs. Medications should not be placed in kitty litter or coffee grounds and discarded in the regular trash. Again, medications are to be destroyed beyond reclamation to avoid any possible diversion.

4. Documentation of the disposal of all medication shall be maintained. Documentation shall include:

- Date of Disposal
- Name of person performing disposal
- Name of witness to the disposal
- Name of youth on prescribed medication
- Name of medication
- Amount of medication being disposed
- Reason for disposal of medication
- Signature of staff person disposing of medications
XVII. MEDICAL ALERT *(REFER TO CHAPTER 3: ADMISSION PROCESS)*

Each DJJ facility shall establish a medical alert system within the overall facility alert system. The medical alert system shall include all youth on prescribed medications that have potentially serious side effects. All youth, who are Medical Grade 5 due to prescribed psychotropic medications, shall be placed on alert. A list or roster of youth’s names shall be kept updated, and confidentially available, in order to provide a quick reference for staff when medical issues exist which may affect the health of the youth or the security and safety of the detention center or residential commitment program staff.

XVIII. YOUTH EDUCATION ON MEDICATIONS

A. All youth who are prescribed medications shall receive instructions and education related to those medications. If the medication is a new prescription medication, (that is, the youth was not receiving it at the time of admission to the facility), it is the responsibility of the prescribing clinician to properly inform the youth and parents of possible side effects.

B. When a youth is instructed regarding medication by an on-site licensed health care professional, documentation of this education shall be recorded on the Health Education Record, in the Individual Health Care Record.

XIX. MODIFIED CLASS II B INSTITUTIONAL PHARMACY PERMITS

Those facilities that have obtained a modified Class II B Institutional Pharmacy permit must follow the general requirements related to the medication management in this chapter, as well those related to their permits. Facilities that are capable of conducting Modified Class II B institutional pharmacies on-site are responsible for obtaining and maintaining the appropriate permits/licenses and for complying with all applicable state and federal laws, rules, and regulations. A formulary and operating procedures for these limited institutional pharmacies shall be developed by the facility and updated as needed. A Pharmacy and Therapeutics Committee (PTC) shall be established and meet at least quarterly in facilities with modified class II institutional pharmacies.

As defined in 64B16-27.300 Standards of Practice – Continuous Quality Improvement Program, the Pharmacy and Therapeutic Committee is a body of individuals consisting of a physician, a pharmacist, nurses and others selected by the facility that provides health care, to oversee issues related to medication use within the facility.

The Pharmacy and Therapeutic Committee shall be responsible for the following components of the quality assurance medication management process:

- Review and approve policies and procedures concerning the appropriate use of drugs;
- Review and approve educational activities related to drug use;
- Manage the formulary system;
- Review and approve quality assurance programs designed to maintain appropriate drug prescribing, distribution and administration of drugs;
- Review and approve adverse drug event monitoring procedures;
- Distribute committee decisions to all staff members involved in direct patient care.

For facilities that do not maintain limited institutional pharmacies (e.g. they obtain the prescription medications from a community pharmacy or pharmacy vendor), a PTC is recommended but is not mandatory. A PTC is strongly recommended for any facility over 100 beds.
CHAPTER TWELVE
PSYCHOTROPIC MEDICATION MANAGEMENT

OCTOBER 2006
I. INTRODUCTION

The prescription of psychotropic medication to youth while in the custody of the Florida Department of Juvenile Justice for the purpose of treatment of diagnosed mental disorders (diagnosed applying the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)) will be conducted and monitored in keeping with the standards set forth by the American Academy of Child and Adolescent Psychiatry or American Academy of Pediatrics, and in accordance with Florida law, Departmental policies and standards and the commonly accepted practices of the psychiatric community. Furthermore, psychiatric services including psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR mental disorder and substantial functional limitations must be provided by a licensed Psychiatrist or a licensed and certified Psychiatric Advanced Registered Nurse Practitioner (ARNP) working under the clinical supervision of a licensed Psychiatrist.

The Department recognizes the seriousness and need for accountability and the utmost safety in the prescription, procurement, storage, administration and monitoring of psychotropic medications. Additionally, the Department is committed to ensuring that the family of a youth who is prescribed psychotropic medication will have the opportunity for involvement. This includes the parental consent when the medication is prescribed, participation in the youth’s psychiatric evaluation, parental notification when/if the medication is changed, and discussion of the medication as part of the treatment team, which the parent is encouraged to attend, if possible.

For purposes of this Manual, a “psychotropic medication” is a medication that exercises certain effects upon the neurotransmitters of the brain and is used to treat symptoms of mental disorders. Psychotropic medications may influence thinking, mood and behaviors. The classifications of psychotropic medication include antidepressants, mood stabilizers, anxiolitics, hypnotics, antipsychotics, and psychostimulants. For the purposes of this Manual, other non-psychotropic classifications of medications such as anticonvulsants, beta-blockers or central adrenergic agonists will be considered psychotropic medications only when prescribed and used to treat thinking, mood and behaviors associated with diagnosed mental disorders.

When symptoms of serious mental disorder or substance abuse impairment significantly interfere with the youth’s functioning, psychotropic medication may provide symptom relief and allow the youth to more successfully participate in mental health activities and activities of daily living. Psychotropic medication refers to medications capable of affecting the individual’s thinking, mood and behavior, which are used to treat symptoms of mental illness. A variety of
psychotropic medications may be helpful in the treatment of youth with mental disorders or substance related disorders. The goal being to provide optimal therapeutic results with the minimum number of different medications.

II. QUALIFICATIONS OF PRACTITIONERS PRESCRIBING AND MONITORING PSYCHOTROPIC MEDICATIONS

Psychotropic medications shall be prescribed only by a licensed Psychiatrist or a Psychiatric Advanced Registered Nurse Practitioner (Psychiatric ARNP) working under the clinical supervision of a licensed Psychiatrist as follows:

A. Licensed Psychiatrist: Within the context of this Manual, a licensed Psychiatrist is a physician licensed under Chapter 458 or 459, Florida Statutes, who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination. A licensed Psychiatrist who is board certified in Forensic Psychiatry by the American Board of Psychiatry and Neurology or American Board of Forensic Psychiatry may provide services in DJJ facilities or programs, but must have prior experience and training in psychiatric treatment with children or adolescents.

1. The Psychiatrist shall have ultimate responsibility for the prescription and monitoring of psychotropic medications in the DJJ facility or program.

2. The Psychiatrist must actively participate in, manage and supervise psychotropic medication services in the DJJ facility/program.

3. The Psychiatrist must personally render psychiatric services or provide clinical supervision of the licensed and certified Psychiatric ARNP also rendering psychiatric services in the DJJ facility or program.

B. Psychiatric ARNP: Within the context of this Manual, a Psychiatric ARNP must be licensed as a Registered Nurse and certified as an Advanced Registered Nurse Practitioner with a specialty in psychiatric mental health, pursuant to Chapter 464, Florida Statutes and Chapter 64B8-35 F.A.C.

1. The Psychiatric ARNP may prescribe and monitor psychotropic medication as specified in the current written collaborative practice protocol with the supervising Psychiatrist filed with the Florida Department of Health. (Note: Verification of required licensure and certification may be accomplished by accessing Medical Quality Assurance (MQA) Services at the Florida Department of Health website: http://www.doh.state.fl.us/).

2. A current and updated copy of the official collaborative practice protocol between the supervising Psychiatrist and Psychiatric ARNP and a copy of the notice required by Section 458.348(1) F.S. must be kept on-site at each DJJ facility or program where the Psychiatric ARNP provides psychiatric services.
A copy of the official collaborative practice protocol must be provided to the Department Regional Contract Monitor prior to execution of a DJJ contract for psychiatric services, including prescribing and monitoring psychotropic medications, which includes a Psychiatric ARNP.

3. Any alterations to the official collaborative practice protocol or amendments filed with the Department of Health must be copied and kept on-site at each DJJ facility or program where the Psychiatric ARNP provides psychiatric services.

C. PSYCHIATRIST’S CLINICAL SUPERVISION OF THE PSYCHIATRIC ARNP:

1. Within the context of this Manual, clinical supervision means that the Psychiatrist provides bi-weekly (every two weeks) on-site supervision of the Advanced Registered Nurse Practitioner’s medication management services. Psychotropic medication management services must be reviewed and approved by the Psychiatrist.

2. The Psychiatrist must be on-site every two weeks and available to evaluate and monitor youths, as needed. However, all youths must receive psychotropic medication monitoring/review every 30 days, at a minimum. (See VI of this chapter).

3. The Psychiatrist must be available for emergency consultation 24 hours a day, 7 days a week.

4. The supervising Psychiatrist must be available to the Psychiatric ARNP by telephone or by other communication device when not physically available on the premises.

5. Consultation with the supervising Psychiatrist must be provided as specified in the collaborative practice protocol and under the following circumstances:
   a. Conditions for which the diagnosis and/or treatment are beyond the scope of the Psychiatric ARNP's knowledge and/or skills;
   b. Changes in youth’s symptoms or impairment not managed by standard interventions (medication adverse effects, non-response or poor response);
   c. Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started;
   d. As requested by the DJJ mental health clinical staff, DJJ administrative staff or youth.

III. PRESCRIPTION OF PSYCHOTROPIC MEDICATIONS:

A. YOUTH CURRENTLY PRESCRIBED PSYCHOTROPIC MEDICATION UPON ADMISSION:
1. Each facility must have an intake screening process and procedures for the identification of youth currently prescribed psychotropic medication upon admission and verification of existing medications as specified in Chapter 11 of this Manual.

   a. Upon admission to the DJJ facility (detention center and/or residential commitment program), it will be determined by designated intake staff and/or designated nursing staff from the Facility Entry Physical Health Screening, preliminary mental health screening, review of past records, and interview of either the youth or the parent/guardian, if the youth has been previously diagnosed with a mental disorder and is currently prescribed psychotropic medication.

   b. The youth’s diagnosed mental disorder will be added to the Problem List in the youth’s Individual Health Care Record with a notation of “history of” until the youth is seen by the Psychiatrist or Psychiatric ARNP.

   c. Designated intake staff or designated nursing staff will determine whether an original or a true copy of the youth’s current, valid Authority for Evaluation and Treatment (AET) is present in the youth’s Individual Health Care Record.

2. Each facility must also have a process and procedures for notification of the Designated Health Authority (DHA); the facility’s prescribing Psychiatrist or Psychiatric ARNP and the Designated Mental Health Authority (DHMA) of admission of youths currently prescribed psychotropic medication.

3. Each facility must have an established procedure for the Psychiatrist or Psychiatric ARNP’s timely review of pre-admission psychotropic medications that the youth was prescribed and is currently receiving at the time of admission.

4. Pre-admission laboratory testing, serum levels of medications (when indicated) and/or the dissemination of any special instructions to the DJJ facility or program should be reviewed, and implemented, with the written consent of the facility/program’s Psychiatrist or Psychiatric ARNP.

5. Medications for which the youth has a verified prescription at the time of admission shall not be adjusted or changed unless, in the opinion of the facility’s Psychiatrist or Psychiatric ARNP, there is a change in the diagnosis, behavior, side effects, or other signs, symptoms which warrant adjustment of the psychotropic regimen.

6. Coordination of Psychiatric Services: It is the responsibility of the Psychiatrist or Psychiatric ARNP or other health care staff to contact the Psychiatrist or other provider treating the youth prior to admission, to coordinate services and obtain treatment records. The Psychiatrist or Psychiatric ARNP is responsible for contacting the prior Psychiatrist or provider with any questions or concerns regarding the effectiveness of prescribed drugs and psychotherapeutic interventions utilized prior to admission.
a. Contact with the previous Psychiatrist or provider treating the youth prior to admission must be documented in the youth’s Individual Health Care Record.

b. The Psychiatrist or Psychiatric ARNP must assume responsibility for delivery and management of the youth’s psychiatric services while in the DJJ facility, including psychiatric assessment and provision of psychopharmacological treatment.

c. The continuation or renewal of psychotropic medications from community providers shall be based on the Psychiatrist’s or Psychiatric ARNP’s timely evaluation of the youth.

7. The psychotropic medications the youth was receiving prior to admission shall continue to be administered until the DJJ facility/program Psychiatrist or Psychiatric ARNP conducts an initial diagnostic psychiatric interview of the youth. The initial diagnostic psychiatric interview must be conducted within 14 days of the youth’s admission. The initial diagnostic psychiatric interview must include: History (medical, mental health and substance abuse history); Mental Status Examination; DSM-IV-TR Diagnostic Formulation (Axis I-V); Treatment Recommendations; Prescribed Medication (if applicable); Explanation of the need for psychotropic medication and Frequency of Medication Monitoring/Review. The initial diagnostic psychiatric interview will be used to determine whether the psychotropic medication prescribed prior to admission should be continued, modified or discontinued.

8. Youth receiving psychotropic medication prescribed prior to admission shall receive medication monitoring/review by the DJJ facility/program Psychiatrist or Psychiatric ARNP. Medication monitoring/review shall be provided and documented as specified in Section VI of this chapter.

9. Any adjustment or change in the youth’s pre-admission psychotropic medication regimen must be based upon a written order of the DJJ facility/program’s Psychiatrist or Psychiatric ARNP (in consultation with the Psychiatrist).

10. If the youth is currently being prescribed psychotropic medication upon admission, the youth should be placed on the facility’s Medical Alert list/system, and assigned a medical grade of “5,” even if the comprehensive physical assessment has not been done, or if the youth was not assigned a medical grade of “5” previously.

B. YOUTH PRESCRIBED PSYCHOTROPIC MEDICATION SUBSEQUENT TO ADMISSION

1. Youth not currently prescribed medication at the time of admission that later exhibit significant changes in their emotions and behaviors which suggests severe emotional disturbance or mental illness must be immediately brought to the attention of the facility/program mental health clinical staff and licensed mental health professional.
2. The facility/program mental health clinical staff and licensed mental health professional must evaluate the youth within 24 hours, and will determine whether a referral to the Psychiatrist or Psychiatric ARNP is needed. If psychiatric referral is needed, the mental health clinical staff or licensed mental health professional will refer the youth to the Psychiatrist or Psychiatric ARNP within 24 hours of the mental health evaluation.

3. Upon examination, if the Psychiatrist or Psychiatric ARNP determines that psychotropic medication is needed, the youth must receive an initial diagnostic psychiatric interview or psychiatric evaluation within fourteen (14) days by a Psychiatrist or Psychiatric ARNP who, under employment, contract, agreement of fee-for-service, is the practitioner utilized by that facility to provide psychotropic medication-related services.

C. PRESCRIPTION OF PSYCHOTROPIC MEDICATIONS: BASIC STANDARDS

1. The Psychiatrist or Psychiatric ARNP shall only prescribe psychotropic medications, which address the youth's specific diagnoses and target symptoms.

2. If psychotropic medications are required, then the lowest dose of medication necessary to achieve therapeutic effect should be used bearing in mind potential benefits and risks.

3. The Psychiatrist and Psychiatric ARNP are expected to be aware of and inform the youth, parent/legal guardian and clinical staff about FDA warnings and advisories for specific psychotropic medications as well as closely monitor or change therapy as appropriate. The Psychiatrist and Psychiatric ARNP should regularly review the FDA's MedWatch website for new information. This site can be accessed at: http://www.fda.gov/medwatch/safety.htm

4. The use of more than one psychotropic medication as part of a mental health treatment regimen requires documented clinical justification by the licensed Psychiatrist or Psychiatric ARNP.

5. Psychotropic medication shall be only one component of the therapeutic program. Additional treatment modalities such as individual, group and family therapy, behavioral therapy, substance abuse counseling and psychosocial skills training shall be utilized in conjunction with the use of psychotropic medication.

6. Psychotropic medication will not be used as punishment; for staff convenience, discipline, coercion, or retaliation; as a substitute for meaningful psychosocial, rehabilitative services; or in quantities that lead to a loss of functional status.

7. There will be no standing orders for psychotropic medications.

8. There will be no emergency treatment orders for psychotropic medication.
IV. INITIAL DIAGNOSTIC PSYCHIATRIC INTERVIEW PRIOR TO THE PRESCRIPTION OF PSYCHOTROPIC MEDICATION:

A. The initial diagnostic psychiatric interview will be used to establish a diagnosis, target symptoms to be treated with the medication, and develop the youth’s mental health treatment plan.

1. The initial diagnostic psychiatric interview must include:

   a. History (medical, mental health and substance abuse history);
   b. Mental Status Examination;
   c. DSM-IV-TR Diagnostic Formulation (Axis I-V);
   d. Treatment Recommendations;
   e. Prescribed Medication (if applicable)
   f. Explanation of the need for psychotropic medication related to:
      - The youth’s diagnosis
      - Target symptoms
      - Initial treatment goals
      - Potential side effects
      - Risks and benefits of taking the medication;
   g. Frequency of Medication Monitoring/Management.

2. The initial diagnostic psychiatric interview may be documented on the DJJ form entitled Clinical Psychotropic Progress (CPPN) (all 3 pages) or in a form developed by the facility or program. The form utilized (CPPN) or facility/program form must be clearly identified as an “Initial Diagnostic Psychiatric Interview”. However, if the initial psychiatric diagnostic interview results in the prescription of psychotropic medications or changes to a youth’s existing psychotropic medication regimen, page 3 of the CPPN must be completed, regardless of the format used to document the psychiatric interview.

V. PSYCHIATRIC EVALUATIONS

All youths currently receiving psychotropic medications at the time of admission or prescribed psychotropic medication subsequent to admission must receive an in-depth psychiatric evaluation or an updated psychiatric evaluation by a licensed Psychiatrist or Psychiatric ARNP working under the clinical supervision of the Psychiatrist within 30 days of admission to the DJJ facility or program (for youths currently receiving psychotropic medications at the time of admission) or within 30 days of the initial prescription of psychotropic medication (for youths prescribed psychotropic medication subsequent to admission).

1. Psychiatric Evaluation Components:
a. The Psychiatrist or Psychiatric ARNP must review available medical, mental health and substance abuse reports, arrest reports and pertinent DJJ records prior to the evaluation.

b. The Psychiatrist or Psychiatric ARNP must complete and document the psychiatric evaluation on the day it was conducted. If a transcription service is used, the Psychiatrist may place a summary note in the youth’s Individual Health Care Record on the day the evaluation is conducted and file the dictated report in the Individual Health Care Record within seven (7) calendar days.

c. The psychiatric evaluation must reflect consideration of the following:

1. The stated reasons and factors leading to the referral;

2. History (developmental history, medical history [including medical disorders, head trauma and prenatal exposure to alcohol or drugs], substance abuse history, school history, social history, emotional development, peer relations, family relationships, interests/talents and traumatic experiences [physical abuse, sexual abuse, neglect, witnessing violence and other forms of trauma]);

   **Note:** When a detailed history has already been documented in a comprehensive mental health evaluation conducted immediately prior or subsequent to the youth’s admission to the DJJ facility or program (i.e., within the past 3 months), the Psychiatrist or Psychiatric ARNP may utilize the detailed history provided in the previous comprehensive evaluation rather than repeating the history. However, pertinent interval history that has been obtained since the last report must be added in this section. A notation must be made in the psychiatric evaluation history section that the history is documented in the previous comprehensive evaluation and the comprehensive evaluation must be attached to the psychiatric evaluation.

3. History of psychiatric illness, psychotropic medication management, mental health treatment and/or substance abuse treatment;

4. Assessment of symptoms (the nature and complexity of the youth’s behavioral difficulties, functional impairments, and subjective distress);

5. Mental Status Examination;

6. Identification of individual, family and/or environmental factors that may potentially account for, influence or ameliorate the youth’s difficulties;

7. Diagnostic formulation (Multi-axial DSM-IV-TR diagnoses);

8. Treatment recommendations and intervention(s) for a youth in order to assist in stabilizing the psychiatric disorder;
9. Prescribed medication (if applicable) and frequency of medication monitoring/management;

10. Explanation of the need for psychotropic medication related to the youth’s diagnosis, target symptoms, potential side effects, risks, and benefits of taking the medication.

11. Most recent applicable therapeutic serum drug levels (laboratory tests); and

12. Signature of the practitioner conducting the psychiatric evaluation.

2. The psychiatric evaluation may be documented on the DJJ form entitled “Clinical Psychotropic Progress Note (CPPN) (all 3 pages) or in a form developed by the facility or program. The form utilized (CPPN) or facility/program form must be clearly identified as a “Psychiatric Evaluation.” However, if the psychiatric evaluation results in the prescription of psychotropic medications or changes to a youth’s existing psychotropic medication regimen, page 3 of the CPPN must be completed, regardless of the format used to document the psychiatric evaluation.

3. Youth with a documented psychiatric evaluation within the past 6 months may receive an updated psychiatric evaluation as follows:

   If a recent psychiatric evaluation (within the past 6 months) is on file in the Individual Health Care Record and/or is obtainable from the youth’s past prescriber’s, the updated psychiatric evaluation conducted on-site shall be documented using either the standardized form, Clinical Psychotropic Progress Note (CPPN) (all 3 pages), or on a form developed by the facility/program as long as all the form is clearly identified as an “Updated Psychiatric Evaluation” and all the components listed paragraph A. above are present.

VI. PSYCHIATRIST OR PSYCHIATRIC ARNP MEDICATION MONITORING/REVIEW OF YOUTH RECEIVING PSYCHOTROPIC MEDICATION

A. Medication monitoring/review includes evaluating and monitoring medication effects and the need for continuing or changing the medication regimen. At a minimum, follow-up medication monitoring/review shall be provided every 30 days.

1. Psychotropic medication monitoring/review shall include, but is not limited to:

   a. Mental status examination;
   b. Monitoring the effects of prescribed psychotropic medication and clinical outcomes as described in the youth’s treatment plan;
   c. Evaluation of potential side effects;
   d. Assessment of medication adherence/compliance;
   e. Evaluation of the need for medication adjustments or discontinuation;
f. Informing the youth and parent/legal guardian of the potential side effects of each psychotropic medication prescribed, dose schedule and anticipated therapeutic effects. (See Section VIII entitled "Consent and Notification Requirements for Youths Receiving Psychotropic Medication");
g. Providing information regarding continuation and maintenance of psychotropic medication;
h. Monitoring of indices such as height, weight and blood pressure or other laboratory findings (e.g., ordering and monitoring serum therapeutic drug levels, EKG, EEG);
i. Ensuring any expected or common side effects of psychotropic medication are effectively communicated to the facility staff that supervises the youth.

B. Psychotropic Medication Monitoring/Review Documentation Requirements:

1. If psychotropic medication is prescribed/dispensed/administered by the Psychiatrist or Psychiatric ARNP, the following information will be documented for each psychotropic medication monitoring/review visit.

   a. Identifying data;
   b. Diagnosis;
   c. Target symptoms of each medication;
   d. Evaluation and description of effect of prescribed medication on target symptom(s);
   e. Prescribed psychotropic medication, if any (name, dosage and quantity of the medication).
      1. Normal dose range;
      2. Ordered Dosage;
      3. Frequency and route of administration;
      4. Reasons for changes in medication and/or dosage shall be clearly documented by the Psychiatrist or Psychiatric ARNP.

   f. Side Effects (description of response to medication(s) both positive and adverse drug experiences or documentation if none present);
   g. Youth's adherence to the medication regime;
   h. Height, weight, blood pressure, most recent serum drug levels or laboratory findings (as appropriate);
   i. Whether there was telephone contact with parent/guardian to discuss medication when one of the following actions is taken by the Psychiatrist or Psychiatric ARNP:
      ✓ Prescribes or otherwise orders a prescription medication which the youth was not currently prescribed at the time of entering the physical custody of the Department, or
      ✓ Discontinues prescription medication(s) (which the youth was currently prescribed at the time of entering the physical custody of the Department)
or discontinues medications which the youth has been prescribed since entering the physical custody of the Department; or

A significant change in the dosage of prescription medication(s), (which the youth was currently prescribed at the time of entering the physical custody of the Department). A “significant change” in dosage of a medication is any increase or decrease in dosage beyond a small increment or beyond the normal dosage for youths of similar age.

j. Signature of the Psychiatrist or Psychiatric ARNP;
k. Date of signature.

2. Psychotropic medication that is prescribed or significantly changed shall be documented on the CPPN. Psychotropic medication that is continued without significant change shall be documented either on the CPPN or in a format developed by the facility or program.

C. The Psychiatrist or Psychiatric ARNP shall prescribe psychotropic medications, as appropriate, which address the youth’s specific diagnoses and target symptoms. If psychotropic medications are prescribed, the Psychiatrist or Psychiatric ARNP will:

1. Monitor target symptoms;

2. Order laboratory tests required by prescribed medication, including serum drug levels to ensure a safe and therapeutic range;

3. Review laboratory test results within 72 hours of notification of results; (The Psychiatrist may accomplish the review of lab results off-site through review of an electronically transmitted or faxed copy of the lab results.)

4. Assist with parental notification;

5. Document medication monitoring/review in accordance with sections A and B above.

D. Reassessment for Non-Response to Psychotropic Medications: A thorough reassessment should occur if the youth does not show a positive response after 6 weeks of treatment with psychotropic medication.

E. Reassessment should include:

a. Thorough review of presentation, symptoms and diagnosis;
b. Evaluate for complicating medical condition or illness not yet diagnosed;
c. Review adherence/compliance;
d. Ensure adequate dose and trial period of medication;
e. Check blood levels in medications with know therapeutic levels;
f. Consider drug-drug interactions that may be lowering plasma level.
F. Supporting Youth Adherence to the Medication Regimen through the following:

   a. Integrate the youth's family in treatment planning and education to the greatest possible extent.
   b. Recognize youth attitudes and behavior with respect to medication.
   c. Simplify the medication regimen.
   d. Thoroughly explain possible side effects to the youth and family so they know what to expect.
   e. Encourage youth to report side effects and what is bothering them about the medication.

VII. PSYCHOTROPIC MEDICATION SIDE EFFECTS MONITORING BY NURSING STAFF AND FACILITY/PROGRAM STAFF

Psychotropic medication side effects monitoring is a collaborative process which requires information sharing and communication between the prescribing practitioner, the family and facility/program staff who are involved in the care of the youth. Clinical staff and direct care staff in regular contact with youth should be knowledgeable of possible psychotropic medication side effects.

