ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Residential Units Written by: K. Winkowski. MS. Dir. Of Clinical Services

PIRC Approval Date: 4/09 SUBJECT: Special Procedures - Physical Restraint and Emergency Safety Intervention Policy

Effective Date: 4/09

I. POLICY

It is the policy of Southwood Residential Treatment facilities to create a physical, social, and organizational culture that limits the use of physical restraints and emergency safety interventions to emergency safety situations in which the client, other clients, staff members, and/or others are at imminent risk of physical harm.

To achieve this goal, Southwood uses the Therapeutic Crisis Intervention System (TCI) that Cornell University developed in the early 1980s under a grant from the National Center on Child Abuse and Neglect. TCI is a crisis prevention and intervention model for residential childcare facilities. TCI guides staff members in preventing crises from occurring, de-escalating potential crises, managing acute physical behavior, and reducing potential and actual injury to clients and staff. TCI physical interventions are not used as a consequence or punishment for client behavior or as a consequence for non-compliance with unit programs or for destruction of Southwood's property.

The following requirements will govern emergency safety interventions with clients (i.e., residents of Southwood RTF facilities) who, as a consequence of mental illness, behavioral disorder or situational stressors: (a) create emergency safety situations and become physically aggressive towards staff members, other clients, or themselves; or (b) pose imminent harm to themselves or others.

All interventions shall:

- Protect and preserve the client's health, safety, rights, dignity, and well-being.
- Be based upon the client's Individual Crisis Management Plan (ICMP) (defined below), which must be developed upon admission and refined throughout the client's treatment.
- Be done in a safe manner with monitoring and reassessment. On-staff nurses are required to respond to and monitor all physical restraints. If a nurse is not available, a supervisor or other TCI-trained staff person will observe and monitor the restraint.
- Follow the recommendations in the client's ICMP and the TCI guidelines, with emergency safety interventions or physical restraint being used as a last resort for a client who creates an emergency safety situation and represents a danger to himself/herself or others.

No intervention shall:

- Involve the use of mechanical restraint, prone restraint, or seclusion.

II. PURPOSE OF TCI TRAINING

The purpose of TCI is fivefold -- helping Southwood staff members to provide the following:

- A model of intervention for supporting physically aggressive behavior of Southwood clients.
- Guidelines for developing and maintaining a team approach to crisis situations that enhances client and staff safety.
- A focus on proactive de-escalation as the initial means of intervention.
- Guidelines for implementing physical restraints and emergency safety interventions for acute client behavior.
- An organized, ongoing crisis education and training program for all direct care employees.

III. DEFINITIONS

For purposes of this Physical Restraint and Emergency Safety Intervention Policy:

"Acute Physical Behavior" means behavior likely to result in physical injury to the aggressive client, other clients, staff members, or other persons in the area. Clients, staff members, and others are at imminent risk of physical harm.

"Code Responders" are TCI-trained staff members who will be designated to respond to crises throughout each program. All TCI-trained staff are to respond to crisis codes, but a specific individual is identified during each shift to act as the primary responder for all codes.

"Emergency Safety Situation" means unanticipated client behavior that places the client or others at serious threat of violence or injury if no intervention occurs and which then requires an **Emergency Safety Intervention** or restraint.

"Emergency Safety Intervention" means the use of restraint as an immediate response to an **Emergency Safety Situation** (defined above).

"IASSIST Intervention" is an acronym for a TCI training active listening intervention that is designed to help de-escalate an agitated or potentially aggressive/violent young person. Staff should make all efforts to exhaust the following seven techniques that correspond to the IASSIST acronym before any physical intervention:

I - isolate the young person or situation;
A - actively listen;
S - speak in a calm, respectful voice tone;
S - state understanding before making any requests;
I - invite the young person to consider positive outcomes;
S - use space to help de-escalate the young person; and
T - use time to help the young person make decisions.

"Individual Crisis Management Plan (ICMP)" means a planning document as well as a working document that provides both a history of each client's crisis behavior and a plan aimed at reducing or eliminating the need for physical intervention. At a minimum, the ICMP should include: a basic screening for any pre-existing medical conditions that would be exacerbated if the client were involved in a physical restraint or emergency safety intervention; a synopsis of the client's crisis behavior; a screening to determine if there is a history of physical or sexual abuse; a plan for specific behavioral interventions; a plan for specific physical interventions; and a review process that allows for update of the ICMP.

"Life Space Interview (LSI)" means a TCI training behavioral intervention designed to help young people understand how thoughts and feelings result in behaviors and how those behaviors affect them and others. A long-term goal of the LSI is to help teach better and more effective ways of dealing with stressful situations. The LSI should be completed with the client after each physical intervention. Although a client may initially refuse to complete the LSI, it is imperative that the LSI be completed at some point. A part of the therapeutic process is working with the client to walk through the LSI and process the event. This allows for therapeutic closure of the event.

"Physical Restraint" means staff members holding or otherwise restricting the movement of a client in order to manage acute physical behavior. Restraints may be in the form of standing holds, seated holds, or supine restraints. Prone restraints are absolutely prohibited. The least-restrictive method of restraint shall be used to contain the acute physical behavior. All physical interventions are to be conducted according to TCI protocol. Only TCI-trained staff may participate in physical intervention.

"Prone Restraint" means a manual restraint in which a child is held face down on the floor.

"Serious Injury" means any significant impairment of the physical condition of the client as determined by qualified medical personnel. This includes, but is not limited to, carpet burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

"Staff Debriefing" means a session or sessions that the milieu manager or shift supervisor shall conduct and that include(s), at a minimum: a review and discussion of the emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention; alternative techniques that might have prevented the need for physical intervention; the procedures, if any, that staff are to implement to prevent any recurrence of the use of physical intervention; and the outcome of the intervention, including any injuries that may have resulted from the use of physical intervention. Staff will document in the client's medical record what debriefing sessions took place and include in that documentation the names of staff who were present for debriefings, and any changes to the client's ICMP that result from the debriefings. This staff debriefing should include: (1) precipitating factors or triggering events; (2) behavioral management strategies attempted; (3) other TCI-approved techniques that were not considered or attempted; (4) recommendations for change in future crisis de-escalation or interventions; and (5) a brief list of coping skills or alternative behaviors identified by the client, at least one of which will be practiced by the client during the life space interview and before returning to programming on the unit.

"Time-Away" means a TCI behavior management technique requiring young people to go to a *quiet* area, such as a bedroom or quiet room, when they are upset and being stimulated by others. Clients may return to the general milieu/community once they have completed an LSI with a unit staff member. **Time-Away** is designed to be used when a client needs time to regroup and think about his or her behavior. The client behavior is usually outside of the norms and rules expected on the unit. **Time-Away** should be a part of a client's **ICMP**. **Time-Away** may be taken in one of the several Time-Out Rooms/Quiet Rooms located throughout the Southwood facilities. **Time-Away** may also be taken in other areas that are designated by staff. **Time-Away** must never be used as a punishment. **Time-Away** is a behavior management intervention for agitated and potentially aggressive clients.

IV. PROCEDURES

A. Training

- All Southwood direct care staff will receive a minimum of 4 days of TCI training during new employee orientation. Such training shall cover: (1) crisis definition and theory; (2) the use of de-escalation techniques; (3) crisis communication; (4) anger management; (5) physical intervention techniques; (6) the legal, ethical, and policy aspects of physical interventions; (7) decision-making related to physical interventions; (8) debriefing strategies; and (9) signs of physical distress and effect on the young person. Staff members must also have demonstrated competency in performing the physical intervention techniques that are permitted under this Policy, which is to be measured and documented according to Cornell University's TCI guidelines. Staff members must score a 80% or higher grade in order to pass the written portion of TCI training. Staff members must also pass the physical skills portion of TCI training before being assigned to a unit. Staff members who do not pass either the written test or the physical skills test may be given the opportunity to retrain and retake the tests. Continued employment status may be contingent on the outcome of TCI testing.
- All TCI-trained employees will attend a quarterly TCI refresher training for 4 hours (i.e., each such employee will attend 4 hours of such training four times per year). This refresher training is conducted quarterly in all RTF programs as well as for the inpatient unit.
- All TCI training will be conducted by Cornell University TCI-certified trainers. Other techniques will not be used by or taught to Southwood employees.

B. Staff Responsibilities

Staff members who participate in crisis situations must:

- Be skilled in TCI behavior management techniques, the "IASSIST" active listening intervention, TCI physical skills and life space interviewing.
- Proactively recognize signs of a potential emergency safety situation and intervene appropriately, in terms of de-escalating the client and/or recognizing the need to call for a code.
- Begin crisis responses by using the "IASSIST" active listening intervention.

- Assess the situation of each crisis team call and identify resources needed to ensure unit safety.
- Arrive at the requesting unit's location in a prompt manner following a "Code Q" or "Code E."
- Remove items at the beginning of a shift, such as jewelry or glasses, that may inadvertently cause injury during a TCI physical intervention.
- Manage the physical environment in an effort to remove any potential weapons from the area, such as chairs, pencils, etc.
- Be present during the completion of the LSI following the crisis.
- Be present during the supervisor debriefing of the crisis intervention.
- Follow only TCI-approved protocols.
- Communicate with the client in crisis during the "letting go" or release process.
- Help support and de-escalate the clients on the unit where the restraint or emergency safety intervention occurred.
- By the end of the staff member's shift, document on the restraint form (and place in the medical record): (1) antecedents to the restraint; (2) all attempts at less-restrictive interventions; and (3) why those less-restrictive interventions were unsuccessful. Such documentation should include: (1) precipitating factors or triggering events; (2) behavioral management strategies attempted; (3) other TCI-approved techniques that were not considered or attempted; and (4) recommendations for change in future crisis de-escalation or interventions.

Nursing Staff who participate in crisis situations must:

- Respond immediately to any Code Q or Code E crisis response calls.
- Contact the treating physician (if available) or the on-call physician to inform them of a potential emergency safety situation and in an effort to obtain an order for restraint. Nursing staff will make every effort to obtain this order before the initiation of an emergency safety intervention or restraint. On the inpatient unit only, the doctor may order PRN medications to assist in de-escalating an agitated client.
- After obtaining an order for the restraint, observe the restraint, checking the client's breathing, skin color, and ROM, and directing the restraint and techniques used by staff. This will be documented in the restraint flow record at a minimum of every 5 minutes.
- Assimilate information provided by direct care staff involved in the restraint process in providing release criteria to the client and determining when to release the client.
- Provide instructions for the client and staff upon release of the restraint, including identifying an area for the client to sit, offering water or bathroom.
- Provide psychological and physical assessment to a client within 1 hour of the termination of the restraint event.
- If any injury occurs to the client as a result of the restraint, assess, treat, and document the nature of the injury. In the case of serious injury, nursing will contact the physician on call in order to determine if further instructions in how to care for that particular client are necessary. If necessary, further medical care may be arranged with an outside entity (typically St Clair Hospital or Washington Hospital).

- Contact the family or legal guardian of the client and notify them of the restraint/emergency safety intervention, including any physical complaints or injuries, within 2 hours of the end of the restraint. If the contact was not successful, the attempt will be documented and continued attempts will occur until the family or legal guardian is reached. This continued contact will not be less than 1 phone call per day to the family/guardian. These attempts will continue to be documented until successful contact documentation is noted.
- Contact the treating physician within 2 hours of the restraint and inform him/her of the restraint/emergency safety intervention.
- Complete the doctor's oral orders for the restraint.
- In the RTF setting, ensure that the client is seen by a physician or CRNP within 24 hours of the restraint or emergency safety intervention.
- Ensure that the Director of Nursing or his/her delegate reviews all restraint documentation within 24 hours of a restraint.

The responsible Milieu Manager or Shift Supervisor must:

- Ensure that an LSI is conducted with each client in crisis by one or more staff members who responded to the crisis. The only exception to attendance at the LSI would be the presence of a staff member who might escalate the situation. This LSI will include: (1) the client's thoughts about what led to the restraint; (2) his/her feelings before, during, and after the restraint; (3) the connection between his/her thoughts, feelings, and actions; (4) a brief list of coping skills or alternative behaviors identified by the client; and (5) an opportunity for the client to practice at least one of the alternative coping skills prior to returning to programming on the unit.
- Make crisis response assignments during the day and evening shifts
- Conduct a staff debriefing session that includes, at a minimum, a review and discussion of the emergency safety situation that required the intervention and what interventions may be successful in the future. This staff debriefing should include: (I) precipitating factors or triggering events; (2) behavioral management strategies attempted; (3) other TCI approved techniques that were not considered or attempted; (4) recommendations for change in future crisis de-escalation or interventions.
- Ensure that staff document in the client's medical record that both LSI and debriefing sessions took place, and include in that documentation the names of staff who were present for the debriefing, and any changes to the client's ICMP that result from the debriefings.
- Ensure the presence of an on-shift unit nurse during any TCI physical interventions.
- Ensure notification of parent or legal guardian, to include any physical complaints or injuries, within 2 hours of the physical intervention. If the contact was not successful, the attempt will be documented and continued attempts will occur until the family/legal guardian is reached. This continued contact will not be less than 1 phone call per day to the family/guardian. These attempts will continue to be documented until successful contact documentation is noted.

- Maintain a cumulative log of all restraints/emergency safety interventions, including the date and time of each restraint/emergency safety intervention.

C. **Procedure for Use of Physical Restraints and Emergency Safety Interventions**

1. The facility will inform both the incoming client and the client's parent(s) or legal guardians of the facility's policy regarding the use of restraint during an emergency safety situation that may occur while the client is in the program. The facility will provide a copy of the facility policy to the client and parent(s)/legal guardian. Acknowledgment, in writing, will be obtained from the client and the parent(s) or legal guardian that he or she has been informed of the facility's policy on the use of restraint during an emergency safety situation. This will occur regardless of the client's age. This acknowledgment must be filed in the client's medical record. The facility's policy provides contact information, including the phone number and mailing address of the Disability Rights Network of Pennsylvania and the Department of Public Welfare (DPW).
2. Physical restraints of Southwood clients should be used only to ensure safety and protection. Physical restraints and emergency safety interventions should be employed only as a response to an emergency safety situation. The client, other clients, staff members, or others must be at imminent risk of physical harm.
3. Because any physical intervention involves some risk of injury to the client or staff, Southwood employees must weigh this risk against the risk of imminent physical harm involved in failing to physically intervene when it may be warranted.
4. Physical interventions must never be used: (1) as punishment; (2) for demonstrating who is in charge; (3) as program maintenance (such as enforcing compliance with directions or rules; or (4) for therapeutic purposes (such as forming attachment as promoted by "holding" therapy advocates or inducing regressive states).
5. Physical interventions should be employed only after other less-restrictive approaches such as behavior management techniques or oral de-escalation have been attempted, unsuccessfully, or where there is no time to try such alternatives.
6. Staff will make every effort to use the least-restrictive method of physical intervention possible; that is, staff will attempt to use standing holds, seated holds, and supine restraints, in that order. **Prone restraints are prohibited.**
7. Staff will initiate physical interventions only when sufficient staff are present; this would include a minimum of 2 staff members for a standing hold or seated hold, and a minimum of 3 staff members for a supine restraint.
8. Emergency safety interventions/physical restraints must be employed only for the minimum time necessary. They must cease when the client is judged to be safe and no longer at imminent risk of harming himself/herself or others, or by meeting established behavioral criteria to end the restraint.
9. Physical interventions may only be undertaken by staff who have successfully completed the TCI crisis management course.
10. Only physical intervention skills and decision-making processes that are taught in the TCI course may be used. All techniques must be applied according to the guidelines provided in the TCI training and in this policy.

11. When possible, staff members will consult with peers and supervisors before initiating any physical intervention.
12. Clients are not permitted to restrain or to assist in the restraint of other clients.
13. An LSI will occur where a staff member provides the client with an explanation for the intervention and offers the client an opportunity to express his or her views on what transpired. This should occur before the client returns to programming.
14. All incidents of physical restraint must be documented on the client's individual progress note for that shift, a restraint form, and a Southwood incident report form.
15. If the order for restraint is oral, the oral order must be given by a licensed physician and received by a registered nurse while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician, as permitted by the state and the facility to order restraint, must verify the oral order in a signed written form in the client's record. The physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention/physical restraint.
16. If the emergency safety situation continues beyond the time limit of the order for the use of restraint, the client will be released from the restraint. If acute physical aggression occurs again, a new physical restraint may be initiated. Each incident of physical restraint requires a new order from the client's attending physician, if available, or from the on-call physician.
17. There may never be a PRN or standing order for restraints.
18. Each order for restraint must:
    - Be limited to no longer than the duration of the emergency safety situation;
    - Be limited to no longer than TCI recommendations for that particular restraint technique; and
    - Under no circumstances exceed 1 hour.
19. Registered Nurse or other medical personnel or physician must examine the client within 1 hour of the termination of the restraint and document this on the restraint form.
20. Staff must document that they have changed position or released every 10 minutes during the restraint or documented a rationale for why they did not. For instance, staff may feel that the position is sufficient and that repositioning may only agitate client and unintentionally prolong the restraint/emergency safety intervention.

D. Documentation of Medical Assessment and Life Space Interview following Physical Restraint

1. An LSI will be conducted within 2 hours for each client involved in a crisis situation by a staff member and documented in the restraint form and placed in the medical record.
2. A Debriefing will be completed with staff involved in the restraint by the end of that shift. This will be documented in the restraint form and placed in the medical record.