Psychotropic medications are capable of producing undesired side effects ranging from rare, mild and localized to widespread, severe and life-threatening, depending on the specific psychotropic medication and the person receiving it. According to the Health and Safety Alert, Excessive Psychotropic Medication and Psychotropic Medication Side Effects (2002), serious side effects common to most psychotropic drugs may include the following:

- Allergic reaction (difficulty breathing, swelling of lips/face/tongue, rash or fever);
- Change in level of alertness (excess sleepiness, insomnia, or confusion);
- Eating problems (nausea, vomiting, weight gain or weight loss);
- Change in heartbeat (slow, fast, irregular);
- Change in blood pressure (high or low);
- Fainting or dizziness (especially with change in position such as standing);
- Abnormal posture, body or muscle movements or gait;
- Yellowing of eyes or skin;
- Unusual bruising or bleeding.

It is imperative that procedures be in place for the prompt documentation and reporting of staff, youth or family observations of possible psychotropic medication side effects as follows:

A. Designated nursing staff shall administer medications and in the absence of nursing staff, designated trained facility/program staff shall facilitate the delivery of medications to a youth so that the youth can actively perform self-administration of oral prescription medications. Both nursing staff and facility/program staff must document the administration (or youth self-administration) of each dosage of psychotropic medication on the Medication Administration Record (MAR) as specified in Chapter 11 of this Manual.
1. Staff administering or facilitating youth self-administration of medication shall document their observations and the youth’s reports of possible side effects on the Medication Administration Record (MAR) as specified in Chapter 11 of this Manual.

B. Mental health and substance abuse clinical staff must document and report to the Psychiatrist or Psychiatric ARNP observations of unusual thinking, mood, behavior, psychomotor activity and other possible side effects experienced by the youth.

1. The nursing staff and mental health/substance abuse clinical staff must document and report to the Psychiatrist or Psychiatric ARNP observations regarding possible adverse side effects including observations reported by non-health care staff or the youth’s family or friends.

2. The facility/program treatment team must have regular communications with the Psychiatrist or Psychiatric ARNP to provide updated information on the youth’s behavior, mental health status and possible side effects. (See Section IX entitled “Treatment Planning and Transition/Discharge Planning for Youths Receiving Psychotropic Medication”).

VIII. CONSENT AND NOTIFICATION REQUIREMENTS FOR YOUTH RECEIVING PSYCHOTROPIC MEDICATION

When a psychotropic medication is initially prescribed, discontinued and/or a significant dosage adjustment is made, parental notification and consent must be obtained.

A. CLINICAL PSYCHOTROPIC PROGRESS NOTE (CPPN):

1. For the prescribing of any psychotropic prescription medication(s) (which the youth was not currently prescribed at the time of entry into the physical custody of the Department), a copy of the 3rd page of the standard form, “Clinical Psychotropic Progress Note” (CPPN) shall be sent via certified mail to the parent/guardian at the address on record, after completion by the prescriber.

2. This form (a copy of the 3rd page of the standard form, “Clinical Psychotropic Progress Note” (CPPN) shall be accompanied by a cover letter (See “Acknowledgment of Receipt of CPPN Form or Practitioner Form [AOR]”) to the parent/guardian).

3. Telephone consent (preferably but not mandatorily, by the Psychiatrist or Psychiatric ARNP) must be attempted and must include a discussion of the information contained on page 3 of the CPPN (Contents of pages 1 & 2 of the CPPN are not to be disclosed to the parent/guardian for purposes of notification/consent for psychotropic medications).

a. Informed consent requires the Psychiatrist or Psychiatric ARNP provide the following information to the youth and parent/legal guardian:
1) The nature of the mental disorder (symptoms/behavior) that is the reason the medication is being given or recommended;
2) The likelihood of improving or not improving without medication;
3) Reasonable alternative treatments available;
4) The name, type, frequency, amount and method of administering the medications, and the probable length of time that the medication will be taken;
5) Anticipated or possible side effects associated with the medication.

4. If a youth has remained continuously in the physical custody of a detention center and is transferred directly from a detention center to a residential commitment program, the residential/correctional facility is not required to send CPPNs for medications that the youth is currently prescribed at the time of entering its physical custody.

5. If a youth has remained continuously in the physical custody of a residential commitment program and is transferred directly to a detention center, the detention center is not required to send CPPNs for medications that the youth is currently prescribed at the time of entering its physical custody.

6. Whenever a new medication is prescribed, a medication is discontinued, or the drug dosage is significantly changed, a copy of the 3rd page of the completed CPPN will be sent to the parent/guardian to provide consistent, updated information concerning the youth's progress and/or recommendations for changes in medications. (A significant change in dosage of a medication is any increase or decrease in dosage beyond a small increment or beyond the normal dosage for youth of similar age.)

7. For psychotropic medication purposes only, a copy of the third page of the CPPN replaces the standardized DJJ Parental Notification form. A cover letter will accompany the copy of the third page of the CPPN mailed to the parent ("Acknowledgment of Receipt of CPPN Form or Practitioner Form [AOR]"). A copy of the 3rd page will be filed in the section of the IHCR, in the section reserved for physician orders, in reverse chronological order (most recent document on top in that section). If desired and included in the facility's FOP, the third page of the CPPN may serve as the prescribing practitioner's medication orders.

8. A copy of the third page of the CPPN may be attached to the youth's individual mental health treatment plan, and will be considered a part of that treatment plan for psychopharmacological interventions.

9. With regard to dosage adjustments, parental notification and consent must always be obtained in the following instances:

☑ The parent/guardian has informed the Department that he/she desires notification of any change;
A youth has been receiving the same total daily dosage of a medication for 90 days or more and the prescriber feels that a change in the total daily dosage is warranted; and,

The dosage change results in a total daily dosage, which exceeds the normal range. If any of these situations exists, the Parental Notification/CPPN/AOR process shall be followed, regardless of the degree of change in the dosage.

IX. TREATMENT PLANNING AND TRANSITION/DISCHARGE PLANNING FOR YOUTH RECEIVING PSYCHOTROPIC MEDICATION

All youth who are determined by the Psychiatrist or Psychiatric ARNP to require continuation or initiation of psychotropic medication in the DJJ facility or program must have an initial mental health treatment plan or individualized mental health treatment plan as follows:

A. Following the initial diagnostic psychiatric interview, youths who are to continue receiving psychotropic medication or who are prescribed psychotropic medication must be referred to the mini treatment team in detention centers or multidisciplinary treatment team in residential commitment programs for development of an initial treatment plan or individualized mental health/substance abuse treatment plan as specified in the DJJ Mental Health and Substance Abuse Service Manual, Chapter 6, Section II, Revised 2006.

B. The use of psychotropic medication must be referenced and incorporated into the youth’s treatment plan.

C. Youth receiving psychotropic medication shall have treatment plans and transition/discharge plans, which address the youth’s diagnoses, target symptoms and psychiatric services needs in the program and upon return to the community.

D. The Psychiatrist or Psychiatric ARNP providing psychiatric services must either be a member of the multidisciplinary treatment team, or must on a weekly basis brief the multidisciplinary treatment team on the psychiatric status of each youth receiving psychiatric services who is scheduled for treatment team review. The briefing may be accomplished through face-to-face interaction or telephonic communication with the representative or treatment team.

E. The parent/legal guardian of youths who are taking psychotropic medication at the time of release/discharge from DJJ custody shall be provided, at least a five (5) day supply of their medication, and a prescription for their medication so they may continue the prescribed treatment upon return to the community.
X. TARDIVE DYSKINESIA (TD) SCREENING

Tardive dyskinesia (TD) refers to abnormal, involuntary movement of the face, eyes, mouth, tongue, trunk and/or limbs. Most common are the perioral movements which involve: Twisting, protruding, darting movement of the tongue; Chewing and sideways jaw movements; and/or Facial grimacing. Antipsychotic medications can cause TD, which can be severe and potentially irreversible.

The Psychiatrist, Psychiatric ARNP and nursing staff must monitor for TD on a monthly basis as follows:

A. For youths prescribed antipsychotic medications, nursing staff will conduct a monthly screening (or more often as ordered) for tardive dyskinesia (TD) on either the DISCUS form or a process/format of the Psychiatrist or Psychiatric ARNP’s choice which will be placed in the Individual Health Care Record, Mental Health section. Designation of the format to be used should be included in the facility operating procedure. If the Psychiatrist or Psychiatric ARNP conducts the TD screening as part of his/her medication monitoring/review and the youth is seen by the Psychiatrist or Psychiatric ARNP on an at least monthly basis, nursing staff are not required to conduct the routine TD screening. However, as with all medications, nurses are responsible for monitoring youth for any noticeable side effects.

B. Basic written information regarding side effects and tardive dyskinesia (TD) will be provided to facility/program staff and the treatment team. Documentation of the provision of this basic information shall be maintained at the facility.

C. Any severe or unexpected side effects that occur will be reported immediately to the Psychiatrist or Psychiatric ARNP. Such notification will be documented in the Individual Health Care Record, Mental Health section.

CLINICAL NOTE: Classifications of psychotropics which are known to have a high incidence of dyskinesias (involuntary movement disorders) warrant designation of the youth as a medical grade 5, as well as placing the youth on Medical Alert. Also, prescription of those psychotropic medications which are known to result in inhibition or induction on the chemical reactions in the body when combined with other medications or foods warrant placement of the youth on Medical Alert until his/her reaction to the medication is known. Examples of potential side effects include, but are not limited to, the following:

- Agranulocytosis or other dyscrasias;
- Toxicity;
- Postural hypotension, (low blood pressure with changes in position);
- Changes in the electrocardiogram (increase heart rate, slow heart rate);
- Insomnia;
- Urinary retention;
- Lowered seizure threshold;
Extra pyramidal symptoms;
- Acute diatonic reactions;
- Neuroleptic malignant syndrome;
- In addition, situations in which a youth is prescribed multiple psychotropic medications ("polypsychopharmacology"), using medications, which have a high potential for disruption in cytochrome activity, may warrant placing the youth on Medical Alert.

XI. RESTRICTIONS: PRO RE NATA ORDERS (PRN) OR EMERGENCY (INJECTABLE) PSYCHOTROPIC MEDICATIONS

There will be no Pro Re Nata (PRN) use of oral or injectable psychotropic medications. There will be no Emergency Treatment Orders for psychotropic medications.

XII. OFF-SITE SERVICES RELATED TO A YOUTH’S PSYCHOTROPIC MEDICATION

A. Each youth’s Individual Health Care Record (IHCR) and Medication Administration Record (MAR) will accompany the youth to provide the prescribing practitioner all necessary information.

1. If the youth is taken off-site for an appointment related to his/her psychotropic medication, the relevant sections of IHCR and the MAR will be taken to the appointment.

B. The process of the CPPN should be explained to the off-site prescribing practitioner ahead of time, and a blank CPPN form must be taken to the appointment. The CPPN form should be provided as template for the type of information requested by DJJ. Either the off-site practitioner should be asked to complete the CPPN, using the standardized form, or to provide documentation of health care in the format typically utilized by the practitioner. The completed CPPN or practitioner’s documentation of health care will be filed in the Individual Health Care Record, in accordance with this policy in the section of the IHCR reserved for physician orders, in reverse chronological order (most recent on top in that section). If the off-site provider requests to keep the original of the CPPN, that is permissible, and a copy of the entire document, or the third page (whichever is applicable) may be filed in the IHCR.

C. The youth’s parent/guardian will be encouraged to attend these appointments if at all possible and/or to have telephone communication with the prescribing practitioner regarding questions or concerns they may have about the medication treatment regimen.

D. The prescribing practitioner must receive consent from the parent/guardian prior to changing the psychotropic medications that a youth is receiving at the time of admission to a secure detention center or residential commitment program. This includes initiating,
discontinuing or, in some instances, changing the dosages of psychotropic medication(s).

E. The prescribing practitioner will attempt to contact the parent/guardian by telephone to discuss the youth’s psychotropic treatment plan. The prescribing practitioner will relate to the parent/guardian specific information regarding side effects, target symptoms, required laboratory testing, range of normal dosages (if the dosage prescribed is outside the normal range), the clinical rational for each medication’s use, and possible treatment alternatives.

F. A Clinical Psychotropic Progress Note (CPPN) Form must be made available to the prescribing practitioner for each psychotropic medication encounter. However, the practitioner may complete the CPPN Form or document health care in the form/format utilized by the practitioner. When the medication regimen is changed, the obtaining of verbal consent (by telephone or in person) by the parents must be attempted. If obtained, the verbal consent must be witnessed by a member of the facilities or off-site prescribing practitioner’s staff and documented on the CPPN or form/format utilized by the practitioner.

G. For new medications, a copy of the 3rd page of the completed CPPN or a copy of the documentation of health care provided by the prescribing practitioner will be sent to the parent/guardian certified mail return receipt requested, along with the cover letter (“Acknowledgment of Receipt of CPPN Form or Practitioner Form [AOR]”) requesting acknowledgement of receipt of the CPPN or documentation of health care provided by the prescribing practitioner, regardless of whether verbal consent was obtained. The mail receipts will be stapled to the copy of the CPPN or documentation provided by the prescribing practitioner, which is maintained in the Individual Health Care Record. The CPPN/AORs related to discontinuances and/or medication adjustments to which a parent has already been noticed may be sent by regular mail, at the discretion of the facility and in accordance with an established facility operating procedure.

H. Signature on the AOR verifies receipt of the CPPN or documentation of health care provided by the prescribing practitioner and parental consent to the medication treatment plan outlined on the CPPN or documentation provided by the prescribing practitioner.

I. When returned by the parent/guardian, the signed AOR should be stapled to the copy of the accompanying CPPN or documentation provided by the prescribing practitioner already on file in the Individual Health Care Record.

J. It is recommended that, to increase the likelihood that the AOR sent to the parent/guardian will be returned, a self-addressed, stamped envelope be included.

K. Upon receipt of witnessed verbal parental consent, psychotropic mediations may be initiated, changed, or discontinued. If the parent/guardian fails to return the AOR following the provision of witnessed verbal consent, the facility should contact the parent/guardian to reinforce the need to return the AOR. See Section XIV for the
process to follow in the event that the parent/guardian fails to return the AOR, even after having provided witnessed verbal consent.

L. If the parent/guardian has concerns about proposed medications changes, or fails to return the AOR, the prescribing practitioner will be notified to discuss any alternative treatment possibilities and risks of delaying or discontinuing treatments.

M. Any subsequent exchange of information between the parent and the prescribing practitioner will be documented in the Individual Health Care Record, Mental Health section (or in the active mental health file, as applicable), in the form of a narrative note.

N. In those situations requiring mailing a completed CPPN/AOR to the parent/guardian, if the parent/guardian fails to return the AOR, and the prescribing practitioner feels that the recommended treatment is essential, the Department's regional counsel shall be contacted by the facility Superintendent or Program Director (see Section XIV). If a medication has been initiated pursuant to the parent/guardian's witnessed verbal consent and the parent/guardian subsequently fails to return the AOR, the prescribing practitioner shall determine the schedule for discontinuance, for those medications which are likely to cause a withdrawal or rebound syndrome. Again, when necessary the regional counsel's office should be contacted.

XIII. YOUTH REFUSAL OF PSYCHOTROPIC MEDICATION

A. If a youth refuses a prescribed psychotropic medication, designated nursing staff or mental health clinical staff shall counsel him/her regarding the benefits of the medication, and shall review with him/her the reasons the medication was ordered. Additionally, staff shall inquire as to the reasons that the youth is refusing the medication.

B. The Psychiatrist or Psychiatric ARNP must be notified immediately upon three (3) consecutive missed or refused oral dosages of psychotropic medication.

C. The Psychiatrist or Psychiatric ARNP's instructions regarding any refusal will be documented in the Individual Health Care Record, Mental Health section (or in the active mental health file, as applicable).

D. A specific order to discontinue medication must be received if the decision is made by the Psychiatrist or Psychiatric ARNP to discontinue the medication. This must be documented in the Individual Health Care Record, in the section reserved for Practitioner's Orders, in reverse chronological order (most recent order/document on top in that section).

E. If (emergency) changes in behavior or symptoms are noted due to the refusal of psychotropic medication(s), the youth will be transported to a facility that provides emergency psychiatric interventions and the youth's parent/guardian will be immediately notified.
XIV. COURT ORDERED PSYCHOTROPIC MEDICATION

A. If a parent/guardian fails to provide consent, or objects, either verbally or in writing, to proposed changes to a youth’s psychotropic medication regimen as described in this policy, the Psychiatrist or Psychiatric ARNP shall contact the parent/guardian and discuss his/her concerns regarding the medication.

B. If the parent continues to object and the Psychiatrist or Psychiatric ARNP determines that there are no suitable alternatives and that the medication is essential to the youth’s health or well-being, the Department’s procedure for obtaining a court order shall be initiated by the facility Superintendent or Program Director.

C. Consent of the parent shall not be required if the physician determines there is an injury or illness requiring immediate treatment and the child consents to such treatment or an ex parte court order is obtained authorizing treatment as specified in Section 985.18.(7).

D. If obtained, the court order shall be filed in the youth’s Individual Health Care Record, directly behind the Authority for Evaluation and Treatment.

E. In the absence of a court order, no proposed changes to a psychotropic medication as described in this chapter to which a parent/guardian has objected may be implemented. If (emergency) changes in behavior or symptoms are noted, the youth will be transported to a facility that provides emergency psychiatric emergency interventions and the youth’s parent/guardian will be immediately notified.

F. Under no circumstances should a court order be interpreted as meaning that a youth would be forced to receive medications (oral or injectable) against his or her will.
I. INTRODUCTION

Exercise is a critical component to the general health of all youth. Every Department of Juvenile Justice facility and program must permit physically capable youth to engage in daily exercise as weather permits. For some facilities and programs, intensive physical training is part of the programmatic regimen while for others, exercise is utilized purely for recreation and basic conditioning.

All Superintendents and Program Directors must maintain an awareness of risks posed to an exercising adolescent. This chapter serves to provide precautionary guidelines on exercise, particularly for youth with chronic conditions, as well as guidelines on exercise in the setting of temperature extremes.

All facilities and programs must consider environmental and exercise stressors as they pertain to the health of youth in the custody of the Department. Facility operating procedures shall address:

- General Exercise Regimens;
- Inclement weather conditions;
- Heat index criteria;
- Environmental stressors.

As it pertains to any type of exercise, all youth shall be instructed to notify staff immediately if they experience chest pain, feel faint, have shortness of breath or otherwise feel unwell during any type of activity. Staff has the responsibility to instruct the youth to immediately stop the activity, then notify health care personnel or depending on the severity of the youth’s symptoms, call “911” and stabilize the youth until their arrival.

II. EXERCISE PRECAUTIONS

A. Some youth have conditions, the potential for conditions, or a family history of specific conditions that warrant exclusion from certain programs or physical activities. The Designated Health Authority or Physician designee, PA or ARNP shall be responsible for determining whether a youth with a chronic medical condition is appropriate for a detention center or residential commitment program’s full exercise regimen, or requires a modified regimen. Presence of any of the following factors does not result in an automatic exclusion, but the program must make necessary accommodations and the Designated Health Authority or designee must be immediately made aware of youth with these existing medical conditions at the facility.
These types of conditions include, but are not limited to:

- Asthma;
- Anorexia Nervosa;
- Cardiac (Heart) Conditions (Family History of Sudden Cardiac Death)
- Cystic Fibrosis
- Diabetes;
- Kidney Disease;
- Obesity, Overweight and/or a De-conditioned state;
- Orthopedic Pins/Rods/Other Appliances;
- Mobility or Sensory Impairment;
- Sickle Cell Disease (Anemia);
- Thyroid Disease

B. The Comprehensive Physical Assessment form permits the examining Physician, PA or ARNP to report any physical activity restrictions.

C. For those youth who do require specific individualized exercise regimens, one shall be designed to become a part of the youth’s medical treatment plan and shall be documented as such in the progress note of the youth’s Individual Health Care Record.

D. All physical activity restrictions or limitations shall be communicated in writing to the facility Superintendent or Program Director. They are then responsible for ensuring staff compliance with the youth’s activity restriction levels.

E. Any program or facility in which youth engage in physical activity (regardless of outdoor climate) must have procedures in place that permit periodic rest intervals and liberal access to water and/or electrolyte replacement fluid.

NOTE: Due to the varying ability of individual programs to accommodate youth with specific medical conditions, the determination of appropriateness of placement in an intensive physical training program should be made on a case-by-case basis by the residential commitment staff.

III. ENVIRONMENTAL PRECAUTIONS FOR HOT WEATHER

A. Exercising youth exposed to hot weather do not adapt as effectively as adults do. Physiologically, youth produce more metabolic heat than adults during physical activities and have a considerably lower capacity to sweat. Consequently, excessive exposure to heat stress during exercise affects their performance and general well-being, increasing their risk for heat-related illnesses. These illnesses, although potentially life-threatening are preventable. ALL staff members must be mindful of the potential hazards of high intensity exercise during hot and humid weather conditions, and take the necessary precautions required to prevent heat-related illnesses.

B. A youth’s risk for heat intolerance increases when the youth has a chronic medical condition associated with excessive fluid loss such as Diabetes, Thyroid Disease, Cystic
Fibrosis, congenital heart defects, anorexia nervosa and obesity. Developmentally delayed youth are at special risk for not recognizing the need to replace the fluid loss. Consequently, this can lead to severe dehydration.

C. Exercising youth are able to dissipate heat effectively in a neutral or a mildly warm climate. When air temperatures exceed 95 degrees, adolescents have a markedly lower exercise tolerance than adults. The hotter the temperature and higher the humidity, the more susceptible youth are to heat stress. High humidity can be a significant factor even without extremely high air temperatures. Consequently, 70% of heat stress is due to humidity, 20% to radiation from the sun and only 10% is due to air temperatures.

D. As it relates to these precautions, each DJJ facility must have an effective means of identifying youth at risk for heat-related illnesses, and developing and implementing individualized exercise treatment plans. The Designated Health Authority or Physician designee, PA or ARNP shall ensure that the Superintendent or Program Director is informed of those youth who are most at risk for adverse outcomes due to inclement weather conditions, environmental stressors or exercise regimens.

E. Assessment of Risk
Each DJJ detention center and residential commitment program must have detailed and written procedures to address the prevention of heat-related illnesses through adherence to accepted heat stress and exercise tolerance guidelines. These procedures shall include:

1. Assessment of a youth’s risk based on physical and medical condition(s) such as obesity, level of conditioning, medications which may affect heart rate response or the body’s heat regulatory mechanisms. This includes specified criteria for individualized exercise programs for de-conditioned youth, overweight youth, and youth who suffer from medical conditions that may make them more susceptible to heat injuries.

2. Environmental conditions contributing to heat stress risks (heat index, environmental temperature, humidity, time of day).

3. The level of intensity of the exercise program and the length of time spent exercising.


5. Recognition of signs and symptoms of heat-related illnesses:
   - Heat cramps;
   - Heat syncope (fainting or sudden loss of strength);
   - Heat exhaustion (heavy perspiration, weakness, cold, pale and clammy skin, normal body temperature, collapse);
Heat stroke (Often preceded by heat exhaustion, symptoms of hot, dry, red skin, accelerated heart rate, confusion, loss of consciousness, rapid rise in body temperature, risk of death).

F. Determination of Heat Index

The heat index (See Heat Index Chart that follows) is the temperature the body feels when heat and humidity are combined. Every facility Superintendent or Program Director or designee, must calculate and be aware of the heat index prior to engaging youth in any form of outdoor strenuous activity (running, contact sports, exercise drills, etc), these activities need to be adjusted according to the daily heat index. The Superintendent or Program Director must have all staff closely supervising youth who are exercising, while being versed in proper hydration and rest procedures.

The following chart shows the health risks as temperature and relative humidity rise.
The Heat Index

| Air Temp (°F) | Relative Humidity (percentage) | 0 | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 | 65 | 70 | 75 | 80 | 85 | 90 | 95 | 100 |
|--------------|--------------------------------|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 135°         |                                | 120 | 126 |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 130°         |                                | 117 | 122 | 131 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 125°         |                                | 111 | 116 | 123 | 131 | 141 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 120°         |                                | 107 | 111 | 116 | 123 | 130 | 139 | 148 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 115°         |                                | 105 | 107 | 111 | 115 | 120 | 127 | 136 | 143 | 151 |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 110°         |                                | 99  | 102 | 105 | 108 | 112 | 117 | 123 | 130 | 137 | 143 | 150 |    |    |    |    |    |    |    |    |    |    |
| 105°         |                                | 95  | 97  | 100 | 102 | 105 | 109 | 113 | 118 | 123 | 129 | 135 | 142 | 149 |    |    |    |    |    |    |    |
| 100°         |                                | 91  | 93  | 95  | 97  | 99  | 101 | 104 | 107 | 110 | 115 | 120 | 126 | 132 | 138 | 144 | 150 |    |    |    |    |
| 95°          |                                | 87  | 88  | 90  | 91  | 93  | 94  | 96  | 98  | 101 | 104 | 107 | 110 | 114 | 119 | 124 | 130 | 136 | 140 | 150 |    |
| 90°          |                                | 83  | 84  | 85  | 86  | 87  | 88  | 90  | 91  | 93  | 95  | 96  | 98  | 100 | 102 | 106 | 109 | 113 | 117 | 122 | 126 | 131 |
| 85°          |                                | 78  | 79  | 80  | 81  | 82  | 83  | 84  | 85  | 86  | 87  | 88  | 89  | 90  | 91  | 93  | 95  | 97  | 99  | 102 | 105 | 108 |
| 80°          |                                | 73  | 74  | 75  | 76  | 77  | 77  | 78  | 79  | 79  | 80  | 81  | 82  | 83  | 84  | 85  | 86  | 87  | 88  | 89  | 90  |
| 75°          |                                | 69  | 69  | 70  | 71  | 72  | 72  | 73  | 73  | 74  | 74  | 75  | 75  | 76  | 76  | 77  | 77  | 78  | 78  | 79  | 79  |
| 70°          |                                | 64  | 64  | 65  | 65  | 66  | 66  | 67  | 67  | 68  | 68  | 69  | 69  | 70  | 70  | 70  | 70  | 71  | 71  | 71  | 71  |

- **= Heatstroke risk extremely high**
- **= Heat exhaustion possible**
- **= Heat exhaustion likely, heatstroke possible**
- **= Fatigue possible**

The following guidelines are to assist staff in developing safe outdoor exercise regimens that account for temperature and humidity.

1. Follow the heat index particularly as temperatures rise between the peak times of 10 AM and 4 PM.
2. Utilize shaded areas as available.
3. If strenuous exercise is planned then there must be a gradual increase from light to heavier exercise to allow for adjustment from indoor to outdoor temperatures.
4. Frequent rest intervals scheduled for rest and re-hydration.
5. Liberal availability of water and electrolyte replacement fluid (e.g. Gatorade).
6. Provide light colored and light textured clothing and hats as necessary.
7. Close monitoring of youth by staff for signs of heat-related illness.
8. Prompt medical attention for those youth experiencing signs and symptoms of heat-related illnesses.
9. Using these guidelines, the decision to forgo outdoor activity for that day shall be left to the discretion of the Superintendent or Program Director under the guidance of the health care staff.
Note: Wilderness programs or those programs that spend a significant period of the day outdoors shall ensure that all youth are properly hydrated, monitored and allowed to rest as necessary.

G. Hydration and Rehydration
Youth frequently do not feel the need to drink enough to replenish fluid loss during prolonged exercise. A dehydrated youth is more prone to heat-related illness than the fully hydrated youth. Youth must always be well hydrated before, during and after physical activity and exercise.

1. Provide each youth with one to two cups (8-16 oz.) of fluid at least 15 minutes prior to exercise;

2. Provide regular rest breaks (in the shade as available) and fluid every 15-20 minutes with at least 16 oz. of water or electrolyte replacement fluid (preferred over water). Fluid should be available at all times.

H. Heat Stress/Exhaustion and Heat Stroke

1. It is important that the staff monitor and observe youth for common symptoms of heat-related illnesses such as heat stress or heat exhaustion that can rapidly advance to a heat stroke. Symptoms of heat stress/exhaustion are early warning signs of heat stroke. The symptoms vary and gradually worsen. These symptoms include, but are not limited to, one or more of the following:

- Tiredness
- Clumsiness
- Weakness
- Headache
- Excessive Dry Mouth
- Heavy thirst
- Flushed Skin
- Pale skin
- Heavy Sweating
- Cool/moist skin
- Abdominal Cramps
- Muscle cramps
- Nausea
- Vomiting
- Dizziness
- Fainting
- Fast/weak Pulse
- Fast/shallow breathing
- Semi-unconsciousness
- Unconsciousness (non-responsive)
2. Heat stroke is a much more acute and dangerous, life-threatening reaction to prolonged or excessive exposure to the heat. It is often preceded by heat exhaustion. The youth’s body temperature will rise to above 105 degrees; symptoms of hot, dry, red skin, accelerated heart rate, confusion, loss of consciousness, rapid rise in body temperature, risk of death.

3. When a youth experiences signs and symptoms of heat stress/exhaustion or heat stroke this is a life-threatening emergency and requires that the staff call 911 for immediate emergency medical intervention and treatment. While waiting for EMS, move the youth to a cool area, remove excess clothing, spray with cool water, and offer sips of water (if conscious and able to swallow) until emergency assistance arrives.

I. Emergency Response
Each facility and program shall have an emergency response plan for youth believed to be suffering from any degree of heat-related illness (any youth exhibiting signs of illness must be assessed by the on-site nurse immediately, and/or transported to the nearest hospital by EMS).

IV. ENVIRONMENTAL PRECAUTIONS FOR COLD WEATHER

A. For those areas of the state where winter temperatures drop below normal, exposure to the cold can pose health risks. In regions relatively unaccustomed to winter weather, near freezing temperatures are considered “extremely cold”.

B. Hypothermia occurs when the core body temperature drops to less than 95 degrees. This occurs when a youth is exposed to excessive cold and is unable to generate enough heat (e.g., through shivering) to maintain a normal core body temperature of 98.6 degrees and can result in the malfunction of the brain, heart and kidneys. Adolescent youth, especially those with pre-existing chronic medical conditions such as diabetes and asthma, are at increased risk for hypothermia due to a reduced ability to generate heat and less of a likelihood to recognize symptoms of hypothermia.

C. Body heat is lost in air temperatures lower than 68 degrees. The body loses this heat through the evaporation of water from the skin, respiration (breathing), and during intense exercise. Heat loss through evaporation and respiration increases in dry, windy weather conditions. Heat loss in cold, wet weather increases the risk of a youth experiencing hypothermia and cold injury. Hypothermia can occur quickly (within a few hours) or gradually depending on the youth’s age, overall health, and the environmental conditions.

D. Outdoor activities may require some additional precautions due to the air quality, cold temperatures, and sun exposure. Each DJJ detention center and residential commitment program must have detailed and written procedures to address the prevention of cold exposure injuries through adherence to accepted cold exposure guidelines. These procedures shall include:
1. Recognition of conditions influencing cold exposure risks (wind chill factor, environmental temperature, humidity, time of day). There must be absolute limits for outdoor exercise when the wind chill factor and environmental temperatures reach unsafe levels. Exposure to temperatures below 30 degrees, in combination with wind speeds greater than 40 mph, poses a very high risk for hypothermia.

2. The level of intensity for the outdoor exercise and the length of time allotted for the event.

3. Specific criteria for routine monitoring and assessment of youth for potential cold related injuries or illness.

4. Recognition of the signs and symptoms of hypothermia:
   - Sensation of cold, exhaustion, and numbness
   - Shivering
   - Pallor
   - Flushed skin
   - Decreased hand coordination
   - Confusion
   - Slurred speech
   - Undressing despite cold temperatures
   - Core body temperature below 95 degrees

5. An emergency response plan for youth believed to be suffering from any degree of hypothermia (any youth exhibiting signs of illness must be assessed by the on-site nurse immediately, and/or transported to the nearest hospital by EMS).

6. Daily determination of type and amount of outdoors activities based on outdoor temperatures and wind chill factors.

E. Prevention of Hypothermia
   The following guidelines are to aid in the prevention of hypothermia:

1. Dress the youth appropriately for the weather conditions. Provide layers of clothing, cover the youth’s head, neck and face as much as possible since the greatest heat loss occurs from these areas.

2. Avoid overexertion (being too active) as this can cause the youth to sweat and chill more quickly.

3. Keep the youth dry to reduce heat loss.

4. Adapt the pace of activity or exercise to the cold and permit frequent breaks.
Note: For guidance regarding a youth’s activity level, consult with the facility Designated Health Authority or Physician designee, PA or ARNP before allowing a youth with chronic condition(s) and/or on medications to exercise in extreme weather conditions.

V. INTENSIVE PHYSICAL TRAINING PROGRAMS / STAR PROGRAMS

A. For the purpose of this chapter, “Intensive Physical Training Programs” shall be defined as any specialty residential commitment program with requirements for regularly scheduled strenuous exercise as a part of the youth's treatment plan. This includes, but is not limited to all Sheriff's Training and Respect (STAR) programs.

B. The Department commitment manager, in coordination with the regional residential staff, the facility or program staff (as applicable) and the Office of Health Services, (as necessary) shall determine if a youth is medically appropriate for an Intensive Physical Training program. This shall be based on a review of the youth’s Comprehensive Evaluation, Health Related History, Comprehensive Physical Assessment, EKG and other available information.

C. Youth otherwise appropriate for a STAR Program shall have a Comprehensive Physical Assessment and resting electrocardiogram (EKG) completed within 60 days before commencement of the program. The resting EKG will screen for baseline arrhythmias and any youth with abnormalities shall be excluded from the program.

Note: A normal resting EKG does not exclude all cardiac disease or the potential for arrhythmias (abnormal rhythms) with exercise. Thus, any youth who complains of chest pain, palpitations (rapid or irregular heartbeats), shortness of breath, or who loses consciousness (faints) while exercising shall be evaluated by the licensed nurse and/or transported to the hospital by EMS.

D. The following mental health/substance abuse conditions will also be automatic exclusions from STAR programs:

- Use of psychotropic medications;
- Developmental disability (defined by an IQ less than 75 or classification as "Educible/Trainable Mentally Handicapped");
- Need for intensive mental health treatment;
- Suicidal risk histories;
- Serious self-injurious behavior;
- High-risk suicidal tendencies;
- History of self-injurious behaviors;
- Diagnoses of substance abuse, dependence or poly-substance dependence;

E. The Designated Health Authority or designee shall review the facility's intensive physical training component. Upon admission to the STAR program, the youth will undergo another physical assessment and urine substance abuse screening test.

F. Pursuant to Florida Statute 985.3091(8): Anytime the health care staff determines that the health or physical safety of a youth has been compromised or is potentially
compromised, they shall remove the youth from all physical activities without prior approval from program staff. Health care staff shall intervene anytime a youth indicates that he or she is in pain and unable to perform as instructed. If the health care staff cannot determine the cause of the pain or discomfort the youth shall be immediately transported to the hospital emergency room. Additionally, transport shall occur if the on-site health care staff is not trained to adequately treat the condition.

All STAR programs must have a Registered Nurse on-site from 7am-9pm daily to address the health care needs of youth at the program.
I. INTRODUCTION

Infectious and communicable diseases in correctional settings, such as detention centers and residential commitment programs, pose recognized risks for all youth and staff. The management of any communicable disease in the closed setting of a facility requires the diligent collaboration and communication between facility operations and administrative staff, the health care staff and often times the local County Health Department.

This Department requires that all detention centers and residential commitment programs develop procedures in accordance with Department policies, established Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control (CDC) Guidelines. These facility-operating procedures must outline the methods of surveillance, screening and management of specific illnesses or potential infectious conditions. These procedures shall include, but are not limited to, the prevention, containment, treatment and reporting requirements related to infectious diseases.

The types or categories of diseases that must be addressed include the following:

- Common, infectious diseases of childhood (e.g., example, measles, mumps, and chickenpox);
- Self-limiting, episodic contagious illnesses (e.g., the common cold);
- Viral or bacterial infectious diseases (e.g., viral or bacterial meningitis);
- Tuberculosis;
- Hepatitis A, B, and C and HIV infectious diseases caused by blood borne pathogens;
- Other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly;
- Outbreaks of pediculosis (lice) and/or scabies;
- Methicillin-Resistant Staphylococcus Aureus (MRSA) and other emerging antibiotic-resistant micro-organisms;
- Food-borne illnesses such as those cause by E. Coli;
- Bio-terrorist agents (e.g., Anthrax, Small Pox);
- Chemical exposures in the workplace.

II. OSHA BLOODBORNE PATHOGENS STANDARD (29 CFR 1910.1030)

Although this section deals with the OSHA Standard related to blood borne pathogens, the facility should respond to any additional health and safety issues, including infectious illnesses or controls in the workplace that are promulgated. For this reason, it is strongly recommended that issues related to the OSHA standard, and concerns related to airborne pathogens be
addressed as part of a facility’s overall plan for health and safety. Although medical personnel may be part of this plan, a designated individual who is responsible for facility and occupational safety generally best addresses these issues.

Each DJJ facility must ensure compliance with federal and state legislation concerning blood borne pathogens.

A comprehensive program of education and prevention must be administered at each facility. This program must include at a minimum the following:

☑ Exposure control plan, (updated annually);
☑ Universal precautions by all staff;
☑ Hepatitis B immunizations;
☑ Comprehensive post-exposure evaluation process;
☑ Training at hire and annually thereafter, on blood borne pathogens and their prevention in the workplace;
☑ Maintenance of records pertaining to staff training on blood-borne pathogens.

III. OCCUPATIONAL SAFETY AND HEALTH STANDARDS

A. EXPOSURE CONTROL PLAN

The Exposure Control Plan shall be written in accordance with OSHA standards (29 CFR 1910). This is a written plan, reviewed and signed annually by the administration of the facility and/or designees. The plan shall be kept on the premises of each facility and should be made accessible to all employees. Training related to each facility/program’s specific exposure control plan shall be conducted at the time of hiring (during orientation) and annually thereafter. The following elements are required in an Exposure Control Plan:

1. RISK ASSESSMENT

The exposure determination includes:

➢ Lists of all job classifications in which all employees have the potential for occupational exposure.

➢ A list of all job classifications in which some employees have the potential for occupational exposure.

➢ A list of tasks or procedures, which would cause the employees in the job classifications, listed above to have occupational exposure. (These classifications are often designated as Risk Classification “A,” “B,” and “C”).
2. METHODS OF COMPLIANCE

These fall into two major categories:

- Infection Control Practices, utilizing standard precautions
- Engineering and Work Practice Controls

Note: The Department endorses Standard (universal) Precaution for the prevention of infection with all human blood and body fluids. All blood and body fluids are treated as infectious for HIV, HBV, and other blood-borne pathogens. The practice of standard (universal) precautions by all employees is the primary method of prevention of transmission of blood borne pathogens in the workplace.

B. ENGINEERING AND WORK PRACTICE CONTROLS

These are procedures and techniques utilized by a facility to minimize or eliminate employee exposure to blood borne pathogens. The development and implementation of engineering and work practice controls requires input and monitoring from all areas of operation (administration, health services, housekeeping, etc.) Procedures shall include, but not be limited to the following Engineering and Work Practice Control requirements:

- Availability of hand washing facilities or, in the absence of adequate hand washing facilities, the provision of appropriate antiseptic hand cleansers, etc.;
- Procedures for proper disposal of needles and other sharps utilized in health care, including procedures with a bio-hazardous disposal company;
- Procedures for maintaining the work site in a clean and orderly manner, including a schedule of routine cleaning;
- Use of specified signs and labels to communicate hazards to employees;
- Procedures for handling of contaminated laundry;
- Availability of personal protective equipment, and procedures for use and cleaning;
- Procedures for post-exposure evaluation and follow-up;
- Procedures for the establishment of a system of confidential medical record keeping for employees with occupational exposure.

Each DJJ detention center and residential commitment program shall utilize Universal (standard) Precautions for the prevention of infection with all human blood and body fluids. Universal Precautions, as defined by CDC, are “a set of precautions designed to prevent the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other blood borne pathogens when providing first aid or health care.”
All blood and body fluids shall be treated as hazardous to humans. The practice of standard universal precautions by all employees shall be the primary method of prevention of transmission of blood-borne pathogens and infectious disease.

C. TRAINING REQUIREMENTS

All direct care staff and nursing staff shall receive training within 90 days of hiring or as directed by the Department and on an annual basis thereafter, on the prevention of transmission of blood-borne pathogens.

All youth shall receive training within seven days of admission into the Juvenile Detention system.

This training must be documented, and records retained in the youth Individual Health Care Record and employee training in the employee personnel file. These files are subject to review by compliance inspectors. In addition to the pre-service core curriculum, training facility specific training shall be completed.

Each youth and employee shall receive infection control training that includes, but is not limited to:

- Hand washing techniques: Universal precautions;
- Prevention and transmission of communicable diseases: (e.g., MRSA, TB, Chickenpox);
- Vaccinations: (e.g. Hepatitis B);
- CDC Guidelines for infection control in the workplace.

IV. NEEDLE STICK INJURIES

The detention centers and residential commitment programs shall establish protocols for needle stick post-exposure intervention and treatment.

Each youth and employee shall receive training on the procedure for immediate reporting of exposure. If it is determined that the type of exposure meets criteria for post-exposure treatment, the post-exposure chemoprophylaxis (PEP) must be offered then initiated immediately after the exposure in accordance with CDC established regulations.

A. POST-EXPOSURE EVALUATION/FOLLOW-UP

In the event that a youth or employee is exposed to bodily fluids (blood) through a needle stick injury or other significant exposure to another person’s blood, the Superintendent or Program Director shall arrange for a confidential medical evaluation and a follow-up post-exposure analysis in accordance with OSHA federal requirements. This may require transport to an emergency room/urgent care center.
Information shall be provided to the exposed youth and/or employee. In the case of an exposed employee, the health care professional that evaluates the employee must provide the following information:

- A copy of the OSHA standard;
- A description of the exposed employee’s duties as they relate to the exposure incident;
- Documentation of the route of exposure and the circumstances under which they occurred;
- Results of the source individual’s blood testing, if applicable;
- All medical records relevant to the appropriate treatment of the employee.

Youth and employees must know to whom to report exposures as well as the evaluation and follow-up process.

B. RECORD KEEPING REQUIREMENTS

Pursuant to OSHA federal regulations, the Superintendent or Program Director shall establish a separate file containing all documents for youth and employees that have experienced a facility/occupational exposure. All records shall be maintained confidentially for a ten-year period. The employer shall provide the employee experiencing the facility/occupational exposure with a copy of all documents relating to the exposure event.

V. HIV COUNSELING AND TESTING

A. Pursuant to CDC regulation, each DJJ detention center and residential commitment program shall routinely offer a youth at risk for HIV infection, counseling, testing, and referral for medical treatment as indicated.

Youth considered to be at risk are those who report:

- Multiple sexual partners;
- IV drug use;
- Tattoos and body piercing;
- Pregnancy;
- Sexually transmitted diseases;
- Hemophilia;
- Active Tuberculosis.

B. The facility shall collaborate with the local County Health Department or other community providers to provide the following services:

1. Counseling and Testing

   a. All DJJ detention centers and residential commitment programs will offer each youth HIV counseling and subsequent testing when indicated or requested by youth. A certified HIV counselor must conduct HIV counseling.
b. Pursuant to Chapter 381.004(3)F.S., any test for the detection of HIV cannot be ordered without an informed consent from the individual being tested. Consent may be obtained from the individual’s legal guardian or other person authorized by law if the individual is not competent, incapacitated and unable to make informed judgment, or is a minor (unless being examined or treated for sexually transmissible diseases as provided in section 384.30).

c. The process of obtaining consent includes an explanation of the individual’s right to confidentiality of test results to the extent provided by law, informing the individual that a positive test result will be reported to the county health department and other specified individuals (See Section C), and informing the individual on the availability of anonymous testing.

d. The mechanism established for HIV testing must ensure appropriate counseling, confirmation of positive test results when indicated, and medical follow-up. The youth should be informed as part of the counseling that their test results, if positive, are reportable to specified individuals (although results will still be confidential).

e. Parental notification of a youth’s HIV testing without the youth’s permission is prohibited by statute.

f. Laboratory results should be sealed in an envelope marked “confidential” and filed in the Individual Health Care Record. If HIV testing is performed off-site, the procedures related to consent should be ensured by that provider. This person may choose to retain the original consent form in which case a copy of the consent should be provided to the facility for the IHCR. When HIV testing is performed on-site, a signed consent form specific to HIV testing must be obtained.

g. In the case of a youth in a detention center, who requests an HIV test, but may not remain in detention long enough for the test results to become available, the certified HIV counselor who conducted the pre-testing should inform the youth as to how his/her results can be obtained.

h. Factors to consider when arranging for HIV testing for youth in DJJ facilities include the following:

- The presence or availability in the community of qualified HIV counselors;
- The likelihood that the youth will remain in the facility long enough to obtain the test results and receive appropriate counseling and follow-up;
- The availability of anonymous testing sites for youth;

i. HIV testing shall be a routine part of pre-natal care. All Pregnant youth shall have an HIV test unless, after counseling by the Physician, PA or ARNP as to
the risks of transmission of HIV to the fetus, she refuses testing. When this occurs, she must sign a waiver (refusal) to decline the test. This shall be filed in the IHCR.

C. REPORTING AND DISCLOSURE REQUIREMENTS

Pursuant to Chapter 381, F.S., HIV test results can be disclosed only to the youth and the following entities:

- The youth’s legally authorized representative;
- Health care providers during the course of consultation, diagnosis or treatment of the individual;
- The Department of Health for purposes of reporting and control of spread of disease;
- Health facility staff committees that conduct program monitoring, evaluation, and service review;
- Medical personnel who have been subject to a significant exposure;
- Health care facility personnel or agents for the health care provider who have a need to know in the course of patient care activities or administrative operations.

D. MANAGEMENT OF YOUTH WITH HIV INFECTION

1. All youth who are admitted or transferred to a DJJ facility known to be HIV positive, or to have AIDS or is identified after admission to be HIV positive, will require a comprehensive medical plan of care. In particular, timely initiation of recommended medication regimens is required. Although a thorough discussion of the guidelines to be used are beyond the scope of this manual, these youth will require an initial evaluation by a physician (if not previously obtained) who specializes in the management of infectious diseases in adolescents and children.

2. The decision as to when to initiate treatment and when to change medication due to increasing viral load results should be done in consultation with or under the direction of an HIV Specialist. Recommendations for offering antiretroviral therapy in asymptomatic patients require analysis of many real and potential risks and benefits. The strength of the recommendation to treat asymptomatic youth should be based on the willingness and readiness of the youth to begin therapy; the degree of existing immunodeficiency as determined by the CDC T-cell count; the risk of disease progression as determined by the CDC T cell count and level of plasma HIV RNA; the potential benefits and risks of initiating therapy in asymptomatic individuals; and the likelihood, after counseling and education, of adherence to the prescribed treatment regimen.

3. The Florida Department of Health and Children’s Medical Services have developed statewide networks of pediatric HIV referral centers. It is recommended that these referral centers be used to obtain the initial medical evaluations in order that an appropriate medical treatment plan can be developed. It should be noted that access
to these referral centers does not mean that the youth’s medications are obtained or paid for through or by the referral center.

VI. TUBERCULOSIS

For the tuberculosis screening, treatment and infection control processes, please refer to Chapter 3: The Admission Process.

VII. LICE (PEDICULOSIS) AND SCABIES

A. The facility superintendent or program director shall establish procedures for the evaluation, identification, treatment, and containment of pediculosis (lice) or mites (scabies). These procedures shall include, but not be limited to:

- Assessment and evaluation of youth entering facility
- Handling and washing of clothing and linen
- Treatment plan/protocol developed by DHA
- Exposure control for containment for prevention of outbreak

B. Each facility shall have in place product-specific procedures for the effective and safe identification, treatment and containment of pediculosis and scabies. These procedures shall include environmental control practices (for example, handling and washing procedures for clothing and bedding).

C. Treatment protocols shall be developed and approved by the Designated Health Authority. An order and/or prescription to treat an individual youth for these conditions may serve as a substitute for designated health authority-approved facility procedures. Similarly, in the event of an outbreak or in attempts to reduce the possibility of an outbreak, orders and/or plans of care for multiple youth made by a County Health Department may substitute for Designated Health Authority-approved facility procedures.

D. Routine administration (e.g., on admission) of a prescription medicated product, cream or lotion used to treat pediculosis (“lice”) and/or “scabies” is permitted only if the following criteria are met:

- A presumptive diagnosis or a definitive diagnosis is made

  And

- There are no contraindications to use of the product for the youth

  And

- Staff is trained in the use of the product, including location of the body on which it is to be applied, length of time it is to remain on the youth, whether or not repeat application is required and/or permitted, and contraindications to the use of the product.
E. Due to the potential toxicity of agents used to treat these conditions, administration of a medicated product is definitely contraindicated and shall not be administered in the following situations (this list is not all-inclusive):

- Open sores, abrasions, cuts or dermatitis;
- Pregnancy (or pregnancy status is unknown);
- Lactating female (secreting milk);
- Any youth six years of age or younger;
- A contraindicated medical condition: Youth is prescribed medications for which administration of these products is contraindicated;
- Youth reports an allergy or sensitivity to the product.

VIII. METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

A. Methicillin Resistant Staphylococcal Aureus (MRSA) is a bacterial microorganism that causes infection. MRSA is transmitted primarily by contact with a person who either has a purulent site of infection, a clinical infection of the respiratory tract or urinary tract, or is colonized with the organism (not actively ill, but carries the organism). Hands of youth and staff are the most likely mode of transmission from one person to another.

B. This bacteria is resistant to most antibiotics that would be expected to treat it. Thus, a MRSA infection can result in an increased risk for serious illness or death.

C. Each detention center and residential commitment program’s DHA or designee shall be responsible for the establishment of infection control procedures in accordance with CDC guidelines for the identification, evaluation, treatment and containment of MRSA. The superintendent or program director shall be involved to ensure full staff compliance and awareness.

D. Youth shall be carefully evaluated for skin infections during the intake screening process at admission to a DJJ facility. Youth with open skin infections shall be referred to the DHA, or designee, PA or ARNP for a medical evaluation.

E. A MRSA infection shall be considered in the differential diagnosis of all youth presenting with skin and soft tissue infections or other clinical presentations consistent with a staphylococcal infection. An empiric diagnosis of MRSA infection will be considered in youth with clinical evidence of staphylococcal infection, and documented associated risk factors.

F. Any youth complaining of “spider bites” and/or sores shall be assessed and cultured for MRSA infection. Prior to initiating antibiotics, bacterial cultures shall be obtained from draining wounds, aspirated pus from soft tissue infections, or aspirated fluid from potentially infected fluid collections. Blood cultures shall be obtained in febrile youth with suspected MRSA infections.
G. Skin and soft tissue infections suggestive of staphylococcal infections that cannot be cultured nor have non-diagnostic culture results shall be evaluated and treated on a case-by-case basis. When an abscess is present, at the initial assessment, the DHA or designee or PA or ARNP shall determine the necessity for wound incision and drainage, use of warm compresses, and the need for antibiotic therapy.

H. Draining wounds shall be cleansed with an antimicrobial skin cleanser, covered with a clean dressing, and changed daily or more frequently when they become soiled. Nursing personnel shall change all wound dressings.

I. Youth with excessive wound drainage shall be excluded from activities where close contact with other individuals occurs, such as athletic activities, until such time that wound drainage is minimized and contained within a dry dressing.

J. Any youth with a diagnosed positive MRSA infection shall receive antibiotic therapy targeted according to the identified drug sensitivities.

K. At a minimum, The DHA shall re-evaluate a youth one week after completion of antibiotic therapy for recurrent skin lesions and/or wound assessment to determine the need for further re-culture and treatment.

L. Effective hand washing shall be utilized in the prevention and cross-contamination of the infectious process. Hands shall be routinely washed with soap and running water rigorously for at least 15 seconds BEFORE and AFTER every contact with an infected youth, even if gloves are worn. The infected youth shall also be instructed on utilization of proper hand-washing procedures before and after meals, using restroom, and touching the wound or bandages.

M. Sheets shall be cleansed and disinfected in hot water.

N. Precautions:

Standard Precautions or Contact Precautions shall be used for all care for the prevention of cross-contamination of infectious processes. The implementation of Contact Precautions in addition to Standard Precautions shall be based on the site and severity of infection. Standard Precautions shall be utilized unless a youth has wound(s) with drainage that cannot be contained within a dressing resulting in frequent dressing changes and/or the wound culture is heavily colonized or infected with MRSA.

Standard and Contact Precautions includes all of the following components:

- Hand Washing:

Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between youth contacts, and between tasks and procedures on
the youth with infectious process to prevent cross-contamination of different body sites.