3. In the Residential Treatment Facilities: Within 1 hour of the initiation of a restraint, a physician or registered nurse (typically the nurse) will conduct a face-to-face assessment of the child/adolescent assessing the physical and psychological well-being of the child/adolescent and document this in the patient/client record.
4. In the Residential Treatment Facilities: Within 24 hours of the restraint event a physician or CRNP must perform the face-to-face assessment assessing the physical and psychological well-being of the child/adolescent and document this in the patient/client record.
5. The RN will contact the family or legal guardian within 2 hours of the termination of the emergency safety intervention/restraint. At this time, the RN will inform the family of the need for the restraint and any subsequent injuries or measure taken for that client.

SOUTHWOOD

PSYCHIATRIC HOSPITAL & RTFs

TO: MANAGEMENT

FROM: _____

SUBJECT: EMPLOYMENT AND CONTRACTOR CLEARANCES -- ALL SOUTHWOOD FACILITIES

DATE: 4/09

It is the policy of YFCS and Southwood to require background checks and clearances to be completed as follows:

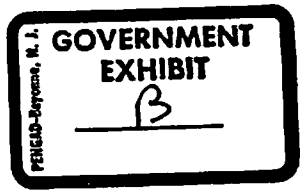
New Employee Hires

Before a candidate can be made an offer of employment, the following clearances ("new hire clearances") and pre-employment screening(s) need to be completed:

1. Trust Screening Systems' "Comprehensive" Criminal Background Check Package
   -- County Criminal Records
   -- Federal Criminal Records
   -- "Identity Plus" -- SSN & Address Trace
   -- US Crime ID -- Crime Locator Database
2. Statewide check through CBY Systems, Inc. of York, Pennsylvania
3. Driving/Motor Vehicle Records ("MVR") check through CBY Systems, Inc.
4. Office of Inspector General ("OIG") clearances
5. Megan's Law Sex Offender clearances
6. Excluded Parties List System ("EPLS") clearances
7. Any required licensure checks (RN, LPN, Licensed Social Worker, etc ....)
8. Current full version of Travelers Insurance's JCP® (Job Candidate Profile™) Development & Validation screening inventory test, which shall be administered by Human Resources

The following clearance(s) and pre-employment screening(s) need to be completed once the offer is made and the candidate accepted but preferably before he/she begins New Employee Orientation:

9. FBI clearances through Department of Public Welfare ("DPW")-required Cogent Systems
10. Pre-Employment Physical through Occupational Med Center
11. Pre-Employment Drug Screen through Occupational Med Center



12. Pre-Employment TB test through Occupational Med Center

The Pennsylvania Child Abuse History Clearance needs to be completed pursuant to Commonwealth of Pennsylvania requirements. If an employee does not obtain this required clearance within the Pennsylvania-required timeframe, he/she will not be permitted to perform his/her duties of the position and -- until such clearance is obtained -- will be removed, without compensation, from the schedule on which employees must be listed in order to have access to enter a Southwood facility for work.

Human Resources will require the Personal Action Form to be signed by the CEO and CFO once the clearances are obtained prior to being able to extend an offer to candidates. If at any point during the application process a clearance is obtained with questionable or concerning information, Human Resources is obligated to review the information with not only the facility CEO, but with the Regional Vice President and the YFCS Director of Human Resources. Human Resources will also be responsible for tracking this information not only in the employee personnel files, but in a spreadsheet format/database so that it can be shared with the Corporate offices and used for audit/reporting purposes. In no event shall an individual be permitted to enter a Southwood facility for work before the "new hire clearances" have been fully obtained and the facility CEO, Regional Vice President, and YFCS Director of Human Resources have determined, upon review, that there is no questionable or concerning information about the individual's background.

The "Employment Screening Checklist" that is attached hereto as "Attachment 1" must be completed before any applicant is placed on payroll. The completed checklist shall, with all other background check information, be kept in the individual's personnel files.

Current Employees

At the time of each employee's annual evaluation, Human Resources will re-run the following clearances:

1. Trust Screening Systems' "Comprehensive" Criminal Background Check Package
   - -- County Criminal
   - -- Federal Criminal Records
   - -- "Identity Plus" -- SSN & Address Trace
   - -- US Crime ID -- Crime Locator Database
2. Statewide check through CBY Systems, Inc.
3. Driving/MVR check through CBY Systems, Inc.
4. OIG clearances
5. Megan's Law Sex Offender clearances
6. EPLS clearances
7. Any required licensure checks (RN, LPN, Licensed Social Worker, etc ...)

If, at any point in time, there are added licensure requirements established by any agencies (DPW, Joint Commission, etc.....), Southwood will add review of the satisfaction of such

requirements to the above list of clearances run on an annual basis for affected employees.

As it is stated in the YFCS policy regarding Licensure/Certification, no employee shall be allowed to work without evidence of current licensure and/or certification, if such is required for the position. Employees whose positions require licensure by state or other regulatory agencies will be responsible for keeping such licensure current and for notifying appropriate facility personnel regarding changes. Any employee who does not comply with this policy shall be subject to disciplinary measures up to and including termination. The facility is under no obligation to continue the employment of individuals who fail to become registered and/or licensed and remain non-licensed where such is necessary legally to perform their duties.

PROCEDURE

1. Prior to employment in, or promotion to, a position requiring licensure/ certification, the individual must supply visual evidence of current licensure/ certification. This will be documented in the employee's permanent personnel file, either by a copy of the licensure (if allowed), or by a log sheet.
2. Employees taking licensure examinations will usually do so on their own time and at their own expense, with the facility arranging work schedules so that time will be available for taking the licensure examination.
    a. Employees with satisfactory performance who pass licensure examinations will be placed in available positions requiring licensure at the appropriate grade and salary if a position is available.
    b. Employees failing licensure examinations will be demoted to available positions at the appropriate salary and grade for which they are qualified, if a position is available. If no position is available, employees will be terminated.
3. Employees will immediately inform their supervisor of changes in their license status and will provide their original license for visual verification or photocopying in accordance with state law.
4. It shall be the responsibility of the employee to provide evidence of renewal to Human Resources, prior to the expiration date. If the new license has not arrived, the employee shall provide documentation that paperwork was submitted on a timely basis; Human Resources will then call the licensing board and obtain oral confirmation of renewal.
5. At the beginning of each month, Human Resources will send a notice to the supervisor, and to the affected employee, of licenses/certification which is due to expire the following month.

If an employee's licensure/certification is expired, Human Resources shall notify a Supervisor the day following expiration. The supervisor shall then be responsible for suspending the employee without pay until such time as renewal is obtained. The Supervisor shall be responsible for any further disciplinary action with the employee.

If at any point during the annual clearance process there is a clearance obtained with questionable or concerning information, Human Resources is obligated to review the information promptly with not only the facility CEO, but with the Regional Vice President and the YFCS Director of Human Resources. Human Resources will also be responsible for tracking this information not only in the employee files, but in a spreadsheet format/database so that it can be shared with the Corporate offices and used for audit/reporting purposes.

Physician Contractors

Before a physician contractor may work at a Southwood facility, the clearances set forth in Southwood's "Credentialing Appointment/Reappointment Process" Procedures, attachment "2" hereto, shall be completed. A physician shall not be permitted to work at any Southwood facility until these clearances are fully obtained and reviewed. If any clearance contains questionable or concerning information, Human Resources is obligated to review the information with not only the facility CEO, but with the Regional Vice President and the YFCS Director of Human Resources. The physician shall not be permitted access to any Southwood property to work until these individuals, upon review, determine that there is no questionable or concerning information about the individual's background.

Non-Physician Contractors

Before a non-physician contractor may work at a Southwood facility, the following clearances on the contractor need to be completed:

1. Office of Inspector General ("OIG") clearances
2. Excluded Parties List System ("EPLS") clearances
3. Act 33/34 Clearances -- Child Abuse/Criminal Record Check Reports, FBI Checks -- Initial
4. Any required licensure checks (RN, LPN, Licensed Social Worker, etc ....)

A non-physician contractor shall not be permitted to work at any Southwood facility until these clearances are fully obtained and reviewed. If any clearance contains questionable or concerning information, Human Resources is obligated to review the information with not only the facility CEO, but with the Regional Vice President and the YFCS Director of Human Resources. The contractor shall not be permitted access to any Southwood property until these individuals, upon review, determine that there is no questionable or concerning information about the individual's background.

SOUTHWOOD PSYCHIATRIC HOSPITAL

This checklist must be completed before the applicant is placed on Payroll.