- **Gloving:**

  Wear gloves (clean, non-sterile) when touching blood, body fluids, secretions, excretions, and contaminated items; put on clean gloves just before touching mucus membranes and non-intact skin. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before touching another person. Wash hands immediately to avoid transfer of microorganisms to other people or environments.

- **Gowning:**

  It is not necessary to wear a gown unless youth care activities are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions or cause soiling of clothes.

- **Handling Laundry:**

  Handle, transport, and process used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucus membrane exposures, contamination of clothing, and transfer of microorganisms to other youth, staff, and environment. Linens shall be changed every other day (more often if visibly soiled). Towels and washcloths shall be changed daily. Linens shall be machine washed at least 25 minutes on HOT water cycle and then thoroughly dried in hot dryer. Air-drying of laundry is prohibited.

O. **Contact Precautions** consist of placing a youth with MRSA in private room or when a private room is not available, the youth may be placed in a room with another youth who has an active infection with MRSA. When these options are not feasible then the youth may be placed in a room with another youth that has no open skin cuts or lesions and has no evidence of a compromised immuno-suppressed medical condition. Room placement shall ultimately be left to the discretion of the Designated Health Authority or designee, the Superintendent and the Program Director. Gloves must be worn when entering the room. During the course of providing care for the youth, gloves must be changed after having contact with infective material. Remove gloves before leaving the room and hands must be washed immediately.

Contact Precautions shall be maintained until wound drainage has ceased for twenty-four hours, or until two consecutive negative wound cultures, at least seventy-two hours apart, are obtained.

The youth’s movement and transport from place to place shall be limited to essential purposes only.
Each facility shall follow established procedures for Bio-Hazard Waste and Blood Borne Pathogens in the handling and disposal of soiled linen and dressings.

P. Each facility shall establish a procedure for environmental sanitation measures for maintaining infection control and preventing the spread of MRSA infection to others. These measures shall include but not be limited to:

- Thorough cleaning of any shower utilized by an infected youth;
- An acceptable cleaning solution (diluted chlorine bleach or tuberculocidal disinfectant) must be utilized for routine cleaning of body fluid;
- Special cleaning that includes walls, floors, and furniture shall be done when the number of MRSA infections increase above endemic levels;
- Exam room surfaces, recreational equipment, and other community based equipment, used by youth with MRSA, shall be routinely wiped clean immediately after contact;
- Youth shall use barriers to bare skin, such as a towel or clean shirt, while using equipment.

Q. Any youth with a skin infection shall receive specific infection control education that includes measures in the prevention and cross-contamination of infectious processes.

R. An investigation of any outbreak shall be conducted and reported to the local County Health Department in accordance with CDC reporting requirements. The index case (youth) shall be interviewed as a part of the investigation. This interview content shall include, but not be limited to a review of the following:

- Potential sources of infection and personal contacts;
- Recent hospitalizations;
- Housing and work assignments;
- Sharing of personal hygiene items with other youth;
- Recent injection drug use;
- Tattooing;
- Sexual contact with other youth;
- Participation of close-contact sports;
- Exposure to other youth with draining wounds or infections.

S. All “spider bites” are to be considered MRSA until proven otherwise.

IX. COMMUNICATION WITH STAFF ON INFECTIOUS DISEASES

The Designated Health Authority or Designee, PA or ARNP shall ensure that information about communicable diseases (the presence of, the prevention of, and the symptoms of) is communicated to the Superintendent or Program Director in order to keep direct care staff adequately informed for their own health and safety.
X. HEALTH DEPARTMENT REPORTING

Any DJJ facility that has three or more cases of any reportable infectious disease shall give an account of these cases to the local County Health Department and/or Centers for Disease Control (as applicable). Specified infectious Diseases should be reported by the Department should be reported within the required timeframe in accordance with the Department of Health requirements. For more information and the Disease Report Form, go to the Epidemiology section at www.doh.state.fl.us.

Infectious Disease reporting shall be reported to the Department of Health on the mandated DOH Disease Report form.
I. INTRODUCTION

The Individual Health Care Record is the youth-specific unified, organized collection of health records (i.e. histories, assessments, treatments, diagnostic tests, reports of consultations, etc.), which relate to a youth’s medical, mental/behavioral, and dental health. This collective information is contained within a folder or chart jacket that is physically separate and distinct from the individual management record that contains the youth’s non-health-related commitment records and notes. The primary purpose of the Individual Health Care Record is to document the care provided to a specific individual youth and to facilitate effective communication among the various providers who treat that youth.

Maintenance of the standardized Individual Health Care Record is particularly important in large organizations, such as the Department, in which health care is delivered through a variety of providers and networks. Although detention centers and residential commitment programs are not primarily health care facilities, health care is provided at/or through these facilities. It is essential that a comprehensive, organized and accurate Individual Health Care Record is developed and maintained for each youth and that these records are stored and secured appropriately.

All Individual Health Care Records shall remain confidential in accordance with state and federal regulations.

II. RECORD DOCUMENTATION

A. PURPOSE AND IMPORTANCE

1. Youth in the custody of a DJJ facility shall have their respective health care files documented in a manner that ensures the following:

- Facilitation of the provision and continuity of care;
- Communication among interdisciplinary health care providers;
- Reduction in duplication or repetition of procedures, tests or treatments;
- Provision of necessary information for facility health care planning and evaluation (which includes utilization review, risk management and internal/external quality assurance);
- Facilitation of record retention that complies with all applicable law and rule;
- Provision of necessary information in an organized record in the event of litigation.
2. Professional, thorough, and consistent documentation is mandatory for all applicable facilities in the DJJ continuum in order to provide care that is consistent with state and federal regulations. All health care providers shall provide documentation in accordance with acceptable standards of documentation practices. Health care records along with the management file shall be kept and maintained in accordance with state and federal regulations. Collectively, these constitute the official case file.

B. KEY ELEMENTS

1. This chapter outlines four required record elements pertinent to documentation entry, collection, and maintenance of the Individual Health Care Record. Some of these elements are individual accumulations for each youth, and some are aggregate (that is, they accumulate data about a number of youth). Additionally, this chapter describes the manner in which the Department requires documentation of health care information.

2. The Individual Health Care Record (IHCR) often known as the “medical record” is youth-specific and moves with the youth as he/she moves through the DJJ continuum.

   The following documents are aggregate and remain at the DJJ facility:

   ✓ Sick Call/Referral Log;
   ✓ Tuberculosis Testing Log;
   ✓ Episodic (First Aid/Emergency) Care Log;
   ✓ Chronic Physical Health Conditions Roster.

3. It should be understood that the Individual Health Care Record would not contain all records and notes of health care provided to that youth. This is because, in many instances, the health care is provided off-site. In those instances, a Summary of Off-Site Care form, completed by the off-site provider, is provided to the facility for inclusion in the Individual Health Care Record (IHCR). Similarly, detailed notes of encounters between a youth and a mental health professional may not be contained in the record. (For more information related to mental health services and documentation, please see the Department's, Mental Health and Substance Abuse Services Manual. (Revised 2006.)

4. Any handwritten documentation in any section of the Individual Health Care Record will be recorded legibly in blue or black ink. No correction fluid or erasure will be used in the IHCR. If it is necessary to correct or delete any entry, the incorrect word(s) will be crossed through with a single line and the deleted section initialed.

5. The health record shall include, but not be limited to, all of the following components:

   ✓ Identifying information (youth’s name, DJJID number, date of birth, gender);
A problem list containing medical and mental health diagnoses as well as allergies;
- Receiving screening and health assessment forms;
- Progress notes of all significant findings, diagnoses, treatments, and dispositions;
- Provider orders for prescribed medication and medication administration records;
- Reports of laboratory, x-ray, and diagnostic studies;
- Flow sheets;
- Consent, refusal and notification forms;
- Results of specialty consultations and off-site referrals;
- Discharge summaries of hospitalizations and other inpatient stays;
- Special needs treatment plan, if applicable;
- Immunization records;
- Place, date, and time of each clinical encounter;
- Signature and title of each encounter.

Health care documents shall be filed in a chronological organized manner to facilitate effective interdisciplinary communication of a youths’ health care.

III. RECORD DEVELOPMENT AND MAINTENANCE

A. RECORD DEVELOPMENT

1. The Individual Health Care Record shall be developed then maintained in an organized manner that divides the record into two broad categories. These categories are Section 1: Core Health Profile and Section 2: Interdisciplinary Health Record. Each category consists of several sub-sections that make up clinical components of the interdisciplinary documentation process for the Individual Health Care Record.

2. Each DJJ detention center shall be responsible for the initial development of a youth’s Individual Health Care Record when a youth is admitted to a facility, unless the youth meets all the following criteria. The youth:

- Has no known health problems, is receiving no prescribed medications and denies health problems during the Facility Entry Physical Health Screening;
  AND
- Experiences no health care problems or concerns during the detention stay and receives no health-related screenings or evaluations other than the initial Facility Entry Physical Health Screening;
  AND
- Is released from detention with no charges pending and/or is released on community control or other form of non-residential departmental supervision;

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AND

☑ Has been in the custody of the detention center no longer than 3 days; and is not committed to the Department for residential placement.

3. When a youth is transferred to or arrives at a residential commitment program and has not had an Individual Health Care Record initiated (e.g. a youth who is placed in a residential commitment program after being under community control), the receiving residential commitment program shall be responsible for obtaining the Health-Related History (HRH) and Comprehensive Physical Assessment (CPA) from the Juvenile Probation Officer. Under most circumstances, if the youth has been on community control while awaiting placement, that youth’s JPO is responsible for ensuring that the youth receives his/her HRH and CPA prior to placement.

4. All initial and cumulative documents contained in the Individual Health Care Record shall become a permanent part of the youth’s record.

B. RECORD MAINTENANCE

1. Each Department of Juvenile Justice detention center and residential commitment program shall maintain an Individual Health Care Record for each youth identified as meeting the criteria for the establishment of an Individual Health Care Record. The Designated Health Authority or Physician Designee shall approve the method of recording entries in the health record and the format of the health record.

2. The IHCR should be maintained INTACT with the original documentation except under certain circumstances:
   
a. When off site (medical or mental health) providers retain the original notes in their files (copies of reports should be sent back with youth);
   b. When Medicaid is billed for services and thus requires the original records to be maintained with the billing party (the residential commitment program);
   c. When the original form has otherwise been lost.

3. In these situations, original, clean, legible copies are acceptable and should be retained in the record as if they were the originals. “COPY” should be written or stamped on the document in an area that does not obscure any necessary information.

4. It is each facility’s responsibility to insure that a complete, intact, cumulative, permanent IHCR is maintained and transported with the youth between DJJ facilities, and that the Individual Health Care Record contains either the original documentation of instances of care or copies of any original documentation of ALL instances of care that are delivered by the facility and outside practitioners. If, for specified reasons the facility chooses to retain records for documentation purposes, then copies are retained at the facility NOT originals. The IHCR must remain intact and unfragmented.
5. Exception shall be made for facilities that must retain an original record of the services delivered for Medicaid auditing purposes. In this case, a clear and legible copy shall be placed in the IHCR.

IV. IHCR SECTION 1: CORE HEALTH PROFILE

The Core Health Profile (CHP) is a collection of Departmentally-standardized forms that are filed in designated sub-sections of the Individual Health Care Record (IHCR). The order listed below is the descending order (top down) in which they should be filed in the Core Health Profile.

The Core Health Profile shall consist of sub-sections identified in this part and shall be utilized in accordance with established procedures.

A. PERSONAL AND HEALTH RELATED INFORMATION

Information about the youth’s usual or prior health care providers, as well as third-party payment information is recorded on the Personal and Health Related Information form at the time of admission by Detention health care or facility staff. Information may be generated from the DJJ computerized system or by contacting the youth’s parent or legal guardian. Residential commitment programs shall obtain any information required that was not obtained while a youth resided in a detention center.

The information on this form should be updated periodically to reflect accurate contact information. All new information shall be added to the current information.

1. Youth Photograph

- Current photograph of a youth shall be taken and placed in front of youth’s identifying demographic information. The photograph shall have the date that the photograph was taken.

- When a youth requires the initiation of a Medication Administration Record (MAR), another photograph shall be taken and attached to the MAR for youth identification when medications are administered. Both the MAR and the youth’s record need a photograph.

B. PROBLEM LIST

1. The problem list shall provide a current list of the youth’s major or chronic physical, dental, or mental health problems to facilitate the identification of information known about a youth’s chronic conditions, as well as information or diagnoses resulting from the Health-Related History or the Comprehensive Physical Assessment (CPA).

2. A major or chronic problem is one that significantly affects the youth’s health, or lasts longer than 3 months. These conditions include, but are not limited to the following:

- Diagnosed chronic (or potentially chronic) illnesses such as diabetes, asthma, or depression;
Recurring symptoms or physical findings, such as “back pain” or “poor exercise tolerance”;

- Injuries which are not expected to heal within a few days (e.g., a broken leg for the duration of the healing process);

- Permanent disabilities, such as paraplegia, visual or hearing impairment;

- Developmental delay;

- Pregnancy (for the duration of the pregnancy);

- Any acute condition, infection (e.g., MRSA), or prescription which warrants inclusion due to its severity or potential for side effects (e.g., Lithium—“monitor for toxicity”, or “On INH therapy”)

3. When problems are further diagnosed or resolved, the Problem List shall be amended and the date of resolution shall be written in the appropriate column.

4. It is not expected that, if major problems are identified and treated off-site, every problem will be entered on the Problem List. This is because off-site providers may not be familiar with the Individual Health Care Record requirements.

5. All health care providers practitioners on-site health care should periodically review the Problem List to ensure that all major problems are listed accurately.

C. AUTHORITY FOR EVALUATION AND TREATMENT (AET) (SEE CHAPTER 4: CONSENT AND NOTIFICATION REQUIREMENTS)

The Authority for Evaluation and Treatment record is the Department’s general consent for medical and mental health evaluation and treatment. When signed by a parent or guardian, it shall give the Department the authority to provide medical, mental and physical health care to youth within the Department’s custody. The original AET should be filed in the Individual Health Care Record. However, if the original is not available, a copy of the original should be filed in the record. When the record does not contain an AET, the parent or guardian and JPO shall be contacted, and a request made to execute/sign the AET.

D. PARENTAL NOTIFICATION OF HEALTH-RELATED CARE (SEE CHAPTER 4 CONSENT AND NOTIFICATION REQUIREMENTS)

1. In general, written Parental Notification of Health Related Care: General shall be required for any youth experiencing a significant change in his or her medical, physical, emotional, and/or mental status.

2. Detention center and residential commitment program health care and facility staff shall assure Parental Notification for any youth requiring medication management after admission into the facility. Initial verbal Parental Notification shall be obtained and documented in the chronological progress note of the Individual Health Care Record.
3. All Parental Notifications are filled in chronological order behind the Authority for Evaluation and Treatment forms. A copy of the original Parental Notification mailed should be stamped as COPY and filed in the same location. At the time the original signed notification has been returned, the two should be merged and filed accordingly.

4. The specific Parental Notification of Health-Related Care: Vaccinations/Immunizations shall be completed, including the publication date of the Vaccine Information Statement VIS, and mailed for parental/guardian signature and returned prior to the youth receiving necessary vaccinations/immunizations. A copy of the notification, VIS form, and proof of certified mail certificate sent should be maintained in the records.

5. Parental Notification of Health Related Care: Medication Management is to alert parents of new non-psychotropic medication changes.

E. **SICK CALL INDEX**

This form chronologically records the occurrence of a youth’s Sick Call complaints. It is to be filled out along with the Sick Call encounter on the standardized form. It is filed in reverse chronological order, in the progress notes. It allows health care staff to clearly recognize when a youth is presenting multiple times over a short period for the same complaints, thus warranting a referral from the nurse to the physician, PA or ARNP.

F. **IMMUNIZATION RECORDS**

The purpose of the Immunization record is to provide a concise listing of a youth’s immunization history. All immunizations that are administered, on-site to a youth while in the custody of the Department, shall be documented appropriately on the DJJ Immunization record and the Medication Administration Record (MAR). The health care provider shall provide a copy of the immunization record to the school district in order that the school immunization record (680) can be updated. A youth’s Immunization record can be accessed from the Department of Health/Department of Education website and attached on top of the Departmental Immunization Record.

G. **FACILITY ENTRY PHYSICAL HEALTH SCREENING (SEE CHAPTER 3: THE ADMISSION PROCESS FOR DETAILS)**

The DJJ facilities shall perform the Facility Entry Physical Health Screening form for each youth admitted or re-admitted to a facility. A new Facility Entry Physical Health Screening should be completed after any interruption in physical custody for a period of greater than 24 hours or when physical custody changes (e.g., detention center to residential commitment program.) For Detention facilities on the DFMS system, the screening shall be performed using the Medical and Mental Health Admission Screening form.

A licensed health care professional shall review the Facility Entry Screening form of each youth within 24 hours of admission to determine the presence of conditions warranting further evaluation.
All prior Facility Entry Physical Health Screenings shall be filed in Section 2 of the Individual Health Care Record.

H. HEALTH-RELATED HISTORY

1. The purpose of the Health-Related History (HRH) form is to provide a medical and Health-Related History to be used in conjunction with the Comprehensive Physical Assessment (CPA).

2. A youth’s health history shall be completed through an interview process with the youth (and parent, if available) by a licensed health care professional.

3. Typically, this form would be completed in conjunction with the first Comprehensive Physical Assessment, or it may be filled out prior to the assessment (for example, through an interview with a nurse at a detention center).

4. Once completed, this form is filed in the Individual Health Care Record, reviewed, and updated as needed during future assessments. Individuals updating the HRH must sign and date the form in the appropriate space. It must be emphasized that, as with the other standardized forms in the Core Health Profile, a new Health-Related History is not filled out with each subsequent assessment, even if it takes place during a later admission or commitment. Rather, the prior Health-Related History is reviewed and updated or corrected if necessary. Review shall occur with every admission/re-admission. However, if a nurse, ARNP, PA or Physician determines that the quality of the HRH is insufficient; a new HRH may be completed with the youth.

Medicaid Note: If the DJJ provider performs/conducts the Health-Related History in conjunction with the Comprehensive Physical Assessment and the performance of that service is Medicaid-reimbursable to the medical provider, the facility may choose to separately retain (for Medicaid audit purposes) the original Health-Related History. In this case, a copy (as opposed to the original) of the completed Health-Related History shall be placed in the Individual Health Care Record, as part of the Core Health Profile. This copy shall be used by all subsequent facilities as if it were the original (that is, a new Health-Related History does not need to be filled out at each subsequent facility). The copy that is filed should be stamped or otherwise noted as a COPY and signed by the record custodian at the facility. The original must be confidentially and securely stored by the program/medical provider and in accordance with all federal and state laws and regulations.

I. COMPREHENSIVE PHYSICAL ASSESSMENT (CPA)

1. The Comprehensive Physical Assessment performed by a Physician, PA or ARNP shall be documented on the Comprehensive Physical Assessment form. The licensed clinician performing the assessment shall assure the utilization of the most current approved form.
2. The purpose of this assessment is to facilitate the establishment of an individual database on each youth that provides for the:

- Identification and treatment of acute, chronic and functional medical and dental problems;
- Promotion of growth and development;
- Prevention of communicable diseases;
- Provision of health education;
- Provision of mental, medical, and dental health care services.

3. The Comprehensive Physical Assessment shall be conducted within specified timeframes in accordance with established Departmental standards. (See Chapter 5, Health-Related History and Comprehensive Physical Assessment).

4. The health care provider shall review and sign off as having reviewed the Health-Related History prior to performing the CPA.

5. When a youth receives a subsequent Comprehensive Physical Assessment, the prior assessment is moved from the Core Health Profile section of the Individual Health Care Record and re-filed in the section reserved for Prior Medical/Physical Assessments and Histories.

Medicaid Note: If a DJJ provider performs the Comprehensive Physical Assessment and the performance of that service is Medicaid-reimbursable to that DJJ provider, the facility may choose to separately retain (for Medicaid audit purposes) the original of the completed standardized form on which the Comprehensive Physical Assessment was performed. In this case, a copy (as opposed to the original) of the completed standardized form shall be placed in the Individual Health Care Record, as part of the Core Health Profile. This copy shall be used by all subsequent facilities as if it were the original (that is, a new Comprehensive Physical Assessment does not need to be conducted at the next facility because the documentation is a copy). The copy that is filed should be stamped or otherwise noted as a COPY and signed by the record custodian at the facility. The original must be confidentially and securely stored by the program/medical provider and in accordance with all federal and state laws and regulations.

J. INFECTIOUS AND COMMUNICABLE DISEASE FORM

This form tracks tuberculosis status (screening [skin testing] and treatment), sexually transmitted disease screening, evaluation and treatment, meningitis, staphylococcal infections (including Methicillin—resistant S. aureus (MRSA), and other infections.) This is a cumulative document and does not need to be re-administered.
K. HEALTH EDUCATION RECORD

1. The Health Education Record documents the health education a youth has received while in the custody of a DJJ detention center or residential commitment program. It is a cumulative document.

2. The Health Education Record shall clearly document the delivery of health education provided to a youth on specific topics considered essential for adolescents. This will enable subsequent programs and providers the ability to develop programs of health education that are not redundant.

3. Reasonable mechanisms for documenting health education shall be in place. For example, if a class is given on personal hygiene as part of the educational curriculum provided by the local school district, a list of all youth attending that class may be provided to a designated individual who documents this education on the Health Education Record.

4. The focus of this record shall be on building upon prior education, as opposed to going over the same topic. The facility may choose to remove the Health Education Record form from the Individual Health Care Record for the duration of a youth’s stay to be placed in a binder that contains all the Health Education Records for every youth, in order to facilitate documentation on the form. However, the facility shall assure that the record is returned to the youth’s permanent health record prior to transfer or discharge from the facility.

5. When health care education is delivered on-site during an individual health care encounter with a health care professional (for example, medication instructions are given to a youth by a nurse, or instructions are given on the prevention of sexually transmitted diseases by a physician during the course of the Comprehensive Physical Assessment), that on-site provider shall document the education on the standardized form in the Core Health Profile. This documentation consists of a simple notation and signature. Additional documentation may be made in the chronological progress notes if desired.

V. IHCR SECTION 2: INTERDISCIPLINARY HEALTH RECORD

The additional sub-sections of the Individual Health Care Record (IHCR) include the following:

☑ On-site orders;
☑ Chronological progress notes (including Summaries of Off-Site Care);
☑ Prior MARS;
☑ Prior Facility Entry Physical Health Entry Screenings;
☑ Prior CPAs and other medical/physical assessments;
☑ Laboratory and radiological results;
☑ Documentation of dental care;
☑ Mental health/behavioral health care documentation.
A. **CHRONOLOGICAL PROGRESS NOTES**

1. All on-site medical health care encounters, including those performed by licensed health care professionals, health care paraprofessionals and other staff shall be documented in the progress notes in chronological order (with exceptions as noted in this chapter).

2. All on-site health care encounters shall contain the following information, commensurate with the credentials and qualifications of the individual rendering care:

   - Date and time of the encounter;
   - Nature of the encounter (Sick Call, emergency care, routine follow-up, etc.);
   - Youth’s complaint;
   - Findings of the individual rendering care (subjective and objective assessment findings, including vital signs and weight, if appropriate);
   - Appropriate assessments for youth identified with a chronic condition (for example, blood glucose finger sticks for a youth with diabetes; peak flows for asthmatics; serum blood levels etc., as applicable);
   - Conclusion/diagnosis, if applicable;
   - Treatment rendered;
   - Notation if the Designated Health Authority, Designated Mental Health Authority, psychiatrist or psychiatric ARNP was notified, time of notification and whether or not there was a call-back/response from this person;
   - Notation if the facility superintendent or program director was notified, time of notification, and whether or not there was a call-back response from the program director;
   - Education and instructions given to youth;
   - A notation if the parent or guardian was notified [by telephone];
   - A notation as to whether a copy of a completed *Parental Notification* was sent;
   - A notation if the dentist was notified or whether the youth was taken off-site for dental care (when applicable);
   - Plans for follow-up and future treatment, if any;
   - Legibly printed name (first name, last name) of the staff member rendering care;

NOTE: If the weight is taken routinely, such as on a monthly basis and the complaint is not related to loss of appetite, diarrhea or other condition where weights would be appropriate, a weight does not have to be taken. However, all youth who are underweight, have an eating disorder or are suspected of having an eating disorder, or who have just been prescribed medications that have loss of appetite or other gastrointestinal side effects shall be weighed at each encounter. If a youth has deliberately stopped eating, that youth must be weighed on a daily basis, even if he/she has not voiced any complaints.

- Appropriate assessments for youth identified with a chronic condition (for example, blood glucose finger sticks for a youth with diabetes; peak flows for asthmatics; serum blood levels etc., as applicable);
- Conclusion/diagnosis, if applicable;
- Treatment rendered;
- Notation if the Designated Health Authority, Designated Mental Health Authority, psychiatrist or psychiatric ARNP was notified, time of notification and whether or not there was a call-back/response from this person;
- Notation if the facility superintendent or program director was notified, time of notification, and whether or not there was a call-back response from the program director;
- Education and instructions given to youth;
- A notation if the parent or guardian was notified [by telephone];
- A notation as to whether a copy of a completed *Parental Notification* was sent;
- A notation if the dentist was notified or whether the youth was taken off-site for dental care (when applicable);
- Plans for follow-up and future treatment, if any;
- Legibly printed name (first name, last name) of the staff member rendering care;
-legible signature (first name, last name) position and credentials of staff member rendering care;

DJJ facility name.

3. All detention centers and residential commitment program health care staff shall document (and file) the delivery of health care and treatment at the time the services are rendered.

4. All efforts to notify parents by telephone or in writing regarding a youth’s medical/physical health care shall be documented in the chronological progress note.

5. When telephone orders are received from an off-site provider, a detailed note must be made in the chronological progress notes by the staff member taking the report. Only an ARNP or RN may take a telephone order. An LPN can receive a telephone order in the absence of an RN, but an RN co-signature must be present prior to implementation of the order. Telephone orders shall be utilized only when necessary and shall not take the place of the actual examination/evaluation of the youth.

Telephone orders shall include the following:

- Date and time of call;
- Name of individual providing information and the organization or facility that is providing the information;
- Information being relayed (medication dosage, discontinuation, other treatment);
- Legibly printed name (last name, first name), position, and DJJ facility of individual taking the call;
- Legible signature of person receiving the order, with credentials;
- Telephone orders must always be read back to the individual who is giving the order for accuracy and this should be documented in the note.