_____ _____

(candidate name) (start date)

EMPLOYMENT SCREENING CHECKLIST

(date completed)

_____ ♦ Application complete, including all explanations and details requested?
_____ ♦ Has the applicant verified that former employers may be contacted?
_____ ♦ Has the applicant signed the Acknowledgment?
_____ ♦ Has the applicant completed and signed the Release Authorization form?
_____ ♦ Comprehensive Criminal package w/ Trust
_____ ♦ Adverse Notice & Copy of Rights provided to the applicant (if applicable)?
_____ ♦ Statewide check through CBY Systems, Inc.
_____ ♦ Driving/MVR check through CBY Systems, Inc.
_____ ♦ Office of Inspector General ("OIG") clearances
_____ ♦ Megan's Law Sex Offender clearances
_____ ♦ Excluded Parties List System ("EPLS") clearances
_____ ♦ JCP Test (if applicable)
_____ ♦ Verified Licenses (RN/Therapist/etc. . .)
_____ ■ FBI clearances through DPW-required Cogent Systems
_____ ■ Pre-Employment Physical/Drug Test/TB Test - Occupational Med Center
_____ * Child Clearances (mailed to employees home & they bring it to HR upon receiving it - normally 10-30 days
_____ * I-9 form complete?
_____ * W-4 form complete?
_____ * Education level verified with diploma/transcript from accredited institution (if applicable)?
_____ * Copy of license/registration (if applicable)?
_____ * Conflict of Interest complete?
_____ * Signed copy of job description complete?
_____ * YFCS Employee Handbook receipt with signature complete?
_____ * Dual Employment/"Moonlighting" Policy receipt with signature complete?

♦ Done before an offer is made to an Employee
■ Done after the Employee accepts but prior to their start date
* Done once Employee begins work

_____

HR Signature Date

SOUTHWOOD PSYCHIATRIC HOSPITAL
PHYSICIAN CREDENTIALING
APPOINTMENT/REAPPOINTMENT PROCESS

1. Application, along with a copy of the ByLaws and Rules and Regulations, mailed or handed to applicant upon recommendation and request of CEO/Medical Director.
2. Application returned and forwarded to credential secretary and it is reviewed for completion and required attachments. Appropriate worksheet filled out.
3. Credentialing process (Primary Source Verification) initiated.

   - State license(s) verified via Internet -- Initial Appointment, Reappointment, Yearly
   - Professional Liability Insurance Verified & Claims Hx Requested (5 yrs.) -- Initial, Reappointment
   - AMA Profile -- Initial, Reappointment
   - Board Certification verified (if applicable) -- Initial, Reappointment, if certification expired
   - Education, Internship, Residency -- Initial
   - Education -- Allied Health Professionals -- Initial
   - ECFMG -- Initial if foreign graduate
   - National Practitioner Data Bank and Healthcare Integrity & Protection Data Bank -- Initial, Reappointment -- every 2 years
   - Office of Inspector General, Excluded Parties Listing System, PA Dept of Public Welfare Medicheck List -- Queried (Internet) -- Initial Appointment, Reappointment
   - Act 33/34 Clearances -- Child Abuse/Criminal Record Check Reports, FBI Checks -- Initial
   - Affiliate Hospitals as identified on application verified -- Initial, Reappointment
   - Personal References as identified on application verified -- Initial
   - Peer Review -- Reappointment (Information collected and presented to Medical Executive Committee)

4. Current copies of License, DEA, Professional Liability Insurance and CV are maintained in credential file.
5. Upon receipt of all Primary Source Documentation, the complete credential file is forwarded to the Medical Executive Committee with Initial Appointment Checklist, Credential's Committee Worksheet and Transmittal Form. Reports received from any primary verification source (Data Bank, Insurance Co., etc.) regarding a specific, possible negative response, are flagged so that it is not missed by Medical Executive Committee.
6. After recommendation regarding the appointment/reappointment is reached by Medical Executive Committee, credential file is forwarded to Governing Body for review and approval/denial.
7. Letter sent to applicant regarding appointment/reappointment. A provisional appointment of one year is granted to initial appointees in accordance with Medical Staff ByLaws. Reappointments are for a 2-year period.

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Prosperity RTF PIC Approval Date: April 09 Written by: L. Machado

Program/Dept. Director: Jeri Jones, Prosperity Clinical Program Director

SUBJECT: Therapeutic Care

Effective Date: 4/09 Revision Date: Page 1 of 1

POLICY:

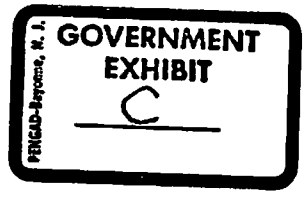
It is the policy of the Southwood Prosperity Campus that therapeutic care as it pertains to the structured clinical activities is carried out in a consistent manner to all residents in the program.

PURPOSE:

The purpose of the Therapeutic Care Policy is to outline the clinical program components related to therapeutic care. This will allow for consistency and uniformity in the delivery of services to the residents at the Southwood Prosperity Campus.

GENERAL PROVISIONS:

- Southwood Prosperity Campus will ensure that the development of an Individualized Service Plan ("ISP") for each resident is completed according to the established Phase System for the program. The assigned clinician will ensure that the resident and his family understands the progression of the Phase System and how the resident can progress through the Phase System by embracing the treatment program outlined in the ISP.
- Southwood Prosperity Campus will employ the Cognitive Behavioral Therapy model in all facets of programming to include milieu, individual therapy, group therapy and family therapy.
- Southwood Prosperity Campus will utilize Master's Level Therapists for the delivery of individual therapy, group therapy and family therapy services. Each Master's Level Therapist will maintain a clinical caseload not to exceed ten (10) residents.
- Group therapy sessions conducted by Master's Level Therapists shall not exceed ten (10) group participants. This allows for the Master's Level Clinician to conduct group therapy sessions with his/her specific caseload as well as conduct group therapy sessions that are topic specific based on residents' ISPs, as well as conduct group therapy sessions with residents in a specified RTF house.
- Group therapy sessions conducted by a Master's Level Clinician shall occur a minimum of once each week day for each resident. Each group therapy session conducted by a Master's Level Clinician shall last a minimum of 45 minutes. Any exceptions to a session lasting less than 45 minutes will be documented in the clinical note. Session documentation will be completed at the time of service delivery.



- Group therapy sessions conducted by Master's Level Clinicians shall focus on problems identified on residents' ISPs. In addition, group therapy sessions will include concepts of Cognitive Behavioral Therapy as well as the topics outlined below. It should be noted that topics will be delivered as applicable to the participants in the group to ensure that we are maximizing treatment opportunities.

  Respect and responsibility training
  Social skills training
  Problem solving skills training
  Cultural diversity training
  Bullying
  Adoption
  Family discord
  Trauma
  Substance Abuse
  Abandonment (real or perceived)
  Forms of abuse (verbal, physical and sexual)
  Divorce

- In addition to Master's Level Clinical Staff conducting group therapy sessions, direct care staff shall conduct milieu/community group meetings each shift. These group meetings will vary in terms of topic based on the shift. Day shift will cover goals for the day as well as periodic journaling and Cognitive Behavioral Therapy ("CBT") Workbooks. Evening shift will cover a recap of goals achieved during the day as well as periodic group assignments. Night shift will not conduct group meetings with the residents. All group meetings conducted on any shift will be documented in the daily shift note.
- Southwood Prosperity Campus will provide individual therapy sessions a minimum of one time per week and more frequently if clinically indicated. Individual therapy sessions shall be conducted by a Master's Level Clinician. Each individual session will last a minimum of 45 minutes with limited exceptions. Documentation of the session will occur at the time of service delivery.
- Southwood Prosperity Campus is committed to ensuring that each resident has the opportunity to participate in a consistently executed therapeutic care program. This program incorporates the above noted programming, which shall be incorporated into the ISP for each resident and reviewed on a consistent basis.

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Medical Records Written by: Tina M. Wood, RHIT
Program/Dept. Director: Tina M. Wood, RHIT PIRC Approval Date: _____

SUBJECT: DOCUMENTATION STANDARDS FOR PATIENT/CLIENT CARE SERVICES

Effective Date: 10/99 Revision Date: 10/99,1/03,11104,12/05, 4/09 Page 1 of 2

POLICY NUMBER: 4

PURPOSE

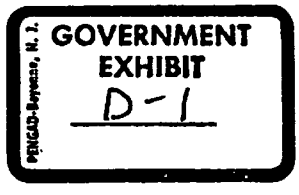
It is the responsibility of the attending physician and other care providers to prepare a complete medical record of each patient. The medical record shall contain sufficient information to identify the patient, support the diagnosis, to justify the treatment and document the results accurately. The medical record shall include identification data, complaint, history of present illness, appropriate person and family medical history, physical examination, and system review, diagnostic and treatment orders, clinical observations, progress notes, special or procedural reports, final diagnosis, condition on discharge, and follow-up note and/or instructions

POLICY

Documentation Guidelines

- All care and services provided are documented for each individual patient whether the patient is or is not billed for these services All patients are registered and given a medical record number and an account number
- A medical record folder is established for each individual patient Folders are pre purchased by the Medical Record Department; therefore, each clinical area is expected to route documentation to the Medical Record Department for permanent filing Records should be routed using the following schedule:
  - acute care - within 1day of patient discharge
  - residential treatment facility - within 7 days of resident discharge
  - family based services - within 7 days of client discharge