6. The Designated Health Authority shall approve all medical standing orders at least annually. All standing orders shall be youth-specific (meaning the standing order sheet must be signed by the Designated Health Authority and the medications on the standing order sheet are checked off for each youth).

7. Progress notes for mental health services shall be filed with all other mental health records and notes, in the section designated for mental health services.

8. If a Clinical Psychological Progress Note (CPPN) and Acknowledgement of Receipt (AOR) were completed as a result of a mental health encounter, the copies that were sent to the parent/guardian are to be filed with the accompanying clinical notes of that encounter in the mental health section.
9. Progress notes detailing dental care shall be filed with all other dental records and notes, in the section designated for dental care.

10. A Physician, PA or ARNP, who is an on-site employee or a contracted on-site employee of the facility and who writes orders on-site can document on a separate Practitioner Orders form or in the Plan section of their Progress Note as long as a procedure is in place for the flagging of new orders. These forms shall be filed in reverse chronological order in a separate section of the Individual Health Care Record.

11. When a medication is ordered on-site using a prescription pad, a copy of each prescription written (with the exception of controlled substances) must be filed in the IHCR. This copy should be stapled or otherwise affixed to the order sheet. If the facility uses a prescription form that has a duplicate, that or a pharmacy receipt will suffice.

B. SUMMARY OF OFF-SITE CARE

1. All medical care ordered and/or administered off-site (by a Physician, PA or ARNP) shall be documented on the standardized form, Summary of Off-Site Care. This form shall be taken to the off-site provider by staff accompanying the youth, filled out by the provider and returned to the facility. All health-related information and documentation shall be placed in a sealed envelope labeled “CONFIDENTIAL” prior to any transportation to ensure confidentiality. The treating off-site provider shall retain his/her own records at the off-site facility. When additional health care documents are returned to the facility, by the off-site provider, (for example, standardized emergency room summaries and instructions), those documents should be transported in a sealed envelope labeled “CONFIDENTIAL” and filed chronologically, along with the Summary of Off-Site Care form.

2. When prescriptions are written by an off-site and/or independent service provider, the facility shall make a copy of the prescription prior to filling it. The copy shall then be filed in the Individual Health Care Record, under Practitioner Orders or in the Chronological Progress Notes.

3. Prescriptions for controlled substances cannot be copied or re-produced, but the duplicate pharmacy label can be affixed to the Summary of Off-Site Care.

4. All documentation received from off-site providers, including discharge instructions from hospitals and clinics, shall be reviewed, initialed and dated by the facility’s Designated Health Authority or Physician Designee, PA or ARNP who provides primary care, and any referrals entered in to the Sick Call/Referral Log.

5. Off-site dental care shall be documented on the standardized form, Summary of Off-Site Care and filed in the Dental Care section of the record.
6. All documentation shall be filed as part of the chronological progress notes in reverse chronological order (most recent on top.)

C. Medication Administration Records (MAR)  
(Medication Administration Record, also known as the Medication and Treatment Record)

1. The MAR is utilized to provide a current record of all prescribed and over-the-counter medications administered on a dose-by-dose basis. All physical health treatments that are ordered on an on-going basis (for example, dressing changes) shall also be documented on the MAR. On-site administration of immunizations and PPD skin test administration shall be documented on the MAR.

2. The MAR is used to document the administration of medications and any physical or dental health treatment that may have been ordered. Facilities, which do not use a pharmacy vendor’s pre-generated MAR, shall use the standard Department MAR.

3. This form may be kept separate from the Individual Health Care Record. (For example, the current MAR should be kept in the area where medications are stored and administered.) A new form is initiated each month and the previous month is filed in the Individual Health Care Record.

4. All previously completed medication and treatment records (or copies if the original must be retained at the facility for Medicaid audit purposes) shall be filed in a separate section.

5. When transferring a youth from one DJJ facility to another the original MAR shall be sent with the Individual Health Care Record. The transferring facility shall keep a copy of the MAR for the facility record. The MAR shall be placed in front of the Individual Health Care Record to provide the receiving facility immediate and accurate medication information for the youth receiving medication therapy.

6. A DJJ facility receiving a youth from another facility should utilize the original MAR provided or initiate a new MAR currently being used at that facility. At no time should there be a break in the scheduled medication administration.

7. The prior facility’s copy of the MAR should be filed in reverse chronological order in the section of the Individual Health Care Record reserved for these prior forms.

D. Prior Medical/Physical Assessments and Histories

All physical and medical assessments and histories, including prior records from private physicians, and previously conducted Comprehensive Physical Assessments shall be filed in a separate designated section, following the Medication Administration Records section.
E. PRIOR FACILITY ENTRY PHYSICAL HEALTH SCREENING

All prior Facility Entry Physical Health Screening forms should be filed in a separate, designated section, following the Prior Medical/Physical Assessment and Histories section. This screening is an admission screening. The original of this current form is always filed in the designated section of the Core Health Profile.

F. LABORATORY TESTS

1. All hard copy laboratory test results (with the exception of test results which require special handling such as confidential HIV test results) shall be filed in a separate designated section. HIV test results shall be placed in a sealed envelope marked “confidential” and filed in the IHCR.

2. When the laboratory test is performed on-site, or when the test is ordered on-site with the results to be sent to the Designated Health Authority or Physician Designee, PA or ARNP for review, the hard copy test results shall be signed and dated by these health care professionals to indicate that they were reviewed.

3. When the laboratory test is ordered and performed off-site by an off-site provider and/or an independent service provider, that provider shall be requested to forward a copy of the test results to the facility when available, to be filed in the laboratory section. This copy shall be reviewed, signed, and dated by the Designated Health Authority, or Physician Designee, PA or ARNP as well.

G. RADIOLOGICAL TESTS

1. All written reports of radiological tests shall be filed in a separate designated section, following the Laboratory Test section. When a chest radiograph is performed, in order to rule out active tuberculosis disease, a notation of that chest radiograph shall be made on the Infectious and Communicable Disease form.

2. When the radiological test is generated and performed on-site, the hard-copy report shall be signed and dated by the Designated Health Authority, or Physician Designee, PA or ARNP to indicate it was reviewed.

3. When a radiological procedure is performed off-site by an off-site provider and/or an independent service provider, that provider shall be requested to forward a copy of the report of the procedure to the facility when available, to be filed in this section.

4. All laboratory, radiological and other tests conducted on any youth shall be signed and initialed by the Designated Health Authority, or Physician Designee, PA or ARNP.
H. MENTAL HEALTH/BEHAVIORAL HEALTH CARE

1. Mental health/behavioral health care histories, assessments progress notes, notes of other encounters, copies of CPPNs/AORs shall be filed in a separate designated section of the Individual Health Care Record.

2. Standards, guidelines, or requirements regarding divulgence or release of mental health information (which are in addition to confidentiality requirements related to health care in general) are discussed in the Department’s Mental Health and Substance Abuse Services Manual, Revised 2006.

I. DENTAL CARE

1. All dental health care histories, assessments, tooth charts, treatment plans, progress notes and treatment encounters by an on-site dentist or dental hygienist shall be filed in a separate designated section.

2. Any available dental histories or records of prior dental treatment shall also be filed in this section.

3. When dental treatment is rendered off-site, documentation of that care shall be made by the provider on the standardized form, Summary of Off-Site Care that shall be filed in the Dental Care section along with any additional documentation received.

VI. HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT: HIPAA

A. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Part of this legislation, Title II known as Administrative Simplification, required that national standards be established for:

1. Data content and format for electronic health care transactions;
2. Privacy of confidential personal health care information;
3. Security and physical access to health care records; and
4. National identifiers for providers, employers, and health plans.

B. HIPAA established new health privacy rights, enforced by the Office for Civil Rights and, to ensure these rights, the Privacy Rule requires certain entities, who routinely handle protected health information, to:

1. Limit uses and disclosures of protected health information;
2. Develop reasonable safeguards, policies and procedures to protect privacy of health information;
3. Train personnel in the policies and procedures and document completion;
4. Designate personnel to handle health privacy violation complaints and issues;
5. Notify individuals about privacy practices and their health privacy rights;
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6. Keep track of certain disclosures of protected health information not authorized by the individual or related to treatment, payment or health care operations.

C. However, the Department of Juvenile Justice and all contracted service providers operating under its authority are “correctional institutions” under HIPAA. As such, covered entities (e.g. health and mental health providers, hospitals, etc.) may disclose protected health information to the Department, and those acting under its authority, pursuant to 45 C.F.R. § 164.512(k)(5), without consent or authorization from the youth, his/her parent or guardian.

D. Thus, youth in the Department’s custody are exempt from HIPAA requirements. This means that disclosure of protected health information contained in a youth’s health care record is necessary and allowable for:

- The youth’s treatment;
- The health and safety of the youth or others in custody;
- The health and safety of officers, employees, law enforcement at the facility;
- The administration and maintenance of the safety, security and order of the facility.

E. Thus, in the above situations, the information can be shared, without prior authorization by the youth or parent:

- Between relevant DJJ personnel;
- Between physicians, hospitals, offices, clinics, DJJ personnel or DJJ contracted providers.

Note: Under the HIPAA Rule, “protected health information” is all individually identifiable health information that is created, received or maintained by a covered entity, regardless of its form, that relates to the past, present or future physical or mental health or condition of an individual or the provision of, or payment for, health care to an individual, living or dead.

F. Pursuant to federal HIPAA and CDC regulations, information related to a youth’s HIV status shall not be released without the youth’s specific consent.

G. With regard to access to records, the individual who is the subject of the PHI, or that individual’s personal representative (for youth under age 18, this is their custodial parent or guardian), has the right to access their health care record. Access should be limited to only health care information and must exclude:

- Psychotherapy notes (which are therapists’ impressions and not their reports);
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding;
- Substance abuse treatment records (unless a written consent for disclosures has been provided by the youth).

H. Any disclosures of information contained in a youth’s individual healthcare record shall only be made for the purposes of providing or obtaining health care for that youth or for evaluating health care delivery.
I. Within the Florida Department of Juvenile Justice, the right to a copy of the youth’s health care record may be denied, in whole or in part, if it “would jeopardize the health, safety, security, custody or rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate.” See 45 C.F.R. §164.524(a)(2)(ii). Under HIPAA, these denials are not reviewable.

J. HIPAA exemption does not preclude all individuals from maintaining a youth’s privacy.

VII. STORAGE, SECURITY AND CONTROL OF THE HEALTH CARE RECORD

A. The Individual Health Care Records shall be stored separately from other files that contain all non-health-related records and notes. The storage area must be locked and inaccessible to youth. Facility Operating Procedures and practice should reflect that access to Individual Health Care Records is controlled and that the records are not accessible to individuals who have not been authorized access to the records by the Designated Health Authority, or Physician Designee or the facility Superintendent or Program Director.

B. The Designated Health Authority or Physician Designee, Facility Superintendent, or Program Director shall provide delegated access to Individual Health Care Records in the absence of health care professionals to facilitate the continuum of health care services. Departmental staff delegated with authority to assist youth with off-site medical care, medication management, etc., shall have access to Individual Health Care Records. A list of authorized staff should be posted at the location of the health record storage area. It is recommended that the Designated Health Authority or Physician Designee, PA or ARNP should establish a sign in/out system for health records that are taken from the main clinic storage area that ensures the location of the record or the staff member responsible for the record is known at all times. When records are received from the health records storage area or medical clinic, the staff member signing out the record will accept full responsibility for the security of the record and any disclosures made while in possession of the record. Every effort will be make to maintain the confidentiality of the health record while it is in the possession of an individual staff member.

C. The following practices should be followed to maintain record confidentiality:

1. Health records and health information will not be stored in an individual’s desk.
2. All health records will be returned to the health record storage area when a staff member is off-duty.
3. E-mail messages containing health information about an individual youth will never be forwarded outside of the DJJ network (exceptions are if e-mail is used to convey relevant information to outside practitioners for the care of the youth).
4. Health records will never be left unsecured (e.g., outside of the clinic area).
5. All documents should be filed as soon as possible, after a service is rendered.
VIII. TRANSFER OF HEALTH RECORDS

A. A youth’s health record should accompany the youth in order to ensure continuity of care and to prevent the duplication of tests and examinations at the receiving facility. For youth with critical or chronic health problems, the health record should be flagged in some fashion to expedite an immediate referral to a medical care provider.

1. The Superintendent, Program Director, or designee should inform health care staff of the youth’s transfer at least 24 hours in advance or as soon as possible prior to the transfer.

2. Upon notification of transfer, the sending facility’s health care staff will notify the receiving facility’s health care staff via telephone if a youth has any need for health care services that are other than routine.

3. The health records of transferred youth will be opened promptly upon arrival at the receiving facility for review by health care staff at the next available shift.

IX. ON-SITE TRACKING LOGS

A. All on-site tracking logs are kept on-site at the facility and are not a part of the Individual Health Care Record. In contrast to the Individual Health Care Record, the on-site tracking log lists certain categories of health care or health care findings.

B. Certain types of care or findings require listing in order to facilitate quick reference for follow-up or to facilitate evaluation necessary for programming and planning. For example, results of tuberculosis skin tests shall be tracked in order to facilitate quick review by a licensed health care professional and to determine trends. Similarly, tracking of sick call and episodic care complaints provides information essential for the identification of need for additional resources and/or clinical trends. The Chronic Physical Health Condition Roster assists in the monitoring and follow-up of youth with chronic illness.

C. The following categories of care and clinical findings shall be tracked on-site through use of running logs:

- Sick call complaints (Sick Call/Referral Log);
- Episodic care (Episodic (First Aid/Emergency) Care Log);
- Tuberculosis screening tests and results (Tuberculosis Testing Log);
- Physician referral and specialty referral (Sick Call/Referral Log);
- Chronic physical health conditions (Chronic Physical Health Conditions Roster).

D. These logs are in addition to the documentation of these items in the Individual Health Care Record. Because these logs contain confidential information, they shall be stored in a secure area with access restricted to individuals authorized by the Designated Health Authority, or Physician Designee and/or the facility Superintendent or Program Director. The exception to this is the over-the-counter (OTC) log that shall be maintained on each
living unit when there is an approved procedure for the use of a limited number of over-the-counter medications to be administered pursuant to a minor complaint.

X. HEALTH SERVICES REPORT

A. An organized, consistent and accurate system of health-care statistical reporting is essential to health care planning and evaluation, utilization review, quality assurance and performance-based budgeting. In addition to assisting the Department in these important activities and mandates, statistical reporting serves the public interest by facilitating improved efficiency and efficacy in the delivery of health care to youth in the Department’s custody.

B. Each detention center shall complete the monthly Health Services Report, while each residential commitment program shall input their data into the Residential Services Monitoring System, (the system in development at the time of this printing) utilizing guidelines, and specific timeframes set forth by the Department.

XI. REQUESTS FOR HEALTH RELATED RECORDS

A. REQUESTS WITHIN THE DEPARTMENT

Requests for youth-specific or youth-identifiable information shall be based on a bona fide need to know. Any health-related material requested by any of the Offices or Branches in Department Headquarters or the Regional offices shall be made available to the requesting entity in a timely manner.

B. REQUESTS MADE BY PARENTS

Generally, parents or legal guardians have the right to request and review copies of the Individual Health Care Records for their child with the following exceptions:

1. Psychotherapy Notes
2. Statutorily protected information (e.g., information related to STD’s, family planning, etc.)

Note: If there is any question or concern, refer the issue to the Regional General Counsel’s Office.

C. REQUESTS MADE BY A PUBLIC DEFENDER, OR STATE’S ATTORNEY, ETC.

These requests should be referred to the Regional General Counsel’s Office.

D. REQUESTS MADE BY THE MEDIA OR OTHER ENTITIES OUTSIDE OF THE DEPARTMENT

These requests should be referred to the Regional General Counsel’s Office and the Communications Office at Department.
HEADQUARTERS AS THE YOUTH INFORMATION IS CONFIDENTIAL AND YOUTH-SPECIFIC IDENTIFIERS (E.G., NAMES, ETC) SHOULD BE PROPERLY REDACTED.
CHAPTER SIXTEEN
HEALTH EDUCATION

OCTOBER 2006
I. INTRODUCTION

Health education is a clinical component required at each detention center and residential commitment program. The extent of health education made available at each facility will vary according to the facility type, rate of turnover, and length of stay.

It is important that each youth receive education in self-care strategies that promote healthy lifestyle choices. The youth can receive education from health care staff, detention staff, residential staff, community health care providers, or volunteers.

The provision of health education can be accomplished through a variety of mechanisms. Unlike some of the other clinical components, there are many opportunities for health education to occur:

- One-on-one teaching between a nurse and a youth;
- Classes conducted by the school system or those providing education at the DJJ facility;
- Classes conducted by the local county health department;
- Videos on certain health topics that can be played with group discussions among the youth;
- Medication training and chronic illness education, with a goal of optimal self-care.

Residential commitment programs with specialized populations, or those with relatively longer lengths of stay, should provide a variety of resources and opportunities for learning about various health-related topics. Youth in detention centers, where a relatively short length of stay is expected, may benefit most by having individual primary health education.

II. HEALTH RELATED CURRICULA

The type of curricula chosen for selected topics of health education and provided to youth shall be consistent with the Centers for Disease Control and Prevention recommendations. Educational programs in detention centers and residential commitment programs shall be age specific. Detention centers and residential commitment programs shall provide youth opportunities to enhance their knowledge of health and healthy lifestyles.

Health education programs shall reflect the consensus regarding priority health issues for adolescents that have been reached by a variety of organizations that are involved with the care of adolescents. These topics shall include, but not be limited to the following:

- Seat belt usage;
- Alcohol and drug related problems;
- HIV/AIDS infection;
Sexually transmissible diseases and prevention of sexually transmitted diseases;
Smoking cessation, use of tobacco products, and effects of smoking;
Dental Hygiene and Preventative dental care;
Basic Personal Hygiene;
Immunizations;
Infection control: Basic hand washing, etc., as well as understanding hepatitis and tuberculosis;
Prevention of sexual and other physical violence;
Nutrition;
Physical fitness;
Self-examinations: Breast and testicular;
Family planning: Parenting skills and pre-natal care (when applicable).

Gender identification issues should be handled by experts in this area. (It is estimated that 10% of the youth in the general population, or who attempt or complete suicide, have unresolved issues in this area. In addition, in the juvenile justice setting, the estimates are as high as 30%.)

III. HIV AND AIDS EDUCATION

The curriculum, content and methods of health education on HIV prevention should conform to CDC recommendations. If CDC-researched programs are available, these should be utilized. Given that many youth in the juvenile justice system have received basic HIV education, it is important to determine the level of understanding in order to best develop a curriculum.

General information on AIDS and STDs transmission and prevention shall be provided, as well as specific meaningful information during health encounters with licensed health care professionals.

Other resources include the local area AIDS network that supplies information, educational materials, and speakers.

IV. DETERMINING HEALTH EDUCATION PRODUCTS

In the absence of CDC information, the following criteria should be by the DJJ facility superintendents/program administrators and health care staff to evaluate either the purchase of specific health education curricula or a proposal for the provision of specific health education services:

- The curriculum has been demonstrated to be effective through application of research findings.
- The curriculum is reasonable in cost.
- The developer and/or provider of the curriculum provide documentation that it is credible and have experience in the area of curriculum development for youth and adolescents.
- The developer and/or provider of the curriculum demonstrate a commitment to a planned, sequential, comprehensive program.
The length of the curriculum is suitable for the average length of stay in the particular DJJ facility.

V. DOCUMENTATION OF HEALTH EDUCATION

A. DOCUMENTATION OF ON-SITE HEALTH EDUCATION

Documentation of on-site health education at each DJJ facility should be made on the Health Education Record that is part of the core health profile in the Individual Health Care Record. Documentation in a concise, clear manner is essential for the ultimate goal of developing an overall health educational program that progress throughout the DJJ continuum.

Documentation may also be made as part of the narrative note written in the progress notes of the Individual Health Care Record, if the health education is provided during an individual encounter with a licensed health care professional (for example, the youth is given instructions by a physician regarding medication, or a youth is given instructions regarding symptoms to report).

If group health education classes are provided on-site and the size of the class or other factors prevent the recording of the information in the Individual Health Care Record, it is suggested that a separate file be maintained at the facility which indicates the date of the class, the content, and the youths who participated in the classes.

B. DOCUMENTATION OF OFF-SITE HEALTH EDUCATION

It may not always be possible to record health education conducted off-site (for example, at a county health department) on the Health Education Record. However, the off-site provider should be requested to include the information related to health education on the Summary of Off-Site Health Care, which is then filed in the Individual Health Care Record. The facility may record the off-site health education on the Health Education Record, using information on the Summary of Off-Site Care, but this is not required.
DEPARTMENT OF JUVENILE JUSTICE HEALTH SERVICES MANUAL

CHAPTER SEVENTEEN
TRANSITIONAL HEALTHCARE PLANNING

OCTOBER 2006
CHAPTER 17
TRANSITIONAL HEALTH CARE PLANNING

I. INTRODUCTION

The Department is committed to the goal of assisting youth as they prepare to be released from the physical custody of a detention center or residential commitment program. Transitional health care planning is a mandatory clinical component of health care services at each DJJ facility. For purposes of this manual, the term refers to the process of planning and information exchange to the extent necessary to maintain continuity of care for a youth who is:

- Released to the community from a detention facility;
- Released to the community from a residential commitment program;
- Transferred from one residential commitment program to another.

The process and scope of transitional health care planning will vary among facilities due to the following factors: the type of facility, the length of stay of the youth, the amount of notice the facility has before the youth is released or transferred, the complexity of the health care needs of the youth, and whether the youth is released to the community or transferred to another DJJ facility.

Because the health status and health care needs of youth in the custody of a DJJ facility can likely have an impact on public health, planning for the health care needs of a youth upon release to the community will benefit the public as well as the youth.

When a youth is transferred between facilities (as opposed to being released to the community), mechanisms of effective communication among facilities are necessary to avoid duplication of services and interruption in the youth’s care.

II. RELEASE TO THE COMMUNITY FROM A DETENTION CENTER

A. The focus of transitional health care planning for youth who are released to the community from a detention center should be on appropriately relaying health care information (current and pending) to outside community practitioners and parents or guardians. When applicable, the detention health care staff should facilitate linkages with community practitioners.

B. If the youth is released to the community under the continuing supervision of DJJ, such as by a day treatment program, a procedure shall be in place in which pending or unresolved health care issues, such as scheduled appointments to see a health care provider, are made known to the juvenile probation officer and the parent/guardian.
C. The Juvenile Probation Officer’s role is to communicate and reinforce the need for follow-up information to the responsible parent or guardian. However, if the youth is not physically in the custody of DJJ (for example, the youth is living at home but under JPO supervision), it is the responsibility of the parent or guardian with whom the youth is residing to facilitate the health care services.

D. When a youth is receiving medication from an individually labeled, youth-specific, prescription container generated by a pharmacy vendor, the youth’s medications may be provided to the parents or guardians at the time of discharge. Written verification of the parents or guardian’s acceptance of an exact amount of medication shall be documented in the Individual Health Care Record. Prescription medications should not be released solely to the youth.

E. For all non-narcotic medications that a youth will continue to take after release, the youth’s parent or guardian should be provided with a 30 day paper prescription from the facility DHA, designee, PA, or ARNP. A copy of this prescription (indicating that it was provided to the parent or guardian) shall be placed in the youth’s Individual Health Care Record.

F. If the youth’s charges (either the current ones or those in his/her history) warrant submission of a DNA specimen, the specimen shall be obtained using the FDLE kit prior to the youth’s release into the community.

G. If applicable, a Parental Notification of Health-Related Care form shall be sent in advance to the parent or guardian by the detention center with any information on upcoming (or the need for) appointments. Final information shall be provided on the Health Discharge Summary/Transitional Plan to the parent or guardian when the youth is released. Specific instructions given to the youth about the need for follow-up health care shall be noted in the Health Education Record.

H. If the youth is under treatment for tuberculosis or other reportable illnesses, the youth and the parent shall be provided with instructions regarding access to care in the community, the need to continue medication, and the need to report to the local county health department. Arrangements shall be made so that the youth does not experience a break in continuity of care and medication therapy.

III. RELEASE TO COMMUNITY FROM RESIDENTIAL COMMITMENT PROGRAM

A. Transitional health care planning shall begin within 45-60 days prior to the youth’s anticipated release to the community from a residential commitment program. For the purpose of this manual, the planning shall focus on communicating information about pending health-related issues and, when applicable, facilitating linkages with community providers. This planning should involve the youth’s parent or guardian (in person or telephonically), the Juvenile Probation Officer, the facility case manager and conditional release provider (as applicable). At this time, the program staff (case managers and health care staff) should begin the process of scheduling those appointments, which
need to occur after a youth’s release. This is critically important for youth who are under the care of a specialist or taking psychotropic medications.

All efforts to make the appointment shall be documented in the Individual Health Care Record.

B. Fourteen (14) days prior to discharge, the program shall again review the need for any upcoming appointments and ensure that the parent or guardian is aware (particularly if insurance considerations prohibit the actual scheduling of the appointment).

C. If the youth is released to the community under the continuing supervision of DJJ, a mechanism shall be in place to communicate health related issues such as pending appointments, treatments or other unresolved health care issues to the Juvenile Probation Officer and the parent/guardian.

D. A summary of health-related needs (pending scheduled appointments, the need for medications, information about community resources, and the like) should be included in the program’s exit conference for the youth. This information should be included on the copy of the Health Discharge Summary/Transitional Plan. Care should be taken not to provide parents health-related information which is statutorily protected, unless the youth has given permission to divulge that information.

E. Youth should be informed of relevant health-related information (for example, the date of the next scheduled immunization if an immunization series is in progress or appointments with specialists). Any transitional health care planning provided to the youth shall be documented on the Health Education Record.

F. When a youth is under treatment for tuberculosis or other reportable illnesses, the youth and parent shall be provided with instructions regarding access to care in the community. Reporting to the local county health department may be required in some cases.

G. The terminal disposition of the Individual Health Care Record shall be accomplished by affixing it to the case management file. Together, these two records comprise the youth’s official file, and are to be stored in compliance with Department policy and state retention law and rule.

IV. TRANSFER FROM ONE RESIDENTIAL COMMITMENT PROGRAM TO ANOTHER

A. Transitional health care planning for youth who are transferred from one residential commitment program to another shall include effective communication and planning regarding a youth’s health care services.

B. The goal of this type of planning is to ensure that continuity of care is maintained between facilities. Information should be presented in a fashion which facilitates a clear understanding by the receiving facility, of all health care services being rendered to the youth, including but not limited to, all required medications, medical and clinical care in
progress and pending or scheduled appointments for medical follow-up evaluations and treatments.

C. Duplication of screenings, risk assessments, and laboratory tests at the receiving facility should be avoided unless clinically indicated, with the exception of the Facility Entry Physical Health Screening.

D. The youth shall participate in the transfer process if he/she has the capacity to do so, by being informed of current health care needs, scheduled appointments or pending immunizations.

E. The summary of health-related needs should be included in the program’s exit conference for the youth. This information is included on the copy of the Health Discharge Summary/Transitional Plan. Care should be taken not to disclose to the parents any health-related information that is statutorily protected from disclosure unless the youth has given permission for such disclosure.

F. All medications and MAR’s shall be transferred securely with youth.

G. Discharge/Transition planning requires timely notification to all participants so that all elements of the process can be accomplished. This includes all documentation, medications, pending medical or diagnostic reports, verbal notifications and copies of the IHCR for those individuals requiring those documents.
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CHAPTER EIGHTEEN
COMMUNITY CORRECTIONS PROGRAMS

OCTOBER 2006
I. INTRODUCTION

The parents and guardians of youth under Departmental supervision, but living in the community are responsible for their child’s health care services. A facility based community correction program is a non-residential day treatment program that is usually housed in a structure with a school setting. However, not every facility has a school setting.

Each facility based community program must have in place procedures for the provision of medical care for youth in need of health care services while youth are physically present at the program. These procedures must include, but not be limited to the following components:

- Medical/physical intake screening;
- Clinical observation and monitoring;
- Non-emergent illness and injury;
- Delivery of first aid;
- Emergency care;
- Medication administration (for youth requiring doses of medication while at the program);
- Infection control: procedures used to address blood-borne pathogen exposure.

Each facility must also comply with public school health care procedures.

II. THE AUTHORITY FOR EVALUATION AND TREATMENT (AET)

(See Chapter 4: Consent and Notification Requirements)

The Department of Juvenile Justice requires that the parent provide the Department with a signed Authority for Evaluation and Treatment form for a youth at the time of admission into the DJJ system.

It is the Juvenile Probation Officer’s (JPO) responsibility to obtain the parent’s signature on the Authority for Evaluation and Treatment form. This signature should be obtained during the parent’s initial intake with the JPO. Only one AET form with the parental or legal guardian’s original signature is required. Once completed, the original Authority for Evaluation and Treatment shall be filed in the youth’s Individual Health Care Record. The JPO shall maintain a backup copy.

For the purpose of the community corrections programs this form, when properly signed by the parent/guardian, authorizes the program component to:
Administer a youth’s prescription medications if there are doses(s) required while the youth is at the program;
Perform drug screening;
Administer on-site first aid;
Provide emergency care;
Provide over-the-counter medications as defined on the AET.

In the case of a life-threatening emergency, the program component shall not be constrained by an unsigned AET when determining whether to access Emergency Medical Services. 911 shall be called immediately as necessary.

III. HEALTH SCREENING ON ENTRY

A. Each facility shall develop a health screening process. At the time of admission, staff shall interview the youth utilizing the established screening process to determine if the youth has a condition that may require medical attention while the youth is in the care of the staff at the program.

These conditions include, but are not limited to:

- Pregnancy
- Diabetes
- Heart Disease
- High Blood Pressure
- Thyroid Disorders
- Asthma

B. When available, the most recent Health Discharge Summary, from prior involvement with the Department, or from a previous residential commitment program, shall be reviewed as part of the health intake assessment. Each facility must incorporate an individual health care plan for each youth with medical needs. The youth’s medical information shall be documented in the youth’s Individual Health Care Record.

C. All chronic medical conditions shall be listed on the DJJ Problem list and maintained in the youth’s case file and individual health care record. This information and any pertinent health related information should be discussed in staff meetings.

D. When there are any concerns or questions about a youth’s medical condition the staff shall make and document all attempts to contact the parent(s) or guardian(s).

E. The information obtained during the initial health screening process shall be “CONFIDENTIAL” and available only to those staff that needs to be aware of a youth’s medical condition in the case of routine care, participation in a specific program, or in an emergency.
IV. OBSERVATION AND MONITORING

The staff shall observe the youth at the time of admission for the following signs and symptoms:

- Tremors
- Sweating
- Injuries
- Physical illness/distress
- Difficulty moving
- Physical handicap
- Intoxication

The program supervisor shall be notified immediately to determine if emergency services is required.

V. NON-EMERGENCY HEALTH NEEDS

It is the responsibility of the program staff to provide routine observation for all youth while in the facility to facilitate the identification of potential non-emergent health care needs. When a youth is suspected of being ill or requiring non-emergency health care, the staff shall contact the parent or guardian and inform them of the possible need for a medical evaluation.

A youth that becomes ill and does not require Emergency services shall be provided a quiet space to await recovery or transportation home.

VI. MEDICAL EMERGENCIES

Each program component shall have an arrangement with a designated licensed general hospital to provide youth with emergency medical services. The program staff shall have specific medical emergency procedures in place for youth within the program component.

In the event of an emergency and/or what appears to be a life-threatening illness or injury, the staff shall utilize EMS and call 911 to arrange for immediate emergency care and transportation by ambulance to the appropriate hospital. The youth’s parent or guardian shall be notified immediately.

VII. NON-LIFE THREATENING EMERGENCY: ILLNESS OR INJURY

The program shall ensure that appropriate transportation is available for use for a youth experiencing a non-life-threatening illness or injury requiring medical attention. The youth shall be transported to the appropriate medical facility for care and treatment. The parent / guardian shall be contacted immediately when the youth requires transportation to the hospital for treatment or evaluation of a non-life-threatening illness or injury.
VIII. FIRST AID

Each program shall have a first aid kit (refer to Chapter 9: Episodic Care for recommended supplies) that must be secured in a designated location at the program component. All staff shall be trained in First Aid and Cardiopulmonary Resuscitation (CPR). The program shall implement a perpetual inventory system for first aid supplies and equipment that shall be replenished as needed.

IX. MEDICATION MANAGEMENT
(Refer to Chapter 11: Medication Management)

Each program shall develop facility procedures in accordance with Federal regulations, Florida state regulations and established DJJ policies that include but are not limited to, the following components:

- Authorization to administer prescribed medications;
- Verification of Prescribed medication;
- Assistance for youth: modified self-administration of medication;
- Security, accountability, and storage of prescribed medications;
- Perpetual Inventory of controlled substances;
- Documentation of delivery of medication.

The parent or guardian is responsible for supplying a youth’s medication to the program for administration. The program component shall ensure that the prescribed medication is obtained from the parent/guardian within 24 hours of the scheduled prescribed time that the youth is to receive medication.

X. EXPOSURE CONTROL PLAN

Each Facility Based Community Corrections Program shall develop an abbreviated Exposure Control Plan, in accordance with the federal OSHA Standard (29 CFR 1910.1030) for the prevention or transmission of blood borne pathogens in the workplace. This plan shall be reviewed annually.

This policy shall include the following components:

- Universal Precautions;
- Personal Protective Equipment;
- Exposure Control Plan;
- Medical Contact and Follow-Up.
I. INTRODUCTION

The Children in Need of Services/Families in Need of Services (CINS/FINS) network of temporary shelters provides a continuum of health care services to support the health of youth who are temporarily displaced from their homes. These core services include physical and mental health screening and assessment with a focus on preventative health care to promote youth wellness.

- The CINS/FINS shelter’s program manager shall be responsible for assuring that the facility has established procedures for the delivery of quality health care in accordance with established Department standards.

II. PHYSICAL HEALTH SCREENING

CINS/FINS facilities shall perform a preliminary physical health screening for each youth at the time of admission to the facility. Non-health care staff conducting the admission process may perform this screening. The preliminary health screening shall include, but not be limited to, the following components:

- Current medications;
- Existing (acute and chronic) medical conditions;
- Allergies;
- Recent injuries or illnesses;
- Presence of Pain or other physical distress;
- Observation for: Evidence of illness, injury, physical distress, difficulty moving, etc.;
- Observation for: Presence of scars, tattoos or other skin markings.

III. MEDICAL EVALUATIONS AND FOLLOW-UP MEDICAL CARE

A. CINS/FINS facility shall establish written procedures to ensure medical care for youth admitted with chronic medical conditions. This shall be accomplished using a thorough referral process. Some typical chronic conditions that can be encountered in a shelter include, but are not limited to the following:

- Diabetes;
- Pregnancy;
- Seizure Disorder;
- Cardiac Disorders;
- Asthma;
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- Tuberculosis;
- Hemophilia (bleeding disorders);
- Head Injuries: occurring during the previous two weeks.

B. All procedures shall outline the mechanism for necessary follow-up medical care as required and/or needed. The parent or guardian may be actively involved in the coordination and scheduling of follow-up medical appointments. The facility shall document all medical referrals on a daily log.

IV. MEDICATION STORAGE, ACCESS, INVENTORY AND DISPOSAL

Each CINS/FINS facility shall establish procedures for the safe and secure storage, access, inventory and disposal of medications in accordance with standards set forth by the Department. (Refer to Chapter 11, Medication Management)

A. MEDICATION STORAGE

All medications shall be stored in accordance with state and federal Pharmacy regulations. Each CINS/FINS facility shall establish procedures that include the following components:

- All medications shall be stored in a separate, secure (locked) area that is inaccessible to youth (when unaccompanied by an authorized staff member);
- Oral medications shall not be stored with injectable or topical medications;
- Medications requiring refrigeration shall be stored in a secured refrigerator that is used for storage of medication only. If the refrigerator is not secure, the room must be secure and inaccessible to youth;
- Narcotics and controlled medications shall be stored behind two locks. (A locked door to a medical clinic or medical office does not constitute two locks);
- Syringes and sharps (needles, scissors, etc.) are secured. Safety needles must be in accordance with OSHA standards.

B. MEDICATION ACCESS

☑ Only designated staff delineated in writing shall have access to secured medications.
☑ Specific staff shall have limited access to controlled substances (narcotics).
☑ All medications shall be inaccessible to youth.

C. INVENTORY PROCEDURES

☑ Perpetual inventory with running balances shall be maintained on all controlled substances.
☑ Shift-to-Shift inventory counts shall be conducted and documented for controlled substances.
☑ Syringes and sharps shall be counted and documented weekly.
Over the counter medications that are accessed regularly from the clinic shall be inventoried weekly by maintaining a daily perpetual inventory.

D. MEDICATION SUPERVISION AND MONITORING

Each CINS/FINS facility shall develop procedures to facilitate the safe delivery, monitoring and supervision of medications. *(Refer to Chapter 11: Medication Management)*

V. MEDICAL AND MENTAL HEALTH ALERT(S)

A. Each CINS/FINS facility shall establish a procedure that ensures that information concerning a youth's medical condition, allergies, common side effects of prescribed medications, food and medication contraindication and other pertinent treatment information is effectively communicated to all staff via a medical alert.

B. The system shall include precautions concerning prescribed medication and medical and mental health conditions.

C. Staff shall be provided sufficient information and instructions that allow them the ability to recognize and respond to the need for emergency care and treatment as a result of the identified medical or mental health problems.

VI. EMERGENCY MEDICAL AND DENTAL CARE

A. Each CINS/FINS facility shall develop procedures that facilitate the provision of emergency medical and dental care. These procedures shall include, but not be limited to the following components:

- Obtaining off-site emergency services;
- Parental Notification;
- Development and implementation of daily log.

B. All staff shall be trained on emergency medical procedures and know that it is each staff member’s responsibility to call 911 when a youth’s condition is compromised.

VII. HEALTH EDUCATION (Refer to Chapter 16: Health Education)

Each youth shall receive health education while residing in a CINS/FINS facility. The education can include, but not be limited to, the following topics:

- Accident Prevention;
- Alcohol and Substance Abuse (General Information);
- Anxiety Reduction;
- Breast Self-Exam;
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☑ Cardiovascular Health/Physical Fitness;
☑ Chronic Disease (If Applicable);
☑ Coping with Anger;
☑ Coping with Depression;
☑ Dental Hygiene;
☑ Family Planning;
☑ General Information on Prevention of Alcohol, Nicotine Products and Substance Abuse;
☑ HIV/AIDS (General Information);
☑ Medication Instruction (If Applicable);
☑ Nutrition Basics;
☑ Parenting Skills;
☑ Personal Hygiene;
☑ Pregnancy Prenatal and Postnatal Care;
☑ Prevention of Communicable Diseases (TB, MRSA);
☑ Sexually Transmitted Disease Prevention;
☑ Smoking Cessation;
☑ Testicular Self-Exam.
I. INTRODUCTION

Youth with developmental disabilities face enormous obstacles in seeking even basic health care. Unfortunately, societal misconceptions of developmental disabilities, even by many health care providers, contribute to this phenomenon. Too few health care practitioners receive sufficient training in treating persons with developmental disabilities. Even those with appropriate training find that our current system offers few incentives to ensure appropriate health care for children and adults with special needs. Thus, individuals with developmental disabilities are more likely to receive inappropriate and inadequate treatment, or be denied health care altogether. Children and young adults with developmental disabilities receive fewer routine health examinations, fewer immunizations, less mental health care and less prophylactic dental care. Those with communication difficulties are especially at greater risk for poor nutrition, overmedication, injury, and abuse.

Although there is a relatively small subset of DJJ youth with developmental disabilities, the Department of Juvenile Justice strives to provide health care to meet the needs of adolescents with developmental disabilities. This chapter describes the fundamentals of health care delivery to youth with developmental disabilities.

Chapter 393.063(10) and (38) F.S. define “developmental disability” as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida or Prader Willi syndrome and that constitutes a substantial handicap that can be expected to continue indefinitely. “Retardation” is defined as a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the period from conception to age 18.

Youth with developmental disabilities may require specific health care to address and support their psychological and physical development process, while fostering relationships in the context of a safe and nurturing environment. The goal of health care delivery to youth with developmental disabilities is to reflect an understanding of their particular developmental needs in the context of their specific medical issues.

While there are developmental similarities among youth, there are unique issues specific to the youth with a developmental disability. These differences must be considered when providing mental and medical health care treatment in the detention centers and residential commitment programs.
II. BASIC PRINCIPLES

A. All detention centers and residential commitment programs need to provide effective health care and services to youth with developmental disabilities. Facility operating procedures shall reflect an understanding of the specific health care issues of the adolescent with developmental disabilities. These youth may have special needs and require close medical supervision or multidisciplinary care. These procedures shall include:

- Training of all staff so they are knowledgeable about youth with developmental disabilities, as well as the identifiable risk factors associated with these youth.
- Individualized treatment plans to meet the mental and medical health care needs of each youth with a developmental disability.

B. Youth with developmental disabilities shall receive equivalent preventative, gender and age related, health care services while residing in a detention center or residential commitment program. State owned and operated DJJ facilities and contract health care providers shall work together to develop treatment plans that incorporate gender, age and cognitively appropriate components in mental and medical health care and treatment. These treatment plans should serve youth with significantly sub-average general intellectual functioning coupled with deficits in adaptive behavior, and should reflect the individual youth’s needs. The treatment plan is individualized, multidisciplinary, and based on an assessment of the youth’s needs. When clinically indicated, the treatment plan should give youth access to the range of supportive and rehabilitative services (such as physical therapy, individual or group counseling, independent living skills training and vocational training) that the treating clinician deems appropriate.

C. Individual treatment plans for the developmentally disabled may focus on assisting the youth to cope with the correctional environment as well as alerting staff to the special needs of the juvenile. In addition, the treatment plan will be individualized to the needs of the patient and include the following as applicable:

1. Diet
2. Exercise
3. Special Medication Administration Requirements
4. Laboratory and other diagnostic monitoring
5. Frequency of follow-up visits
6. Youth education

D. Developmental disabilities may have implications for health education, informed consent and the manner in which the youth may perceive and respond to verbal communication from facility staff. Youth with intellectual limitations can easily become victims in a correctional environment and may need special housing arrangements.
III. IDENTIFICATION OF YOUTH WITH DEVELOPMENTAL DISABILITIES

A. Because of their cognitive limitations, youth with developmental disabilities are likely to have difficulty understanding rules, following directions and adapting in the correctional setting. Early identification of youth with developmental disabilities is critical to providing appropriate care and access to needed services.

B. Staff must be cognizant of information and behaviors, which suggest developmental disabilities such as:

1. A psychological or mental health evaluation that indicates an IQ below 70.
2. School records which indicate exceptional education classes, particularly Educable Mentally Handicapped (EMH) classes, Trainable Mentally Handicapped (TMH) classes or Profoundly Mentally Handicapped (PMH) classes;
3. The youth has difficulty understanding and answering questions;
4. The youth has difficulty understanding and following directions; or
5. The youth’s abilities appear far below other youths his/her age.

Note: Youths classified by the school system or psychological testing as Profoundly Mentally Handicapped (PMH) or Trainable Mentally Handicapped (TMH) must be immediately brought to the attention of the facility superintendent or program director or designee and placed on constant supervision. (See “Severe Developmental Disabilities” paragraph below.)

C. All facilities shall have procedures in place to address youth identified as possibly having developmental disabilities so that they are brought to the attention of the facility superintendent, program director or designee and referred to the mental health and medical staff to determine the youth’s cognitive functioning, treatment needs, safety or security risks.

D. Severe Developmental Disabilities: All facilities and programs shall have procedures in place for youth identified as possibly having severe developmental disabilities so that they are immediately brought to the attention of the facility superintendent, program director or designee and placed on constant supervision in the DJJ facility or program. Youth identified as having a severe developmental disability should also be brought to the attention of the DJJ regional counsel if they are not already aware.

Severe developmental disabilities are suggested when, the youth:

- Lacks basic survival and self-care skills;
- Is dependent on others to assist with personal care;
- Is at risk of harm to self or others.
IV. THE ADMISSION SCREENING PROCESS FOR YOUTH WITH DEVELOPMENTAL DISABILITIES (Refer to Chapter 3: Admission Process)

A. The Medical and Mental Health screening (Detention) and The Facility Entry Physical Health Screening (Residential Programs) is a process of structured inquiry and observation designed to determine if a newly arrived youth has an acute injury or illness, a chronic condition or a disability, in order to then provide the necessary care or services. In detention facilities this screening is to be performed by using the Medical and Mental Health Admission Screening form found on the Detention Facilities Management System (DFMS) Wizard, in residential commitment programs, this screening shall be performed using the Facility Entry Physical Health Screening (FEPHS) form. The admission screening should be conducted in a manner that accommodates the needs of those with physical (e.g., speech, hearing, visual) or mental disabilities. Youth with developmental disabilities are often unable to give complete or accurate information in response to health status inquiries. Therefore, it is imperative to utilize information gathered from other resources (parent/legal guardian, JPO, previous records, etc.) and communicates with the youth in a manner that is non-threatening and easy to interpret.

B. During the Admission Screening Process, medical staff are to make efforts to explore potential risk for suicide. Depending upon the youth’s cognitive ability and symptom severity, some of the typical manifestations of the disability may be misinterpreted as signs of depression or suicidal intent.

C. These signs/symptoms may include:

- Communication difficulties
- Speech and posture irregularities
- Impaired level of consciousness
- Disorganization and memory defects
- Neglect of physical health
- Neglect of personal hygiene
- Agitation

Note: Refer to the Mental Health and Substance Abuse Services Manual (Revised August 2006) for complete information on screening for suicidal ideation.

Youth with developmental disabilities may respond adversely to the admission screening. Physical and emotional trauma can be minimized and the effectiveness of the initial evaluation enhanced by utilizing some of the components listed below:

- Minimize environmental noise (e.g., intercom pages, loud music).
- Explain to the youth what is being done.
- Include the youth in the decision-making process as much as possible.
- Plan ahead for how to cope with potentially challenging behaviors.
V. COMMUNICATION ON PATIENTS WITH DEVELOPMENTAL DISABILITY

A. Communication shall occur between the treating health care staff and the facility administration regarding any youth’s significant health and disability needs that must be considered in all decisions, in order to preserve the health and safety of that youth, other youths and staff. Clear communication is imperative to ensure that facility administration, custody staff, mental health professionals and other facility workers are aware of the special needs and any limitations they must accommodate.

B. Medical or mental health problems may complicate housing assignments, work assignments, program assignments, disciplinary management, or transfers to another facility. Communication shall be documented in the youth’s Individual Health Care Record and must follow the protocol below and contain the following elements:

1. Medical Alerts will be entered into the facility alert system to ensure that the appropriate personnel are notified.

2. All staff at the facility or program are advised of the youths special needs that may affect housing, work, and program assignments; disciplinary measures; and admissions to and transfers from institutions.

VI. SPECIALIZED MEDICAL SERVICES

Each DJJ detention facility superintendent and residential commitment program director in conjunction with the Designated Health Authority or Physician Designee shall be responsible for ensuring that facility procedures are in place to provide all necessary medical services to the youth with developmental disabilities. These shall include the same services as those provided to youth in the general population.

A. NUTRITION

The licensed professional health care staff shall provide routine monitoring of the youth’s nutritional and weight status during their custody. Nutrition education shall also be provided.

B. HEALTH PROMOTION

As with other populations, health promotion and disease prevention are multifactorial for youth with developmental disabilities. They need to be empowered with adequate and understandable information and reinforcement to avoid health risks and maintain healthy personal habits. Due to the potential for modeling behaviors, health promoting knowledge and habits of health care providers provide a tertiary method of instruction.
C. AFTER CARE PLANNING

To reduce the risk of recidivism and increase the potential for positive outcomes, DJJ facilities shall plan as far in advance as possible for the release of youth with developmental disabilities. This shall include collaboration with existing community agencies and organizations to provide youth with developmental disabilities with goal-setting activities, extensive planning, guidance, follow-up and community support.

Prior to the release of the youth, health care staff will review the medical record and determine the need for:

- After care referral
- Notification of health department or other service providers
- Medication requirements

Necessary actions and referrals will be documented in the Individual Health Care Record. All actions accomplished will be shared with the youth, parent or guardian, JPO, or person assuming custody of the discharging youth. Youth who are transitioning to the community should be referred to the Agency for Persons with Disabilities for appropriate developmental disabilities services.

VII. Common Behaviors, Triggers, Co-morbid Ailments and Important Topics on Youth with Developmental Disabilities

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Medical Phenotypes of Specific Disorders in Persons with Developmental Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disorder</strong></td>
<td><strong>Possible Medical Phenotypic Expression</strong></td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>Gastrointestinal: drooling, swallowing disorders</td>
</tr>
<tr>
<td></td>
<td>Neuromusculoskeletal: chronic pain (lumbosacral, hip, leg), muscle spasticity, seizures, osteoporosis, scoliosis</td>
</tr>
<tr>
<td></td>
<td>Pulmonary: recurrent infections secondary to aspiration</td>
</tr>
<tr>
<td></td>
<td>Urinary: incontinence</td>
</tr>
<tr>
<td>Cri du chat syndrome</td>
<td>Cardiac: ventricular and atrial septal defects</td>
</tr>
<tr>
<td></td>
<td>Orthopedic: scoliosis</td>
</tr>
<tr>
<td></td>
<td>Pulmonary: recurrent upper respiratory infection with otitis media</td>
</tr>
<tr>
<td>Down syndrome</td>
<td>Cardiac: adults without apparent congenital heart disease may have valvular disease including mitral valve prolapse and aortic regurgitation</td>
</tr>
<tr>
<td></td>
<td>Dermatologic: seborrheic dermatitis of scalp and face, eczema of hands and feet, tinea infections including onychomycosis</td>
</tr>
<tr>
<td></td>
<td>Endocrine/metabolic: hypothyroidism, diabetes, obesity</td>
</tr>
<tr>
<td></td>
<td>ENT: recurring cerumen impactions, hearing loss, upper airway obstruction, obstructive sleep apnea</td>
</tr>
<tr>
<td>Condition</td>
<td>Gastrointestinal: GERD, often with Schatzki's ring and Barrett's esophagus, celiac disease</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Neurologic: dementia, seizures</td>
</tr>
<tr>
<td></td>
<td>Ophthalmic: strabismus, cataracts, decreased visual acuity</td>
</tr>
<tr>
<td></td>
<td>Orthopedic: atlantoaxial instability, patellar subluxation, hip disease, osteoporosis</td>
</tr>
<tr>
<td>Neurofibromatosis</td>
<td>Cancer: neurofibrosarcoma</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular: hypertension</td>
</tr>
<tr>
<td></td>
<td>Neurologic: tumors may develop in the brain, on cranial nerves, or on the spinal cord</td>
</tr>
<tr>
<td></td>
<td>Orthopedic: enlargement and deformation of bones, scoliosis</td>
</tr>
<tr>
<td>Prader-Willi syndrome</td>
<td>Dermatologic: leg edema or ulceration, lesions on head and anterior legs from skin picking</td>
</tr>
<tr>
<td></td>
<td>ENT: obstructive sleep apnea</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal: gastroparesis, acute idiopathic gastric dilatation</td>
</tr>
<tr>
<td></td>
<td>Metabolic: insulin resistance, hyperlipidemia, hypertension, growth hormone deficiency, water intoxication, obesity</td>
</tr>
<tr>
<td></td>
<td>Neurologic: exaggerated responses to standard dosages of anesthetic and sedative agents</td>
</tr>
<tr>
<td></td>
<td>Orthopedic: scoliosis, osteoporosis</td>
</tr>
<tr>
<td>Rett syndrome</td>
<td>Cardio respiratory: prolonged QT interval, episodic apnea or hyperpnea</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal: drooling, GERD, swallowing difficulties caused by oropharyngeal and gastro esophageal incoordination, constipation with functional megacolon, gallbladder dysfunction</td>
</tr>
<tr>
<td></td>
<td>Neuromusculoskeletal: seizures, gait apraxia and truncal ataxia, scoliosis, osteoporosis</td>
</tr>
<tr>
<td>Tuberous sclerosis</td>
<td>Cardiac: congestive heart failure, hypertension</td>
</tr>
<tr>
<td></td>
<td>Dermatologic: facial, ungual angiofibromas</td>
</tr>
<tr>
<td></td>
<td>Neurologic: seizures, obstructive hydrocephalus</td>
</tr>
<tr>
<td></td>
<td>Ophthalmic: retinal hamartomas or phakomas</td>
</tr>
<tr>
<td></td>
<td>Orthopedic: cystic defects in the metacarpals, metatarsals, or phalanges; erosions of the tufts of the distal phalanges</td>
</tr>
<tr>
<td></td>
<td>Pulmonary: fibrosis, pneumothorax</td>
</tr>
</tbody>
</table>

*ENT = ear, nose, and throat; GERD = gastroesophageal reflux disease.*
### TABLE 2

**Behavioral Phenotypes of Specific Disorders in Persons with Developmental Disabilities**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Behavioral Phenotype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angelman's syndrome</td>
<td>Absence of speech but with paroxysmal laughter and smiling; fascination with water; sleep disturbance</td>
</tr>
<tr>
<td>Prader-Willi syndrome</td>
<td>Obesity, food-seeking and food-hoarding behaviors; antisocial with temper tantrums; obsessive-compulsive features such as skin picking, ordering impulsivity; labile affect; psychosis; sleep disturbance</td>
</tr>
<tr>
<td>Williams syndrome</td>
<td>Overly friendly and highly sensitive to rejection; impulsivity; incessant chatter; fearful and worrisome; has few friends</td>
</tr>
<tr>
<td>Fetal alcohol syndrome</td>
<td>ADHD; inappropriate sexual behavior and sexually offending behaviors (e.g., touching, incest); substance abuse; anxiety disorders, depression, mania; sleep disorders; aggression, conduct disorders, oppositional defiant disorders, adjustment disorders; visual-motor/visuospatial coordination deficits; speech/language impairments</td>
</tr>
<tr>
<td>Down syndrome</td>
<td>Depression; obsessional slowness; obsessive-compulsive disorder; autism; dementia after 50 years of age</td>
</tr>
<tr>
<td>Rett syndrome</td>
<td>Repeated movements, hand stereotypy, facial twitches; social interaction (autistic-relating) problems; mood disturbance, fear, anxiety; insomnia; autistic behaviors</td>
</tr>
<tr>
<td>Fragile X syndrome</td>
<td>Hyperarousal, anxiety, ADHD, aggression, autism</td>
</tr>
<tr>
<td>Phenylketonuria</td>
<td>Autism, ADHD, agoraphobia</td>
</tr>
</tbody>
</table>

### TABLE 3

**Triggers for Challenging Behavior in Persons with Developmental Disabilities**

<table>
<thead>
<tr>
<th>Type of Stressor</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional phase</td>
<td>Change of teacher or residence; adolescence; retirement of patient</td>
</tr>
<tr>
<td>Interpersonal loss or rejection</td>
<td>Loss of parent, job, romantic partner</td>
</tr>
<tr>
<td>Environmental</td>
<td>Stress at group home or day program</td>
</tr>
<tr>
<td>Family, social support problems</td>
<td>Neglect from family, friends, caregivers; abuse</td>
</tr>
<tr>
<td>Medical or psychiatric illness</td>
<td>Tooth pain; depression</td>
</tr>
<tr>
<td>Anger, frustration</td>
<td>Being teased; inability to complete tasks</td>
</tr>
</tbody>
</table>
# TABLE 4

**Topics to Address Regarding Relationships, Sexuality, and Protection from Harm in Persons with Developmental Disabilities**

**Protection from harm**
- Alcohol and drug use
- Physical, emotional, and sexual abuse
- Pregnancy
- Sexually transmitted diseases

**Relationship development**
- Respecting the boundaries of other persons
- Setting boundaries

**Sexuality**
- Appropriate and inappropriate behaviors
- Appropriate and inappropriate dress
- Appropriate and inappropriate places for behavior (e.g., masturbation)
APPENDIX A: FORMS

The forms located in the forms appendix are italicized throughout the chapters of this manual.