- Documentation occurs at the time the care and services are rendered. Minimum data requirements are established in the policy that covers minimum data requirements for patient care services
- All forms utilized for clinical documentation must be approved, with a form number assigned Forms that have not been approved will not be considered a permanent part of the medical record and will be returned to the originating department. The policy that covers the forms systemization process should be followed to introduce new forms or revise existing forms
- All entries must be legible and the documentation must be recorded in BLACK INK



- All documentation is identified by the patient's name, medical record number, and date.The person making the entry must sign, date and time all entries.
- All patient records will be assembled in chronological order and follow the chart divisions established by the Medical Records Department procedure concerning chart order

Documentation Guidelines According to Service Type

Definition of Service Types
- acute care
- residential treatment facility
- family based services

Documentation Guidelines

1. *Discharge Information Sheet* - This form is generated at the time of discharge by the acute care and residential treatment facility programs.
2. *Southwood Family Based Services Discharge Log Form* - This form is generated at the time of discharge. Physicians/clinical staff are to document final diagnoses, aftercare follow-up, and medication instructions. The patient/family sign the Discharge Information Sheet identifying they understand the outcome and they are given a copy.
3. Physician's Order(s)
4. History and Physical Examination and/or Physical Screening
5. Patient Assessment/Plan for Treatment
6. Test Results
7. *Patient Monitoring.* Progress Notes, Nurse's Notes, Multidisciplinary Notes, callback/ follow-up documentation
8. Consultation Reports: if applicable
9. Discharge Note and/or Discharge Summary
10. Consent forms

Monitoring and Compliance

a. Medical Records will review a sample of records on a monthly basis as a part of the clinical monitoring process. Results of this review are reported to the PIRC, Medical Staff Department, and Administration.

b. At the time of discharge the Medical Records department will assign diagnosis and procedure codes based on the clinical documentation on the Discharge Information Sheet or the Discharge Log Form in the medical record

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Medical Records Written by: Tina M. Wood, RIHA

Program/Dept. Director: Tina M. Wood, RHIA PIRC Approval Date: 12/30/04

SUBJECT: DOCUMENTATION REQUIREMENTS

Effective Date: 10/99 Revision Date: 10/99,1/03,11/04,11/08, 4/09 Page 1 of 6

POLICY NUMBER: 5

PURPOSE

All records are analyzed to guarantee staff maintain the required documentation in the patient's medical record as it applies to the process of patient care provided.

POLICY

General overall policy for records regardless of Program.

The patient's medical record is a legal document and must be maintained with accuracy at all times.

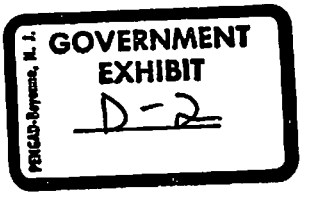
The record is analyzed by the Medical Record staff for the following appropriate entries:

Authentication of chart entries are made by original signature of the person documenting in the record;

The employee's first initial and full last name and title (credential) will be used when signing any part of the patient's record The date and time of the authentication is required;

Personnel who may document in the medical record include utilization review nurses, physicians, registered nurses, LPNs, child care specialists and associates, social workers, registered dietitians, therapists, activity coordinators and associates, intake and assessment staff, unit clerks and case managers;

Erasures and white out are not permitted in the medical record. Any corrections of errors made by the author of an entry requires a line through the error, print "error" at top of entry, initial, and date of the correction. Any chart alteration made by someone other than the author of the entry requires the signature and date of the correction. Chart revisions must not be obliterated Addendum(s) must also be signed by the author and if possible should be underneath the original entry. Addendums should also state why the addendum was added to the entry.



Only black ink is appropriate for documentation. Pencil should not be used in the medical record.
Other patient names are not to appear in the medical record.
Correct patient information should be on the corresponding medical record.
Check that all forms are in the proper patient chart.

Behavior patterns and interpersonal interactions of the patient must be recorded (i.e sleeping, eating, physical appearance, medical responses, etc)

Psychiatric Evaluation - Acute Care - an initial psychiatric evaluation will be written or dictated within 24 hours of admission.
Residential Treatment Facility - an initial psychiatric evaluation will be written or dictated within 7 days of admission. The typed report is reviewed and signed by the dictating physician.

Physical Exam - The physical exam is completed and signed by the nurse practitioner and medical physician or by the attending physician. The time frames for completion and documentation of the history and physical examination is:

Inpatient - within 24 hours of admission.
Residential - within 7 days of admission.

Medical History Form - Is completed by the patient/parent and reviewed by the nurse within the shift that the patient was admitted. This form is also reviewed by the attending physician but does not required verified signature.

Immunization Form - Is completed by the patient/parent and reviewed by the nurse within the shift that the patient was admitted. This form is reviewed by the attending physician but does not require verified signature.

Admission Assessment - The admission assessment is initiated at the time of admission by the Intake and Assessment Department's licensed staff. When intake assessment services staff is not available, the admission assessment is completed by the staff nurse An effort is made to complete the assessment within the shift of admission. If the form is unable to be completed due to the unavailability of the family or the patient being unable to provide all pertinent information, follow up data collection is completed by the staff nurse within 24 hours of admission

The admission nurse assessment is completed by the admitting nurse at the time of admission.

Laboratory Reports - All laboratory reports are to be reviewed and initialed, dated and timed by the attending physician at the time of review

If at any time during the length of stay the Medical Record Department receives reports they will be sent to the unit to be put on the chart

Sleep Graphs - The sleep graph should be completed by the night staff (during the 11 p.m. to 7 a.m shift)

Social History - The social history form is required to be completed for all patients admitted to Southwood Hospital. The social history form is to be completed within 24 to 48 hours of admission.

Discharge Summary Sheet- The discharge summary sheet is to be completed by the FIS/CM and nurse at the time of discharge and signed by FIS/CM, nurse and parent/guardian.

Psychological Testing - Psychological testing (when ordered) is to be completed and signed by the staff psychologist within 7 days of the physician order. There must be a written outcome of the Psychological Evaluation in the progress notes or consultation report at the time the results are determined.

All consultations (when ordered) are to be completed and signed by the consultant within 2 days of the physician order.

Treatment Plans

Inpatient - Initial Treatment Plan and the Master Treatment Plan - the interdisciplinary plans will be initiated within the first 24 hours of admission.

Residential - Master Treatment Plan - The master treatment plan is required to be completed by the 14th day of admission. The Initial and Master Treatment Plans are to be reviewed and signed by the members of the treatment team including the attending MD and the assigned social worker. This plan must be reviewed, signed and dated by the team every 30 days. The attending physician's Recertification of Need for Care must be completed, signed, and dated by the physician every 30 days. The Recertification should be a detailed assessment of the resident's progress and should explain why he/she continues to need this residential level of care.

Intervention Objectives -Intervention objectives are a crucial part of the Master Treatment Plan. They are to be developed by the interdisciplinary team.

Patient/Family Education related to Medication, Health and Discharge Planning is documented in the multidisciplinary progress notes by the RN, CRNP, CCS and CCA.

Physician Orders - Chart contents should always correspond with physician orders. Medications, special diets, and any additional orders by the physician will be reviewed and authenticated every 30 days.

Physician orders may only be written by members of the medical staff who have privileges for direct patient care.

Verbal or Telephone Orders may be accepted by registered nurses. Verbal orders or phone orders shall be accepted when a physician is not available and timely intervention is warranted. To assure accuracy upon acceptance of a V.O. or T.O., the RN should repeat the order to the physician prior to writing it down. Nurses should indicate that the order is either a verbal order (V.O.) or telephone order (T.O.). Orders must be dated and timed at the time they are written as well as transcribed by the RN. All V.O. and T.O. are to be signed by a physician the next working day.

Progress Notes - Documentation in progress notes must include the date and time of occurrence. Notations will never be done prior to an occurrence.

> If a progress notation is out of sequence please indicate "note out of sequence" or clearly distinguish between the time of the entry and time of the event.
>
> Lines should never be skipped. If at the end of the page a note is completed and a few lines remain empty, spaces must be crossed out.

Progress notes are to be signed by the staff member completing the note. Progress notes that continue from one page to the next page are to be signed at the bottom of the first page in addition to the end of the note.

> Progress notes should include progress over time, (notes should be recorded as soon as possible after the event occurs), documentation of patient care, the treatment provided, and its results.
>
> Quoted material should be used with discretion, however; it is often helpful to quote important material or that which is an unusual occurrence.
>
> A discharge progress note is to be completed by the attending physician and a separate discharge progress note is to be completed by the discharge nurse.