All forms will be available on the Department of Juvenile Justice, Office of Health Services web-site link a [www.djj.state.fl.us](http://www.djj.state.fl.us), as well as in the Forms Library.

Required forms are listed in bold and only available in a PDF version.

However, recommended forms are available as samples in a Microsoft Word version. These forms may be altered to meet the specific needs of each department facility or program.
<table>
<thead>
<tr>
<th>NUMBER</th>
<th>FORM NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Acknowledgement of Receipt of Clinical Psychotropic Progress Note (Required)</td>
</tr>
<tr>
<td>002</td>
<td>Authority for Evaluation and Treatment (Required)</td>
</tr>
<tr>
<td>004</td>
<td>Chronic Physical Health Conditions Roster</td>
</tr>
<tr>
<td>005</td>
<td>Custody of Health Care Record (Required)</td>
</tr>
<tr>
<td>006</td>
<td>Clinical Psychotropic Progress Note (Required)</td>
</tr>
<tr>
<td>007</td>
<td>Comprehensive Physical Assessment (Required)</td>
</tr>
<tr>
<td>008</td>
<td>Controlled Medication Inventory Record (This or the pre-printed pharmacy form is Required)</td>
</tr>
<tr>
<td>008</td>
<td>Controlled Medication Inventory Record – Without Automatic Medication Calculations</td>
</tr>
<tr>
<td>009</td>
<td>Episodic Care (First Aid/Emergency) Care Log</td>
</tr>
<tr>
<td>010</td>
<td>Facility Entry Physical Health Screening (Required)</td>
</tr>
<tr>
<td>011</td>
<td>Guidelines for Obtaining Parental Signature on the AET</td>
</tr>
<tr>
<td>012</td>
<td>Health Discharge Summary – Transfer Note (Required)</td>
</tr>
<tr>
<td>013</td>
<td>Health Education Record (Required)</td>
</tr>
<tr>
<td>014</td>
<td>Health Related History (Required)</td>
</tr>
<tr>
<td>015</td>
<td>HIV Youth Consent</td>
</tr>
<tr>
<td>016</td>
<td>Immunization Tracking Record (This or a Dept. of Health/ Education equivalent is Required)</td>
</tr>
<tr>
<td>017</td>
<td>Individual Health Care Record Checklist and Internal Quality Control (Required)</td>
</tr>
<tr>
<td>018</td>
<td>Infectious and Communicable Disease Form (Required)</td>
</tr>
<tr>
<td>019</td>
<td>Medication Administration Record (Required)</td>
</tr>
<tr>
<td>020</td>
<td>Parental Notification of Health Related Care: General (Required)</td>
</tr>
<tr>
<td>021</td>
<td>Parental Notification of Health Related Care: Medications (Required)</td>
</tr>
<tr>
<td>022</td>
<td>Parental Notification of Health Related Care: Vaccinations/Immunizations (Required)</td>
</tr>
<tr>
<td>023</td>
<td>Personal and Health Related Information (Required)</td>
</tr>
<tr>
<td>024</td>
<td>Practitioner’s Orders</td>
</tr>
<tr>
<td>025</td>
<td>Prescription Medication Verification Checklist</td>
</tr>
<tr>
<td>026</td>
<td>Problem List (Required)</td>
</tr>
<tr>
<td>027</td>
<td>Refusal of Treatment Form</td>
</tr>
<tr>
<td>028</td>
<td>Request For Parent/Guardian Signature on The Authority for Evaluation and Treatment</td>
</tr>
<tr>
<td>029</td>
<td>Sexually Transmitted Disease Screening Form (Required)</td>
</tr>
<tr>
<td>030</td>
<td>Sick Call Index (Required)</td>
</tr>
<tr>
<td>031</td>
<td>Sick Call/Referral Log (Required)</td>
</tr>
<tr>
<td>032</td>
<td>Sick Call Request (Required)</td>
</tr>
<tr>
<td>033</td>
<td>Summary of Off-Site Care Consultation Report (Required)</td>
</tr>
<tr>
<td>034</td>
<td>Treatment Flow Sheet: Asthma</td>
</tr>
<tr>
<td>035</td>
<td>Treatment Flow Sheet: Diabetes</td>
</tr>
<tr>
<td>036</td>
<td>Treatment Flow Sheet: General</td>
</tr>
<tr>
<td>037</td>
<td>Treatment Flow Sheet: Hypertension</td>
</tr>
<tr>
<td>038</td>
<td>Treatment Flow Sheet: Seizure Disorder</td>
</tr>
<tr>
<td>039</td>
<td>Treatment Flow Sheet: Tuberculosis / INH Therapy</td>
</tr>
<tr>
<td>040</td>
<td>Treatment Plan: Asthma</td>
</tr>
<tr>
<td>041</td>
<td>Treatment Plan: Diabetes</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>042</td>
<td>Treatment Plan: General Medical</td>
</tr>
<tr>
<td>043</td>
<td>Treatment Plan: Hypertension</td>
</tr>
<tr>
<td>044</td>
<td>Treatment Plan: Seizure Disorder</td>
</tr>
<tr>
<td>045</td>
<td>Treatment Plan: Tuberculosis/INH Therapy</td>
</tr>
<tr>
<td>046</td>
<td>Tuberculosis Testing Log</td>
</tr>
<tr>
<td>047</td>
<td>Male Body Diagram (Required)</td>
</tr>
<tr>
<td>048</td>
<td>Female Body Diagram (Required)</td>
</tr>
<tr>
<td>049</td>
<td>Report of On-Site Health Care by Non-Health Care Staff</td>
</tr>
<tr>
<td>050</td>
<td>Oral Health Assessment Form (Required)</td>
</tr>
<tr>
<td>051</td>
<td>Probation Medical and Mental Health Clearance Form (Required)</td>
</tr>
<tr>
<td>052</td>
<td>Additional Reviews to Comprehensive Physical Assessment</td>
</tr>
<tr>
<td>053</td>
<td>(STOP) Medical Receipt, Transfer &amp; Disposition Form (Required)</td>
</tr>
<tr>
<td>054</td>
<td>(STOP) Non-Licensed Staff Medication Record (For Youth During Transport) (Required)</td>
</tr>
<tr>
<td>055</td>
<td>(STOP) Youth Transport Card (Required)</td>
</tr>
</tbody>
</table>
INTRODUCTION TO GLOSSARY

The continuum of health care services in the Department of Juvenile Justice affects a wide range of staff and clinicians who have varying experiences in and understanding of health care issues and information. The terminology used in this manual may be unfamiliar to some readers. The definitions used in this manual were derived from multiple professional references, statutes, rules and regulations, or in certain instances developed specifically for the Department. For clarification and to facilitate understanding, the terms in this manual are defined below.

Acknowledgement of Receipt of CPPN (AOR): The cover letter which accompanies a copy of the 3rd page of the Clinical Psychotropic Progress Note (CPPN), or provider note, both of which are mailed to the parent/guardian whenever a youth’s psychotropic medication regimen changes, in accordance with applicable DJJ requirements. The parent/guardian is to sign the AOR and mail it back to the facility.

Administration: The act of giving medication.

Administrative Component: An operational or managerial requirement, specification, procedure, position or function that promotes and facilitates the delivery of clinical health services to youth in a DJJ detention center and/or residential commitment program. For purposes of this manual, the term applies to the following four (4) components: (1) designated health authority; (2) service agreements; (3) health care provider credentialing process and, (4) interdisciplinary risk reduction processes.

Adolescence: The period of life which begins in puberty and ends with completed growth.

Adrenal Insufficiency: Reduced adrenocortical function.

Advanced Registered Nurse Practitioner (ARNP): Individuals licensed by the State of Florida per Ch. 464, Florida Statutes, to practice professional nursing and certified in advanced or specialized nursing practice. The advanced registered nurse practitioner may perform acts of treatment, prescription, and operation that are identified and approved as specified in Ch. 464, Florida Statutes.

Adverse Drug Event, Actual: An unfavorable or antagonistic result of medication administration and/or ingestion.

Adverse Drug Event, Potential: A situation in which there is a possibility for an unfavorable or antagonistic result of medication administration and/or ingestion.

AIDS: A disease of the immune system characterized by increased susceptibility to opportunistic infections, as pneumocystis carinii pneumonia and candidiasis, to certain
cancers, as Kaposi's sarcoma, and to neurological disorders: caused by a retrovirus and transmitted chiefly through blood or blood products that enter the body's bloodstream, especially by sexual contact or contaminated hypodermic needles.

**AIDS Virus:** A variable retrovirus that invades and inactivates helper T cells of the immune system and is a cause of AIDS and AIDS-related complex.

**Airborne Infection Isolation Rooms (All Rooms):** A single-occupancy patient-care room used to isolate person with suspected or confirmed infectious TB disease. Environmental factors are controlled in All rooms to minimize the transmission of infectious agents that typically are spread from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids.

**Alert:** Mentally responsive and perceptive; quick.

**Alert System:** A facility's system, which will alert staff when mental health, medical or security issues exist which may affect the security and safety of the program. This system is intended as a tool for staff to use in making treatment, security and safety decisions as they relate to youth behavior, but will not provide detailed information about the conditions that resulted in the youth being identified for inclusion in the alert system.

**Allergy:** An altered bodily reaction to an antigen in response to an exposure; exaggerated or pathological reaction (as by sneezing, respiratory embarrassment, itching, or skin rashes) to substances, situations, or physical states that are without comparable effect on the average individual.

**Anaphylaxis:** A severe, sometimes life-threatening, allergic reaction that occurs within minutes of exposure an allergy-causing substance (allergen). Anaphylaxis also is called anaphylactic shock.

**Anorexia Nervosa:** An eating disorder usually occurring in young women, characterized by fear of becoming obese, a persistent aversion to food, and severe weight loss, often causing amenorrhea and other physiological changes.

**Anti-Tuberculosis Medications:** Any medication administered either to prevent the development of active tuberculosis in an individual, or to treat active infectious tuberculosis.

**Arrhythmia:** Any disorder of the normal heart rate or rhythm.

**Assisted Self-Administration:** A highly structured procedure in which a staff member facilitates the safe delivery, supervision, and oversight, of an appropriately prescribed medication to a youth with the youth’s active participation during the medication administration process. This term is not to be confused with actual self-administration by a youth.
Asthma: A chronic lung disorder that is marked by recurring episodes of airway obstruction (as from bronchospasm) manifested by labored breathing accompanied especially by wheezing and coughing and by a sense of constriction in the chest, and that is triggered by hyperreactivity to various stimuli (as allergens or rapid change in air temperature.)

Auditory: Related to hearing.

Authority for Evaluation and Treatment (AET): The document that, when signed by a parent or guardian gives the Department the authority to assume responsibility for the provision of necessary and appropriate physical and mental health care to a youth in the Department’s physical custody, in most circumstances.

Automated External Defibrillator: An electronic device that administers an electric shock of preset voltage to the heart through the chest wall in an attempt to restore the normal rhythm of the heart during ventricular fibrillation.

Baker Act: The Florida statute governing mental health services is Chapter 394, which is known as the Florida Mental Health Act or Baker Act (named after Maxine Baker, former State representative from Miami who sponsored the Act). The “Baker Act” provides Florida law covering voluntary and involuntary mental health examination and placement for persons with mental illness.

Body Mass Index (BMI): A key index for relating a person’s body weight to their height. The body mass index (BMI) is a person’s weight in kilograms (Kg) divided by the height in meters (m) squared.

Bulimia: A serious eating disorder that occurs predominately in females and is characterized by compulsive overeating usually followed by self-induced vomiting or laxative or diuretic abuse.

Cancer: General term frequently used to indicate any of various types of malignant neoplasms, most of which invade surrounding tissues and may metastasize to several sites.

Chronic Health Condition: Any illness, disability, or condition that, at the time of its diagnosis or during its expected course will produce one or more of the following current or future long-term sequelae: limitation of age-appropriate functions; dependence on medication or special diet for control of condition; dependency on medical technology for functioning; need for more medical care or related services than usual for the child’s age; special ongoing treatments at home or in school; or, disfigurement. For purposes of this manual, a “chronic condition” is permanent, or is reasonably believed to be permanent, or is a condition that lasts 3 months or more.
Clinical Psychotropic Progress Note (CPPN): A standard departmental form, which is utilized by the prescribing practitioner to document treatment in instances involving psychotropic medication.

Cognitive: Of or pertaining to the mental processes of perception, memory, judgment, and reasoning, as contrasted with emotional and volitional processes; conscious intellectual activity (as thinking, reasoning, or remembering).

Communicable: Capable of being transmitted from person to person, animal to animal, animal to human, or human to animal.

Comprehensive Physical Assessment (CPA): This form documents a comprehensive physical assessment (exam) performed by a physician (MD), osteopathic physician (DO), physician's assistant (PA), or advanced registered nurse practitioner (ARNP). The purpose of this assessment is the establishment of a data point which is used to facilitate the following: (1) identification and treatment of acute, chronic, and functional medical and dental problems; (2) promotion of growth and development; (3) prevention of communicable diseases; and, (4) provision of health education. The comprehensive physical assessment is not conducted at each admission, but only at specified intervals.

Congenital: Existing at birth, referring to certain mental or physical traits, anomalies, malformations, diseases, etc. which may be either hereditary or due to an influence occurring during gestation up to the moment of birth.

Congenital Heart Diseases: An abnormal organic condition of the heart or of the heart and circulation existing at birth.

Consciousness: Full activity of the mind and senses, as in waking life (as that to which one returns after sleep, fever, etc.) in which one's normal mental functions are present.

Contagious: Communicable by contact; capable of being transmitted by bodily contact with an infected person or object; carrying or spreading a contagious disease; tending to spread from person to person.

Controlled Substance: Drugs that come under the jurisdiction of the Federal Controlled Substances Act. They are divided into five schedules (I through V). Requirements of the Controlled Substances Act and a list of controlled drugs can be obtained from any office of the Drug Enforcement Administration (DEA). For purposes of this manual, the term controlled substance may also be used to describe any substance or object which a facility superintendent or program administrator has determined to be controlled, due to its potential for abuse or risk in the setting of a DJJ facility.

Core Health Profile: A section of the individual health care record, which contains standardized forms that are filed in designated sub-sections of the Individual Health Care Record (IHCR).
Cystic Fibrosis: A hereditary disease prevalent especially in Caucasian populations that appears usually in early childhood, involves functional disorder of the exocrine glands, and is marked especially by faulty digestion due to a deficiency of pancreatic enzymes, by difficulty in breathing due to mucus accumulation in airways, and by excessive loss of salt in the sweat.

Designated Health Authority: The individual that is responsible for the provision of necessary and appropriate health care to youth in the physical custody of a detention center or residential commitment program. Individual Designated Health Authorities must be a physician (MD) or osteopathic physician (DO) who holds a clear and active license (pursuant to Chapter 458 or 459, Florida Statutes, respectively) and meet all requirements to practice independently in the State of Florida.

Designated Mental Health Authority: The Designated Mental Health Authority is a licensed mental health professional (a psychiatrist licensed pursuant to Chapter 458 or 459, F.S., psychologist licensed pursuant to Chapter 490, F.S., mental health counselor, clinical social worker, or family therapist licensed pursuant to Chapter 491, F.S., or psychiatric nurse as defined in Section 394.455(23), F.S.) who, through employment or contract, is designated as accountable to the facility superintendent for ensuring appropriate coordination and implementation of mental health services in each departmental facility with an operating capacity of 100 or more youths.

Designee: An individual delegated the responsibilities of another. For the purposes of this manual, the Designated Health Authority can delegate responsibility for clinical services to another physician, a PA or ARNP. In addition, a facility superintendent or program director can delegate their responsibilities to another qualified individual.

Developmental Disability: A cognitive, emotional, or physical impairment, especially one related to abnormal sensory or motor development that appears in infancy or childhood and involves a failure or delay in progressing through the normal developmental stages of childhood. Under Florida law, a “developmental disability” means a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida or Prader Willi syndrome and that constitutes a substantial handicap that can be expected to continue indefinitely.

Diabetes: A disorder of carbohydrate metabolism, usually occurring in genetically predisposed individuals, characterized by inadequate production or utilization of insulin and resulting in excessive amounts of glucose in the blood and urine, excessive thirst, weight loss, and in some cases progressive destruction of small blood vessels leading to such complications as infections of the limbs or blindness.

Direct Supervision: The physical presence of a qualified licensed health care provider responsible for the supervision of another licensed health care professional or non-licensed staff member providing health related services.
**Endocrinologist:** A physician who specializes in the diagnosis and treatment of conditions affecting the endocrine system (e.g., diabetes, thyroid disorders, etc.).

**Endodontics:** The branch of dentistry dealing with the cause, diagnosis, prevention, and treatment of diseases of the dental pulp; including root canal therapy.

**Epinephrine (Epi-pen or Epi-pen Jr.):** A medication that is commonly administered to an individual in response to a severe allergic reaction or anaphylaxis.

**Episodic Care:** One of the mandatory components of care, this component includes basic first aid care and/or emergency care in response to unexpected illnesses, accidents, or conditions of a nature which require immediate attention or which require an immediate professional assessment to determine their severity. Although some episodes of episodic care are easily recognized, emergency care also refers to health care received in response to unexpected injuries or accidents, including those which require immediate transfer to a hospital and those which do not necessarily require transfer (for example, a sprained ankle). Episodic care also includes responses to those complaints, which can result in severe pain or suffering, even if the youth's life does not appear to be in danger. Severe pain, including dental pain, requires an emergency response, as do conditions in which the severity of the illness or injury is unknown. Episodic care must also be provided for unexpected mental health illnesses or conditions of a nature that require immediate attention or which require an immediate professional assessment to determine their severity.

**Exempt:** To free from an obligation or liability to which others are subject.

**Facility Entry Physical Health Screening (FEPHS):** A standardized initial health screening, conducted at the time of a youth’s admission or re-admission to each secure detention center and residential commitment program. The purpose of this screening is to ensure that the youth has no immediate health conditions or medical needs that require emergency services.

**First Aid Care:** A type of episodic health care that may be delivered on-site to a youth for an unexpected or unscheduled illnesses or injuries. First Aid care is the immediate and temporary treatment of a youth experiencing sudden illness or injury while awaiting the arrival of medical aid. The essentials of first aid treatment include bandaging of wounds, splinting for fractures and dislocations, cardiopulmonary resuscitation (CPR), and treatment of shock, fainting, bites, stings, burns, heat illness and frostbite.

**Focused Medical Evaluation:** A brief evaluation or assessment of a youth’s specific complaint or follow-up of a youth’s complaint or status by a physician (MD), osteopathic physician (DO), advanced registered nurse practitioner (ARNP) or physician’s assistant (PA).
Glaucoma: A disease of the eye marked by increased pressure within the eyeball that can result in damage to the optic disk and gradual loss of vision.

Glucagon: A synthetic injectable glucose elevating medication used to increase the blood glucose level in severe hypoglycemia (low blood sugar). Glucagon is used for emergency treatment of insulin-induced hypoglycemia (insulin shock).

Gynecologist: A physician specializing in branch of medicine that deals with the diseases and routine physical care of the reproductive system of women.

Head Injuries, Head Trauma: Harm or damage that is sustained to the head.

Health Care Paraprofessional: Certified nursing assistants, certified nursing technicians, emergency medical technicians (EMTs) and paramedics.

Health Care Professional: Physicians, Physician Assistants, Advanced Registered Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses.

Health Care Provider Credentialing Process: A process to be used by the DJJ entity responsible for hiring or contracting for health care providers, whether on-site or off-site. This process is required for DJJ employees, for independent fee-for-service providers, and for health care providers who render health care services subject to contracts with medical providers who have contracts with the Department. In the last instance, the contracting health care agency (who has the contract with the Department) or company is responsible for conducting the credentialing process on its individual providers and providers secured through separate contracts it negotiates and making the verification available to the DJJ entity that is responsible oversight of the main contract, should such verification be desired.

Health Care Staff (See Health Care Professionals): Individuals responsible for the delivery of health care to the youth in detention centers or a residential program. They may be licensed independent contractors or trained employees of the Department of Juvenile Justice.

Health Related History (HRH): A standardized, comprehensive medical and health-related questionnaire.

Health Care Delivery System: A systematic process for the delivery of health care to youth in detention centers or residential commitment programs.

Health Transfer Packet: The packet that contains all of the health related information of a youth who is in the custody of the Department of Juvenile Justice and is being transferred from one facility to another.

Heat Index: The temperature the body feels when heat and humidity are combined.
Hemophilia: A hereditary blood disorder that occurs almost exclusively in males and is characterized by delayed clotting of the blood and consequent difficulty in controlling hemorrhage even after minor injuries.

Hemoptysis: Expectoration (coughing up) of blood from some part of the respiratory tract.

Hepatitis: A disease or condition (as hepatitis A or hepatitis B) marked by inflammation of the liver, caused by infectious or toxic agents and characterized by jaundice, fever, liver enlargement, and abdominal pain.

HIV: Human Immunodeficiency Virus.

Hyperglycemia: An abnormally high level of glucose (sugar) in the blood.

Hypertension: Arterial disease in which high blood pressure is the primary symptom.

Hyperthyroidism: An overactive thyroid gland; pathologically excessive production of thyroid hormones or the condition resulting from excessive production of thyroid hormones.

Hypotension: A disease or condition characterized by decreased or lowered blood pressure.

Hypothyroidism: An under active thyroid gland; a glandular disorder resulting from insufficient production of thyroid hormones.

Immunization Record (Comprehensive): A standardized tracking form for immunizations. Immunizations received prior to admission to the custody of the Department are recorded on this form. All immunizations administered while in DJJ custody are also recorded. This form is included in the core health profile of the Individual Health Care Record.

Independent Service Provider: Any corporate and/or individual health care provider whose provision of service generates a separate cost which is not included or subsumed within a DJJ state-operated or private program employee's salary.

Individual Health Care Record (IHCR): The unified cumulative collection of records, histories, assessments, treatments, diagnostic tests, etc., which relate to a youth's medical, mental/behavioral, and dental health, and which have been obtained to facilitate care while the youth is in the custody of a DJJ detention center or residential commitment program or which document care provided while the youth is in the custody of these facilities.

Informed Consent: For purposes of this manual, a legal and bioethical concept which requires that a patient (and, for minors under the age of 18, the parent/guardians) reasonably knows and understands the expected benefit(s), dangers, and available alternatives to a proposed health care treatment, procedure, or medication(s). In accordance with section 743.07(1), Florida Statutes, informing the parent/guardian and/or obtaining
consent from the parent/guardian for medical or mental health treatment is not routinely required when the individual receiving the medical or mental health treatment is 18 years or older. In that instance, the youth (who is 18 years of age or older) must be appropriately informed and may give or withdraw consent.

**Interdisciplinary Risk Reduction Process:** An established process whereby representatives from all disciplines providing on-site physical or mental health care, programming, behavior management, and discipline to youth in a DJJ facility meet and/or communicate on a regular, documented basis for the purpose of ensuring continuity of care and addressing potential risk factors.