HIV - Any information referring to or containing information regarding a patient's HIV testing will be separated from all other notes, (consent to HIV treatment, progress notes, and results are documented separately) and filed in a "confidential" folder (marked with a red dot sticker) in the back of the chart on discharge by the Medical Record Coordinator

Any loose or late filing containing HIV information regarding a patient's HIV testing shall be filed in the "confidential" folder within the patient chart at the time it is received in Medical Records

Progress notes surrounding the time of HIV testing shall be scanned to ensure confidential information was not included with the rest of the chart.

If progress notes are located on the same pages as HIV information, the unit supervisor will immediately be notified of the error. The pages will be copied, the HIV information will be blacked out, and the copy will be filed with the patient's progress notes The original progress note will be filed in the "confidential" section of the chart by the Medical Record Coordinator.

No information regarding HIV testing is to be released unless proper authorization is given by the patient

Discharge Summary Sheet - This form is completed by the discharging nurse and the assigned social worker. A copy of this sheet is given to the patient for follow up discharge instructions. The Final Diagnosis is coded by the Medical Record staff.

Health Management System (HMS) - Every patient record from every program is abstracted into the HMS System at the time of Discharge by the Medical Record staff.

Psychiatric Discharge Summary - The discharge summary is to be dictated by the attending physician within 15 days after the patient is discharged. The discharge summary will contain: reason for hospitalization, significant findings, procedures performed and care, treatment and services provided, condition on discharge, instructions to patient/family. The typed report is to be reviewed and signed by the dictating physician.

Consent to Treatment - The patient's consent to treatment should be signed by the patient or parent/guardian if under the age of 14. The consent form is also to be signed by the attending physician and the admission RN.

Residential Programs - The residential program medical records contain additional forms (as well as the ones mentioned above) which are specific to the type of program in which the patient is enrolled. These forms are to be completed by the staff members assigned to coordinate each specialty program and are outlined in the program policy and procedure manual.

Student or resident documentation is to be reviewed and co-signed by supervising staff members.

In the event that a clinical staff member resigns or leaves the organization, it is the responsibility of the acting supervisor to complete any outstanding documentation deficiencies.
Each discipline will adhere to the policy guidelines for their specific required documentation as outlined in their policy and procedure manual.

All Medical Record forms are organized in an ongoing form book according to number and date of acceptance by the Performance Improvement Committee (PI Committee).

It is a requirement that all required documentation be in the medical record and completed 30 days after patient discharge.

ANALYSIS

- Once the medical record is assembled, the chart is analyzed for documentation completion.
- Typed reports (Discharge Summary, Psychiatric Evaluation, and Psychological Testing) are accounted for and signed.
- Each form is reviewed for completeness and proper documentation A colored tab is placed beside any deficient areas of the form(s)
- All deficiencies are recorded in the deficiency system
- Deficiency sheets are copied and distributed weekly
- It is a requirement that a chart be complete 30 days from the date of discharge
- Form completion time frames must comply with the documentation procedure or the chart is delinquent

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Prosperity RTF Programs Written by: Mary Cay Macik, M.Ed., Executive Director

Program/Dept. Director: Prosperity Executive Director PIRC Approval Date: 2/28/07

SUBJECT: ASSESSMENT

Effective Date: 2/28/07 Revision Date: 4/5/09 Page 1 of 6

POLICY:

It shall be policy of the RTF programs that are currently housed in Prosperity, Pennsylvania to establish appropriate clinical criteria for admission and discharges in regard to treatment services. Admission shall be limited to individuals who can emotionally, behaviorally, and physically participate in the program (with reasonable accommodations), and who can be expected to profit from the services offered. The RTF programs' policies on Admission and Discharge criteria shall be subject to ongoing evaluation in the overall agency Performance Improvement Program.

PROCEDURE:

ADMISSIONS PROCESS

Intake Specialist

Southwood Hospital shall employ an individual to function as the Intake Specialist. This staff member shall serve as the primary contact person for soliciting information on any potential referral for treatment. All referral packages that the Intake Specialist compiles are required to consist of the following information before the Admissions Department may consider admission:

1. A letter of referral from an outside referral source;
2. Name, age, current address of individual;
3. All pertinent family information and history;
4. Presenting issues necessitating placement;
5. A plan of care/treatment plan;
6. A psychiatric evaluation completed within the last 30 days;
7. A medical history and physical completed within the last 30 days;
8. A case summary, including the following:
   a. Most recent diagnostic impressions;
   b. Medication history (including any medication allergies and sensitivities);

c. Significant psychiatric/medical/behavioral/cognitive and intellectual/cultural information;
d. A summary of any past or pending custody or legal issue(s);
e. Any history of any serious aggressive behavior;
f. Any history of maladaptive sexual behavior;
g. A comprehensive educational history (including most recent IEP, if applicable, notification of special education status, and county responsible for educational coordination); and
h. Copies of immunization records, Social Security card, and birth certificate.

Upon receipt of this information, the Intake Specialist shall complete an admission assessment worksheet and forward the referral packet to the Admissions Review Committee, which meets regularly to review referrals and decide on appropriate admissions and which shall. If more or better information is needed to determine whether the applicant should be accepted, the Intake Specialist shall be directed to obtain whatever is necessary. No individual shall be considered for admission to a Prosperity RTF program except upon recommendation of a licensed psychiatrist (who is not a Southwood attending psychiatrist) based upon medical necessity.

Each applicant's presenting problems must be identified and investigated carefully before he is accepted to one of the Prosperity RTF programs. Efforts should be made to interview parents and referral sources and, whenever possible, to conduct a face-to-face interview with the applicant to gauge the level of appropriateness for the Prosperity campus. The applicant and his family shall be encouraged to tour the RTF facilities during the admissions process. To ensure that all individuals referred to Prosperity RTF programming are being appropriately placed for treatment services, a "RTF Resident Referral Review Checklist Form" -- attachment "1" hereto -- shall be used by the Admissions Team.

The final decision to accept or reject a referral for placement shall be based upon recomendations of the Treatment Team and shall be made by Southwood's Chief Executive Officer in conjunction with review by the Regional Clinical Program Director who is responsible for Southwood. The determination shall be made based upon the required and available information and upon several factors, including but not limited to the "criteria for admission" and the "exclusionary criteria" set forth below. In no event shall a referred individual be accepted to the Prosperity RTF programs before he is medically stable.

Any omitted pertinent case information preventing Southwood from making a clinically sound admissions determination shall preclude an individual from being considered for admission. It shall be the responsibility of the parent, guardian, and/or referral source to provide whatever is deemed necessary in order to consider the case for services.

Criteria for Admission

Although presenting characteristics will vary by applicant, the Prosperity RTF programs shall generally consider for admission individuals who meet the following criteria:

1. Individuals ranging in age from 6-18;
2. Individuals who meet the criteria for one or more of the following DSM-IV diagnoses:
    - Disruptive Behavior Disorders
    - Impulse Control Disorders
    - Mood Disorders
    - Anxiety Disorders and/or
    - Axis II Personality Traits
    - ADHD
    - Abuse History
    - Asperger's Disorder/PDD
3. Individuals who are assessed as intellectually, cognitively, and emotionally able to benefit from a Prosperity RTF program.
4. Individuals who are not capable of benefitting from a less restrictive level of care.
5. Individuals with persistent and pervasive behavior that severely impacts social, familial, occupational or educational functioning as exemplified by the following:

    - Family-related adjustment problems, including communication difficulties, lack of respect for the rights of others, running away, persistent lying, stealing within the home, argumentative behavior, non-compliant behavior, physical aggression, lack of emotional bonding, or violation of family rules;
    - Problems related to personal and emotional functioning, including poorly modulated affect, low self-esteem, impulsivity, inadequate decision-making skills, low frustration tolerance, or temper outbursts;
    - Problems functioning within the community and social relationships, including history of substance use, stealing, vandalism, difficulty in maintaining peer relationships, lack of respect for authority figures, minimal involvement in pro-social activities, minimal sexual acting out issues;
    - Academic difficulties, including truancy, failure to achieve consistently with ability level, disruptive behavior, delinquent acts, poor work and study habits, disrespect for authority, or lack of motivation.

Exclusionary Criteria

The Prosperity RTF programs shall exclude from admission individuals with the following characteristics:

1. Individuals who are moderately mentally retarded (IQ below 60 with deficits in adaptive functioning);
2. Individuals who are actively suicidal, homicidal, or psychotic;
3. Individuals with terminal conditions;
4. Individuals with severe psychiatric disorders in need of 24-hour acute inpatient hospitalization;
5. Individuals who are medically fragile or who are severely physically handicapped (requiring high levels of assistance in self care, hygiene, locomotion, etc.);
6. Individuals with antisocial behavior or violence creating an ongoing danger to self or others;
7. Individuals who are judged to be non-amenable to treatment based on history and information obtained from face-to-face assessment;
8. Individuals with significant history of sexually maladaptive behaviors or actively sexually acting out;
9. Individuals with violent felony charges or currently adjudicated with violent felony history;
10. Individuals with primary diagnosis of significant drug and/or alcohol history that needs to be addressed currently in treatment.

Southwood shall not deny admission to any individual based on gender, race, ethnic origin, religious beliefs, or sexual orientation. Nor shall it base its decision on social, cultural, or spiritual beliefs/practices of any individual.

When an individual is determined to be inappropriate for services, the Intake Specialist shall contact the family, guardian, or referral source to explain the Southwood's reasons for denying admission. The hospital shall make all attempts to assist in the process of locating and obtaining more appropriate placement options on behalf of the individual.

INTRA-AGENCY PROGRAM CHANGE

Process for Intra-Agency Program Change

Southwood Psychiatric Hospital makes every effort to place residents in the most appropriate unit/site upon admission; however, there are times that -- after a resident has been placed and a more thorough evaluation of his needs and presenting issues has been completed -- the Treatment Team determines that movement to a different unit/site is in his best interest. In those situations, the following steps will he taken:

1. The resident's Family Intervention Specialist (FIS)/Therapist shall present to the Treatment Team concerns with the current placement and the goals of a program transfer. This will be reviewed with the resident's psychiatrist and Southwood's Executive Director for a final decision.
2. When a program move is approved by the Treatment Team, the FIS/Therapist will make written recommendations to the referral source as to the reason for the recommendation. This can be done in the resident's regular monthly report or in a special memo, depending on the time of the month. All outgoing correspondence shall be reviewed by the Executive Director.
3. On the day that a resident is discharged and admitted to one of the other program sites, the FIS/Therapist or Case Manager who has supervised the case will complete the **Discharge Information** form and submit it to Medical Records and the Billing Office. In addition, the Shift Supervisor will send an administrative report fax notification in the same manner that admissions and discharges are reported nightly.

DISCHARGE CRITERIA

Criteria for Involuntary/Administrative Discharge

Individuals who are to be discharged or transferred to another facility shall have the reasons clearly explained to them by the Treatment Team. Family members and/or guardians as well as referral sources shall be invited and encouraged to attend the staff meeting discussing the planned discharge/transfer. The following are criteria for potential discharge:

1. Serious and/or physical violence toward staff and peers;
2. Serious threats made to residents or staff;
3. Distributions of alcohol, drugs or other contraband to residents;
4. Serious destruction of property;
5. Repeated AWOL/elopements or attempts;
6. Failure to benefit from treatment services after numerous revisions to MTP;
7. Oppositional, disruptive, and/or antisocial behavior resulting in unsafe situations for the resident population such as:
   a. Instigating AWOL/elopements and attempts;
   b. Room barricades;
   c. Fire starting;
   d. Posing a danger or threat to the community at this level of placement;
   e. Repeated sexual acts on campus or coerced sexual activity;
8. If, at any time, the Treatment Team and FIS/Therapist determine that a potential admission or continued stay could threaten the integrity and provision of safe care to the residents.

Successful Discharge Criteria

The Prosperity RTF programs shall place a high priority on effective discharge planning and follow-up services. The Treatment Team shall be responsible for all aspects of discharge planning and follow-up services, with the final decision of discharge determined by the FIS/Therapist, Treatment Team, and Executive Director. The following are the criteria for successful discharge from the Prosperity RTF programs:

1. The abatement of psychiatric/behavioral illness;
2. The individual has reached a level of stability at which this level of placement is no longer necessitated and the individual can be safely managed in a less-restrictive environment;
3. The individual displays a significantly improved condition by exhibiting little or no major maladaptive behaviors;
4. The individual is able to articulate plans to manage his emotional and/or behavioral responses in regard to various psycho-social stressors;
5. The individual, it is felt, will be better able to manage potential family conflict;
6. The family of the individual, when appropriate, has demonstrated a commitment toward successful reunification based on its level of participation in the placement of the individual;
7. There are reasonable expectations that the resident shall be compliant with family rules and expectations, as well as remaining free of legal involvement;
8. The resident has articulated plans to manage independent living skills, i.e., employment, school, post-secondary school, etc.;
9. The resident has taken an active part in discharge planning and can reasonably be expected to follow through on all aspects of the discharge plan.

RTF Resident Referral Review
O MRDD O Prosperity O SMB

Name of Individual Assessed_____ Date of Review_____

Assessment Method O face to face O records review O other _____

_____A. Previous treatment for emotional problems:
Note: _____

_____B. Failure of outpatient services and / or less restrictive environment
Note: _____

_____C. Continued difficulty in two or more areas (academic, social, family, legal)
Note: _____

_____D. Elopement risk / history
Note: _____

_____E. History of suicidal thoughts, plans, or attempts
Note: _____

_____F. History of physical aggression directed towards others and / or environment
Note: _____

_____G. School refusal / academic difficulties due to behavior (temper outburst, low self – esteem, low frustration tolerance)
Note: _____

_____

_____

_____H. History of psychotic behaviors

Note: _____

_____

_____

_____I. Developmental delays causing interpersonal / intrapersonal difficulties

Note: _____

_____

_____

_____J. History of substance abuse and / or dependency

Note: _____

_____

_____

_____K. Intense family discord

Note: _____

_____

_____

_____L. Unresolved sexual / physical abuse

Note: _____

_____

_____

_____M. Ongoing display of conduct disorder related behaviors

Note: _____

_____

_____

_____N. Sexual molest of siblings (alleged or found true)

Note: _____

_____

_____

_____O. Sexual molest of others (alleged or found true)

Note: _____

_____

_____

_____P. Display of obsessive preoccupation (sexual thoughts, comments, gestures, or fantasies)

Note: _____

_____

_____

_____Q. Use of force or aggression in order to gain "victim compliance"

Note: _____

_____

_____

_____R. Has engaged in different sexually maladaptive behaviors (exhibitionism, voyeurism, obscene phone calls, stalking, frottage, beastiality, or fetishes)

Note: _____

_____

_____

Other : Note: _____

_____

_____

_____

Approved for: O Admission to Residential Program O SMB O Prosperity O IRTF

_____

_____

_____

_____

Denied for Admission : O

Reasons for denial_____

_____

_____

Possible treatment / placement options:

The following team members reviewed this case for admission:

Staff signature _____ Date _____

Staff signature _____ Date _____

Staff signature _____ Date _____

Staff signature _____ Date _____

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Residential Written by: Barbara Sisarcick, RN, BSN, CPHO

Program/Dept. Director: Program Director PIRC Approval Date: 1/03

SUBJECT: Discharge of the Resident

Effective Date: 12/02 Revision Date: 4/10/09

POLICY: The interdisciplinary team will create a discharge plan that is fully explained to the resident and/or guardian at the time of discharge, based on the resident's needs as they have been assessed starting at the time of admission and continuing throughout the resident's stay.

PURPOSE: To provide guidelines to the interdisciplinary treatment team, enabling them to assist the resident and/or guardian in exploring aftercare options and securing discharge plans.

DISCHARGE PLANNING

Interdisciplinary Treatment Team

1. Begin discharge planning at time of admission.

2. Document all discharge planning on the interdisciplinary team meeting minutes in the resident's medical record.

3. Create a tentative discharge plan during the first family therapy session or treatment team meeting, to be confirmed/revised by the treatment team as needed, but at least monthly during treatment team meetings.

Family Intervention Therapist and Case Manager/Coordinator

1. Discharge planning shall be discussed at least one time per month, or as indicated with the resident's psychiatrist during treatment team meetings.

2. Document each discharge planning session held with the treatment team or that occur during family therapy sessions.

AFTERCARE PLAN

Family Intervention Specialist/Therapist Or Case Manager/Coordinator

Complete the Discharge Summary form

1. All follow-up plans are made prior to discharge;

2. Instructions related to medical problems requiring follow-up should be documented in the MEDICAL FOLLOW-UP RECOMMENDATIONS section;

3. Instructions related to parenting skills, additional medication instructions, and follow-up lab should be documented in the DISCHARGE PLAN section;

4. All sections should be filled out completely; any section that doesn't apply to the resident should be marked accordingly;

5. At the time of discharge, review completed plan/summary with the resident and/or guardian by phone if guardian is not present;

6. Clarify any areas that the resident and/or guardian doesn't understand prior to obtaining their signature at the bottom of the form;

7. Sign completed form with the date and time included;

8. Give the resident and/or guardian the YELLOW copy of the signed form; in cases where the guardian is not present, give the yellow copy to the person transporting the resident or mail the yellow copy to the guardian;

9. Document a discharge summary in the progress notes, including guardian's understanding of discharge plan whether by phone or in person.

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Residential Written by: Lynne Struble, CEO

Program/Dept. Director: Lynne Struble, CEO PIRC Approval Date: 8/05

SUBJECT: Residential Program Family/Child/Adolescent as Treatment Team Members

Effective Date: Revision Date: 1/03, 8/05, 4/09 Page 1 of 1

POLICY

It is the policy of Southwood's RTFs that, from the time of referral to the time of discharge, the child/adolescent and his family participate in the treatment planning process. All members of the interdisciplinary team will work cooperatively to ensure the participation of the child/adolescent and family in addressing the identified treatment issues.