**Intramuscularly:** Administered by entering a muscle.

**Intravenously:** Administered by entering a vein.

**Inventory:** A detailed itemized list of all items in stock such as medications and/or supplies that includes an itemized record or report. An inventory is done on a routine schedule for the purpose of accountability and control.

**Ketosis:** An abnormal increase of ketone bodies in the body in conditions of reduced or disturbed carbohydrate metabolism.

**Kidney (Renal) Failure:** Inability of the kidneys to excrete wastes and to help maintain the electrolyte balance.

**Laceration:** A torn and ragged wound.

**Licensed Health Care Professional:** A general term that refers to health care professionals who hold licenses to practice their respective disciplines in the State of Florida. For purposes of this manual, and when referring to physical/medical health care services to youth in the custody of applicable DJJ facilities, the term, licensed health care professionals includes licensed practical nurses (LPNs), registered nurses (RNs), physician’s assistants (PAs), advanced registered nurse practitioners (ARNPs), physicians (MDs), osteopathic physicians (DOs), and dentists, all of whom must be duly licensed and satisfy all requirements for practice in the State of Florida. This term may also be used in the context of mental health professionals (see the Mental Health and Substance Abuse Services Manual).

**Mantoux Skin Test (See also Tuberculin Skin Test):** The skin test for screening for exposure to tuberculosis. This test consists of the intradermal injection of 5 International Units (IU) of the International Standard of Purified Protein Derivative Standard (PPD).

**Mandatory Component:** A broad category of physical health care which must be made available to youth in the custody of an applicable DJJ facility. Mandatory components include the following: (1) routine screenings and evaluations; (2) periodic evaluations and
on-going treatment; (3) episodic care; (4) sick call care; (5) medication management; (6) health education; and, (7) transitional health care planning.

**Medical Alert Roster:** That portion of a facility’s Alert System that lists youth who have a medical condition that may affect the security and/or safety of the program or facility.

**Medical Classification System:** A classification system through which a medical grade (1 through 5) is assigned to a youth.

**Medical Grade:** One of five (5) categories or grades that can be assigned to a youth as part of the medical classification system.

**Medication Administration Record (Medication and Treatment Record) (MAR):** The form used to document, on a dose-by-dose basis, the administration of medications (including prescribed and over-the-counter), and any physical health treatments which have been ordered for an individual youth.

**Musculoskeletal:** Of, relating to, or involving both muscle and skeleton.

**Necessary and Appropriate Health Care:** Essential medical, mental/behavioral and dental care, goods, or services which are reasonably expected to become necessary in the course of custody and care of juveniles, and which are consistent with generally accepted professional standards within the organized medical, mental health, or dental communities. This shall not include non-essential care, goods or services such as cosmetic surgery.

**Neurologist:** A person specializing in neurology; a physician skilled in the diagnosis and treatment of disease of the nervous system.

**Neuro-Muscular Conditions:** Conditions referring to the relationship between nerve and muscle, in particular to the motor innervation of skeletal muscles and its pathology.

**Non-Health Care Staff:** An employee who is not a health care professional or paraprofessional as defined in this manual. This term usually refers to direct care staff.

**Off-Site Health Care Provider:** Corporate and/or individual health care providers who provide services outside of a facility or program on a contractual or fee-for-service basis.

**On-Site-Tracking Log:** A log maintained permanently at each facility that collectively lists certain categories of care or health care findings (e.g., the Sick Call Log, Episodic (Emergency/First Aid) Care Log, and Tuberculosis Testing Log).

**Ophthalmologist:** A physician who specializes in ophthalmology.

**Optometrist:** A specialist licensed to practice optometry.
Over-The-Counter Medication (OTC): Any drug that normally does not require a physician's prescription. Examples include the types of medications, which may be purchased in a retail store, such as Tylenol, Motrin, Advil, etc.

Parenteral Medication: Medication taken into the body or administered in a manner other than through the digestive tract, as by intravenous or intramuscular, or subcutaneous injection.

Parental Notification of Health-Related Care: A written notice of health related care provided to the parent of a youth regarding the need for delivery of specified health care services or medications. A standard departmental form is utilized for documentation of those circumstances in which written notice of health care must be sent to the parents.

Periodic Evaluation: A follow-up focused medical evaluation for youth by a physician (MD), osteopathic physician (DO), advanced registered nurse practitioner (ARNP) or physician's assistant (PA) for youth with chronic conditions or communicable diseases, at specified time intervals. For youth who have a chronic condition or communicable disease but who are not prescribed medications, the maximum time interval between periodic evaluations is three (3) months.

Perpetual Inventory: A working medication inventory process for the daily distribution of non-controlled prescription medication and over-the-counter medications that begins with a known total quantity of medications and the number of remaining tablets/pills/liquid are deducted each time a dosage is given. Documentation of this process is maintained on the youth's Medication Administration Record (MAR).

Pharmacy and Therapeutics Committee: A body of individuals consisting of physicians, pharmacists, nurses and others selected by the facility to oversee issues related to medication use within the organization.

Phlebotomy Equipment: Equipment used to obtain blood for transfusion, apheresis or diagnostic testing.

Physician: A health care professional trained and licensed pursuant to Chapter 458, 459, Florida Statutes, to practice medicine. This person may be a Medical Doctor (MD) or Doctor of Osteopathic medicine (DO).

Physician Assistant: A person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed pursuant to Chapter 458 Florida Statutes, to perform medical services delegated by the supervising physician.

Physician Designee: The physician delegated clinical responsibilities by the Designated Health Authority. For the purposes of this manual, Physician Designee is NOT interchangeable with PA or ARNP, as it refers to responsibilities required of a physician.
Practitioner: One who provides or practices health care. For the purposes of this manual, the term refers to Physicians, Physician Assistants and Advanced Registered Nurse Practitioners.

Preeclampsia: A serious condition developing in late pregnancy that is characterized by a sudden rise in blood pressure, excessive weight gain, generalized edema, proteinuria, severe headache, and visual disturbances and that may result in eclampsia if untreated.

Pregnancy: A state of carrying a developing embryo or fetus within the female body from the time of conception until birth.

Problem List: A current list of the youth’s major or chronic physical, dental, or mental health problems. It is developed as a result of the comprehensive physical assessment, any dental or mental health assessments, and any subsequent health care encounters in which a major and/or chronic physical, dental, or mental health problem is diagnosed.

Profuse: Plentiful; copious.

Progress Note: Interdisciplinary documentation of medical health care encounters that explain the forward course of action, events and time of any health care activity.

Prophylaxis: Protective measures designed to preserve health and prevent the spread of disease; preventive treatment.

Protocol: The precise and detailed plan for a course of medical treatment developed by the Designated Health Authority that describes a patient's treatment regimen; a detailed plan for the delivery of health care treatment, procedures, tests, medications and dosages.

Psychotropic Medication Evaluation: A focused evaluation/periodic evaluation of a youth by a prescriber of a psychotropic medication, for the explicit purposes of ascertaining the effectiveness of the youth’s psychotropic medication regimen, determining if side effects are occurring, and determining whether the medication regimen needs adjustment.

Psychotropic Medication: Medications capable of affecting the mind, emotions and behavior that are used to treat mental illness. These medications may reduce the severity and duration of mental disorder.

Restricted Housing: All situations involving segregation, isolation, or separation of a youth for any reason, including disciplinary, medical, or mental health reasons. Thus, this term includes disciplinary confinement, room restriction, secure observation, or any other form of housing which is separate from that of the general population.

Reverse Chronological Filing: Making entries in the respective areas of the Individual Health Care Record in such a way that the page with the most recent entry is filed on top of the other pages in that section.
Revocation: Nullification or withdrawal.

Routine Screening and Evaluation: One of the mandatory components of health care required at each DJJ facility. Those procedures, tests, examinations, and assessments that are required by the Department to be provided for each youth. At a minimum, all youths in secure detention centers (with specified exceptions, based on length of stay) and residential commitment programs shall receive the following routine screening and evaluations: (1) A comprehensive physical assessment; (2) evaluation of tuberculosis status; (3) Screening for sexually transmitted diseases; (4) Assessment of immunization status; and, (5) Vision and hearing screening. A facility entry physical health screening is another form of routine screenings and evaluation; it is completed upon intake to each facility by the admitting staff member.

Seizure Disorders: Uncontrolled electrical activity in the brain, which may produce a physical convulsion, sensory disturbances minor physical signs, thought disturbances, a combination of symptoms or loss of consciousness.

Self-Administration: The process by which a youth gives him/herself a medication. (See Assisted Self-Administration.)

Service Agreements: Written agreements that routinely and/or frequently are used by health care providers who render either on-site or off-site health care services whose provision of service are rendered without the presence of an executed departmental contract and which generate a separate billing/cost that is not subsumed by employment by DJJ. Examples of health care providers to whom this term applies include off-site physicians who agree to provide care on a fee-for-service basis, ambulatory care centers, tertiary facilities (hospitals), and, in some instances, community mental health providers.

Sharp: Any object that can penetrate the skin, including but not limited to, hypodermic needles, scalpels, blades, broken glass, broken capillary tubes, breakable culture dish, and exposed ends of dental wires.

Sick Call: The official method for a youth to request health care services for an illness or injury. This is the health care delivery system component intended to provide care in response to complaints of illness or injury of a non-emergent nature but which require some form of assessment and/or decision-making.

Sick Call Index: A chronological standardized record of occurrences of a youth’s sick call complaints, which are not suitable for inclusion on the Problem List. The purpose of this form is twofold: (1) to provide a quick reference of these types of complaints to health care providers; and, (2) to serve as a safeguard against the possibility of a youth reporting to sick call multiple times for the same complaint without referral to an ARNP, PA or Physician.
Sickle Cell Anemia: A chronic anemia that occurs in individuals (as those of African or Mediterranean descent) who are homozygous for the gene controlling hemoglobin S and that is characterized by destruction of red blood cells and by episodic blocking of blood vessels by the adherence of sickle cells to the vascular endothelium which causes the serious complications of the disease (such as organ failure).

Sickle Cell Trait: A usually asymptomatic blood condition in which some red blood cells tend to sickle but usually not enough to produce anemia, which occurs primarily in individuals of African descent, and which results from heterozygosity for the gene controlling hemoglobin S.

SOAP: The complete and organized format used to document in progress notes an encounter with a youth. The subjective (S) portion of the note includes any verbal complaints and/or statements. The objective (O) portion of the note includes any observations and results of an examination that follow or respond to the subjective complaint/statement. The assessment (A) portion of the note includes any diagnoses/conclusions and the professional's opinion whether the objective findings support the subjective complaint/statement. The plan (P) portion of the note indicates the treatment provided, if any, and the logical conclusions to the encounter with the youth.

Standard (Universal) Precautions: The method of acceptable work practice by individuals for the protection against transmission of blood-borne pathogens and other infectious diseases in the workplace. It is the practice of treating all human blood and other material as if it is infectious and avoiding all direct contact with this material by utilizing: hand washing after patient contact; gloves when touching blood, body fluids, secretions, excretions, and contaminated items; mask, eye protection, and gown during procedures likely to generate splashes or sprays of blood, body fluids, secretion, or excretions; precautions when handling contaminated patient-care equipment and linens; care when handling sharps; and a mouth piece or other ventilation device as an alternative to mouth-to-mouth resuscitation.

Spina Bifida: A neural tube defect marked by congenital cleft of the spinal column usually with hernial protrusion of the meninges and sometimes the spinal cord.

Standing Orders: An authoritative direction or instruction by the Designated Health Authority regarding some aspect of a youth’s health care to be followed until notified differently.

Summary of Off-Site Care: The summary of off-site health care services provided for a youth by an off-site health care provider. This summary is documented on the standardized Summary of Off-Site Care form that is sent with the youth. This form shall be filled out by the provider of health care and returned to the facility for filing in the Individual Health Care Record.
**Supervision:** Responsible regulation and control, which requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the ARNP or PA.

**Suture Kits:** A case containing a set or collection of tools, supplies, instructional matter, and material used surgically to close a wound or join tissues.

**Symptomatic:** An outward showing of clinical signs of a medical condition or disease.

**Tanner Stage:** A stage of puberty in the Tanner growth chart, based on the growth of pubic hair in both sexes, the development of the genitalia in boys, and the development of the breasts in girls.

**Transitional Health care Planning:** This is the process of planning and information exchange to maintain continuity of care for a youth who is either discharged to the community from a facility or transferred between facilities.

**Traumatic:** A serious injury or shock to the body, as from violence or an accident; an emotional wound or shock that creates substantial, lasting damage to the psychological development of a person, often leading to neurosis; an event or situation that causes great distress and disruption.

**Tuberculosis:** A highly contagious infectious disease of the lungs caused by a type of bacterium called mycobacterium, a usually chronic highly variable disease, that is caused by a bacterium of the genus Mycobacterium (M. tuberculosis). Symptoms include weight loss, fever, and cough, often associated with blood-streaked mucus. It is usually transmitted by inhalation of the airborne causative agent that affects the lungs but may spread to other areas such as the kidney or spinal column.

**Tuberculin Skin Test (TST):** The skin test for screening for exposure to tuberculosis. This test consists of the intradermal injection of 5 International Units (IU) of the International Standard of Purified Protein Derivative Standard (PPD).

**Unlicensed Assistive Personnel:** Florida Chapter 64B9-14 FAC provides the authority for the licensed nurse to delegate unlicensed trained staff (the Unlicensed Assistive Personnel) to serve as assistant to the Registered Nurse or Licensed Practical Nurse. Unlicensed Assistive Personnel are persons who do not hold licensure from the Division of Health Quality Assurance of the Department of Health, but who have been trained and assigned to function in an assistive role to registered nurses or licensed practical nurses in the provision of patient care services through regular assignments or delegated tasks or activities under the supervision of a nurse. For the purpose of this manual, the term refers to appropriately trained direct care staff that assist with the delivery, supervision, and oversight of youth who perform the self-administration of medication(s). The nurse must supervise this trained staff member’s duties by periodically performing direct observation of skills, inspecting the
Medication Administration Record(s) and the required documentation assigned to the staff member.

**Wet Mount:** A glass slide holding a specimen suspended in a drop of liquid (as water) for microscopic examination.

**Working Inventory:** The smallest number of necessary syringes, needles, phlebotomy equipment, suture kits, and all other potentially dangerous sharps and other devices that are kept in the area where they are to be used.
APPENDIX C: FREQUENTLY ASKED QUESTIONS ABOUT THE DJJ HEALTH SERVICES MANUAL REQUIREMENTS

1. What is the difference between parental consent and parental notification?

The Authority for Evaluation and Treatment (AET) is the Department’s general parental consent form authorizing specific medical care and treatment for youth in the custody of the Department. For the purpose of the AET document, departmental custody includes those DJJ facilities where youth are housed 24 hours per day, such as, Detention Centers and Residential Commitment Programs. The AET provides limited authority for youth in DJJ facility-based non-residential programs. There are certain types of care that requires additional written consent that is not addressed in the Authority for Evaluation and Treatment.

Parental notification refers to notifying parents of specific events that have occurred related to the youth’s health care. This notification may be provided verbally, or by telephone followed by notification in writing. Written notification is required for any additional health-related care not addressed in the signed Authority for Evaluation and Treatment. This is accomplished by sending the parent the necessary standardized Parental Notification of Health Related Care for any additional health-related care not addressed in the signed Authority for Evaluation and Treatment. (Refer to Chapter 4.)

2. Is parental notification required every time we give a youth a Tylenol or a band-aid? What about other Over-the-Counter medications?

No. Parental consent for providing a youth Acetaminophen (Tylenol), Ibuprophen (Motrin), Pepto Bismol, Milk of Magnesia, Maalox, and Triple Antibiotic Ointment is provided when the parent signs the Authority for Evaluation and Treatment (AET).

Each facility or program must then send the parent/guardian a facility-specific list of OTC’s used. Adequate time must be allowed for the parent/guardian to respond if they do not permit the youth to receive these medications.

3. Is the Authority for Evaluation and Treatment required before we can do the Comprehensive Physical Assessment or provide any health care?

Yes. The purpose of this consent process is to ensure that youth who are in the physical custody of the DJJ facility or program are provided the opportunity to give consent after being duly informed, (including the right to refuse treatment, when applicable), in accordance with federal and state laws. (Refer to Chapter 4.)
4. **Is each detention and residential facility required to obtain a new parental consent for the Authority for Evaluation and Treatment form?**

No. The Authority for Evaluation and Treatment is valid for as long as the youth is under any type of supervision, custody or other form of legal control by the Department; or for one year after it was signed by the parent/legal Guardian, whichever comes later, or until the youth’s 18th birthday. Legal control includes probation and conditional release. (Refer to Chapter 4.)

5. **Does the Individual Health Care Record have to be standardized?**

Yes. The Individual Health Care Record is the youth-specific unified, organized collection of health records (i.e. histories, assessments, treatments, diagnostic tests, reports of consultations, etc.), which relate to a youth’s medical, mental/behavioral, and dental health. It is essential that a comprehensive, organized and accurate Individual Health Care Record is developed and maintained for each youth to facilitate effective communication among the various health care providers who treat each individual youth.

6. **What is the purpose of the mandatory components of the Health Services Manual?**

The critical mandatory components of the Health Services Manual are to ensure that the medical services provided to all youth meet constitutional, national and the Departmental standards. The primary goals are: (1) Assure health care services provided in DJJ facilities and programs are rendered in accordance with state and federal health care regulations and rules, and professional standards of care; (2) Promote delivery of high quality health care services and (3) Assist medical and clinical health care staff in developing and consistently implementing necessary and appropriate health care services. (Refer to Chapters 1 and 2.)

7. **Are there different types of sick call?**

Yes. Sick call is the component of health care that responds to a youth’s complaints of illness or injury of a non-emergent nature but which requires a professional nursing assessment and possibly, a nursing or medical intervention. Sick call procedures ensure that a youth has access to regularly scheduled Sick Call to address two types of sick call (1) non-emergent and (2) episodic health-related complaints. A youth experiencing a health-related condition or complaint that is considered an emergency must receive immediate medical attention and is not part of the sick call process. (Refer to Chapter 6.)

8. **Does a youth have to submit a sick call request each time he or she requires over-the-counter medications for minor health complaints?**

No. A process must be in place for all youth to have timely access to sick call care and treatment. The process by which youth indicate their respective need for Sick Call may vary as long as access is not denied. However, a youth must be provided a Sick Call Request form and a pencil when requesting to see a nurse or physician. A limited number of Over-the-Counter medications can be stored in Master Control or the Shift Supervisor’s office for minor complaints. (Refer to Chapter 6.)
9. Is it necessary to repeat the Comprehensive Physical Assessment at every facility?

Not necessarily. If a Comprehensive Physical Assessment was performed on a youth during a prior admission (either to a detention center or a residential commitment program) and is considered “current,” that CPA should be reviewed as the youth is examined, but not necessarily duplicated or repeated by the Physician, PA or ARNP unless, in the clinician’s professional opinion, a new CPA is necessary. A current CPA is one that has been performed within one (1) year for youth with Medical Grades of 2, 3, 4, or 5 and within two (2) years for youth with a Medical Grade of 1. This holds true, only if there have not been any interim changes (new conditions, new medications, etc.). (Refer to Chapters 3 and 5.)

10. How is the Facility Entry Physical Health Screening different than the Comprehensive Physical Assessment?

Each youth receives a Facility Entry Physical Health Screening by a staff member (health care or non-health care) admitting the youth to a detention center or residential commitment program. The purpose of this screening is to ensure that the youth does not have any health conditions that would require emergency services. This screening does not take the place of the Comprehensive Physical Assessment or other required evaluations.

The Comprehensive Physical Assessment is the standardized physical assessment of a youth, conducted by a Physician, an Advanced Registered Nurse Practitioner or Physician Assistant at Departmentally specified intervals. (Refer to Chapters 3 and 5.)

11. What documentation is required for off-site health care providers?

All medical care ordered and/or administered off-site (by a Physician, PA, or ARNP) must be documented on the standardized form, Summary of Off-Site Care. This form is filled out by the provider and returned to the facility. Additionally, the off-site health care provider must submit any medical treatment orders and prescriptions, as indicated, in order for the facility to provide the appropriate medical care and clinical treatment for the youth. (Refer to Chapter 15.)

12. Is each facility required to initiate new “core health profile” forms found on the left side of the Individual Health Care Record?

Not necessarily. Many of the documents in the core health profile section of the Individual Health Care Record are cumulative documents in that an entry in made into the record as a recurrence of an event transpires. However, certain documents (i.e. Comprehensive Physical Assessment) may require a new form to be completed due to the youth requiring a new physical examination. (Refer to Chapter 15.)
13. Are non-health care staff members permitted to make entries in the individual health care record?

Yes. All on-site medical health care encounters, including those performed by licensed health care professionals, health care Para-professionals, and other trained facility staff shall be documented in the chronological progress notes in chronological order (with exceptions as noted in Chapter 15). Any person, licensed or non-licensed, administering medication and/or treatment to a youth must document on the Medication and Treatment Record (MAR) any medications, physical or dental health treatment rendered pursuant to physician’s orders. Any medications administered outside of scheduled sick call shall be documented accordingly on the MAR as well. (Refer to Chapter 15.)

14. Are there areas of this manual that dictate to health care professionals how to practice their respective disciplines?

No. The Health Services Manual provides policy and guidelines regarding delivery of health care services in all of the Florida Department of Juvenile Justice facilities and programs. It is intended to provide guidance and practical direction to state and contracted health care service providers, clinicians, and administrators, direct care staff and others involved in the supervision or treatment of youth with health care needs. This manual is designed to provide a resource that assists in establishing health care services within the DJJ continuum of services, which promote adolescent health, well-being and development while adhering to state and federal regulations.

Section 985.01(1)(b) Florida Statutes grants statutory authority with regard to health services made available to youth in the Department of Juvenile Justice Custody. One of the purposes of Chapter 985 is: “To provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; and to promote the health and well-being of all children under the state’s care.”

15. In addition to required forms, can other forms, for other purposes, be utilized to provide documentation in the health care record?

Yes with stipulations. The forms located in the forms appendix are italicized throughout the chapters of this manual. All forms are available on the Department of Juvenile Justice Office of Health Services web-site link at www.djj.state.fl.us and the Forms Library. Required forms are available in a PDF version. However, sample forms are available in a Microsoft Word version. These forms may be altered to facilitate the specific needs of each departmental facility. Facility may create additional forms if they so choose, but the required forms should not be altered.

16. When a youth has a positive PPD and exhibits no signs and symptoms of TB is it a requirement that the youth be placed in isolation?

No. A youth who has symptoms suggestive of TB disease and has a positive PPD/TST shall immediately receive a medical evaluation and shall be placed in an Airborne Infection Isolation Room until TB disease has been ruled out. The licensed nurse must provide the
youth and staff a NIOSH approved disposable particulate TB respiratory mask. The nurse shall be responsible for fit testing the youth and staff to assure the proper sizing of the respiratory mask. (Refer to Chapter 3.)

17. Can a non-health care departmental staff member administer medication to a youth?

No. However, if a sufficient number of licensed nurses are not available on-site to administer all oral prescription medications or OTC’s, then the delivery, supervision, and oversight of youth who are performing self-administration of medications must be carried out by trained non-health care staff. All facilities must have operating procedures in place that include the training of non-health care staff whose responsibilities include these duties. (Refer to Chapter 11)

18. Does a youth have the right to refuse medication?

Yes. The forced (involuntary) administration of medication is not permitted under any circumstances. Each facility must develop a Medication Refusal form or utilize the Department’s Right to Refuse Care form. This form should be completed each time a youth refuses care. (Refer to Chapter 11.)

19. Is parental notification required for a pregnant female receiving prenatal services if she requests that the parent not be notified?

No. Although statutorily the consent or notification of the parent or guardian is not explicitly required, the youth should be encouraged to allow for parental notification when medical issues arise. Because of the Department’s unique responsibility for the health and safety of the youth and unborn child, if the youth refuses, the facility superintendent, program director, or designee shall consult with the regional general counsel’s office. (Refer to Chapter 10.)

20. When is a written procedure or protocol required?

Written procedures and protocols are necessary only for those items in which it is specifically stated to do so in the manual and if one is required for the QA processes. A written procedure or protocol may be implemented with the facility decides that one is needed to clarify how a particular operation or procedure is to be implemented.

21. Can duplicate copies of a document be destroyed?

If duplicate identical copies of a document (i.e., the HRH or CPA) exist in a youth’s IHCR; the replicates may be shredded as long as they contain the exact same information as the copy that remains in the youth’s record.
APPENDIX D: REFERENCES

5. American Dietetic Association: http://www.eatinghealth.com
8. American Red Cross
10. Children’s Hospital of Boston Division of Adolescents: http://www.childrenshospital.org
11. Children’s Hospital of Pittsburg: http://www.chp.edu
12. Collier County Health Department: http://doh.state.fl.us
13. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised
15. FDJJ Policy 5000 Statewide Transportation Offender Policy
16. Florida Department of Education: http://doe.state.fl.us
17. Florida Department of Health: http://doh.state.fl.us
18. Florida Department of Health, Girl’s Health: www.girlshealth.gov
19. Florida Department of Health: Pharmacy Services (April 2005) by Bureau of Pharmaceutical Services
22. Florida Department of Juvenile Justice: Quality Assurance Standards for Mental Healthcare
23. Florida Department of Juvenile Justice: Quality Assurance Standards for Healthcare

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25. Florida Health Start: www.healthystartflorida.com
26. Florida Statutes (F.A.C.): 10D-128; 64B9-4.010; 64B-16. 64F-12.;
27. F.S. Chapter 39.407; 154; 287; 381; 384.24; 392; 458; 459; 464; 465; 499; 893
28. Florida Statutes: Sections 381.88; 393.063(10); 393.063(38); 401.165; 402.165;
   743.015; 743.064; 985.224;
30. DOHP: 250-8-01; 250-10-01; 250-15-01; 250-20-01; 250-23-01; 250-26-01
32. HIPPA: Health Information Portability Accountability Act: 45 CFR: 164 (k)(5)
33. Keystone Treatment Center, Robert Perkinson: http://robertperkinson.com
34. Medical Care of Adults with Mental Retardation-American Family Physician: http://www.aafp.org/afp/20060615/2175.html
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43. Office for Civil Rights HIPPA Compliance Assistance, Summary of HIPPA Privacy Rule, April 3, 2003
44. Occupational Safety and Health Administration: http://www.osha.gov
45. OSHA (29CFR 1910)

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