PROCEDURE

1.0 Planning procedure is as follows:

1.1 All treatment planning meetings and subsequent reviews will occur at a time and in a place that allows for adequate notification to and participation of the team members. Videoconferencing shall be made available at a Southwood facility.

1.2 When individual treatment team members cannot attend a treatment planning meeting, their input will be sought by the treating Therapist by telephone, e-mail, or family meeting. The Therapist shall document such input in the child/adolescent's chart.

1.3 The child/adolescent and family member(s) will indicate their agreement with treatment plans by signing them.

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: All Residential Programs Clinical Services

Written by: Kregg Winkowski, MS, Dir. of

Program/Dept. Director: Program Director

PIRC Approval Date: 8/22/07

SUBJECT: Family Therapy and Family Contact

Effective Date: 9/1/2007 Revision Date: 4/09 Page 1 of 2

POLICY:

In order for treatment to be effective, it is critical that the family of each resident be involved in all aspects of his/her treatment. All residents admitted to Southwood Residential Programs will have consistent family therapy and family contact during their time of residence. It is the policy of Southwood to incorporate all pertinent family issues into each resident's treatment experience. To help accomplish this goal, the Residential Programs seek to include all involved family members and guardians not only in the development of the ISP/Master Treatment Plan but also in on-going activities such as family education, conflict-resolution between residents and family members, and case coordination efforts. Relatedly, the Residential Programs seek to keep family members/guardians apprised as to each resident's progress in treatment. The therapist and case manager assigned to each resident are responsible for all efforts involving the inclusion of outside interested parties.

PROCEDURE:

1.0 During the intake process, all efforts will be made to obtain relevant family contact information and to include the input of the family in treatment planning. To this end, the first family or guardian contact and family therapy session should occur within the first 7 days after admission. This will preferably be face-to-face at the time of admission, or as a last resort a session during this time frame by videoconference or -- if the family does not have access to videoconferencing -- by telephone. This contact will be documented by the therapist in a family therapy note, and by the case manager in a case management note.

2.0 Each week, there will be a 30-60 minute family therapy session or contact between a Master's-trained therapist and the resident's family regarding the progress of the resident within the treatment program. During this session/contact, the participants shall also address referral concerns related to the resident's functioning and role in the family and the community of origin. The clinician may also discuss therapeutic leave goals and progress or may conduct a collateral session with the parent or guardian regarding the resident's functioning in the family. If feasible, the therapist/case manager should schedule a consistent time each week for this contact to be made. The efforts to do so

should be documented in family therapy or case management notes. Case managers shall, on a monthly basis, mail invitation letters to families to inform them of the proposed scheduled days and times of their children's treatment team meetings for the upcoming month. Videoconferencing shall be made available for all family therapy sessions at a Southwood facility. For those residents without families, staff will document in the family therapy section that there is no family involvement in the case and will coordinate care with the legal guardian.

3.0 When family therapy sessions have been missed and phone contact has been unsuccessful, the therapist/case manager should make additional attempts to reach the family. The therapist/case manager must attempt to call the family at different times of day and must also use alternative telephone numbers when available. If the family has an e-mail account, an e-mail shall be sent by the therapist or case manager to the available e-mail address(es). In the event that these further efforts to contact the family are unsuccessful, the therapist must contact the referral source to determine whether there has been a change in the family's contact information or telephone number. After 14 days without contact, the therapist must mail a certified letter to the family reminding them of the importance of ongoing participation in their child's treatment. The relevant Managed Care Organization should be copied on this letter. Each attempt to contact the family should be documented, and a copy of any correspondence should be placed in the resident's chart.

4.0 Each month, the medical records department will provide a report regarding the amount of family contact that each resident has received during the prior month. The clinical director and executive director will use this data to ensure that family contact is prevalent throughout each program.

5.0 The case manager will summarize and document the dates that family therapy occurred on the 30-day treatment team review form and also for review in the continued stay reauthorization meetings with the MCO.

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Residential Written by: Barbara Sisarcick, RN, BSN, CPHQ, DON

Program/Dept. Director: Program Directors PIRC Approval Date: 1/03

SUBJECT: Residential Program Therapeutic Leave

Effective Date: 7/99 Revision Date: 1/03, 1/06, 4/09 Page 1 of 2

POLICY:

Therapeutic passes will be used to facilitate the generalization of positive gains made by children/adolescents and their families by permitting leave to the home, school, and community environment. The treatment team will determine the use of such passes. Therapeutic leave to visit family is each resident's right -- subject to the treatment team's determination of therapeutic appropriateness -- and shall never be viewed or used as an incentive, reward, or punishment. For so long as such leave is deemed to be therapeutically appropriate by the treatment team, and subject to family cooperation, each residential program should make available to each resident each month at least two therapeutic leaves.

PROCEDURE

1.0 Determination of the implementation of a therapeutic leave will be made by the treatment team, which includes the family.

1.1 For each therapeutic leave, a Therapeutic Leave Form shall be used in the form attached hereto.

1.2. For each therapeutic leave, a Timed Therapeutic Leave Check form shall be used in the form attached hereto.

2.0 The treatment team will determine the purpose of the therapeutic pass and delineate target behaviors for the child/adolescent and/or family during the period of leave. The therapist shall document the purpose and target behaviors on the Therapeutic Leave Form and include goals, expectations, and crisis plans when necessary.

3.0 The physician will be responsible for approving all leave. Nursing staff will obtain the physician order for the leave and will ensure that there is documentation on the Therapeutic Leave Form that there has been a review of medications and treatment goals for the leave before it begins.

4.0 The staff on duty on the shift on which the child/adolescent leaves on the pass is responsible for ascertaining:

4.1 That the appropriate sections of the Therapeutic Leave Form and of the Timed Therapeutic Leave Check are accurate and complete;

4.2 That the person taking responsibility for the child/adolescent during the therapeutic leave has signed the Therapeutic Leave Form and that a staff member has witnessed the signature;

4.3 That the pass contract has been reviewed with the child/adolescent and family before the child/adolescent leaves on the pass;

4.4 That any medication prescribed has been given and/or that arrangements have been made for the child/adolescent to take the medication(s) with him/her with clear instructions for taking as prescribed;

4.5 That the progress notes document that the child/adolescent is on a therapeutic pass.

5.0 The Supervisor on duty on the shift in which the child/adolescent returns from therapeutic leave is responsible for promptly, during that shift:

5.1 Ascertaining that the "return" sections of the Therapeutic Leave Form and of the Timed Therapeutic Leave Checklist have been completed;

5.2 Ensuring that the progress notes document both that the child/adolescent has returned from therapeutic leave and the results of the pass;

5.3 Ensuring that staff is assigned to complete -- and does complete -- a thorough check of the resident and his/her belongings prior to him/her returning to his/her unit.

6.0 As soon as possible, upon the resident's return from the leave, the therapist must ensure that all goals and the outcome of the leave are reviewed with the resident and his/her family/guardian. Within 5 days after the resident's return, the therapist shall document on the Therapeutic Leave Form the therapeutic results of the pass. Such documentation shall be made available to the interdisciplinary team within 15 days following the resident's leave.

7.0 Therapeutic leave documentation will be charted for each resident to ensure that the maximum days are not exceeded per calendar year.

Southwood Psychiatric Hospital
Residential Program

label

Resident Therapeutic Leave

Name: _____ Date: _____

Responsible person for Resident: _____

Relationship to Resident: _____ Telephone: _____

Leave From		
Day of Week	Date	Time

Return		
Day of Week	Date	Time

Check if Completed:

Medication readied with instructions?	
Physician's Order obtained?	

Treatment Objectives to be addressed during leave (from treatment Plan)

1. _____

2. _____

3. _____

_____

Signing below indicates that the responsible person for the resident during the leave will attempt to implement the above objectives, monitor the resident closely, and provide feedback to staff upon return, and promptly notify staff of any change in the residents condition including illness or injury, and to return the resident at the time and date listed above. Therapeutic leave requires 24 hour supervision while the resident is away from the RTF and should be used to gauge the resident's progress. The resident and belongings will be checked immediately upon return to the program.

Person Responsible: _____

Resident Signature: _____

Time Left:		Staff	

Pass Restrictions: When resident requires permission for leave from DHHR/CYS/JPO, indicate that authorization was obtained:

Person Contacted	Date	Time	Authorization Obtained*

Staff:	

*If DHHR/CYS/JPO is unavailable, but message left and return call requested to confirm, check ☐

Staff: _____ Date Submitted: _____

GOVERNMENT EXHIBIT E-4 Attached

Southwood Psychiatric Hospital
Residential Program

Resident Return from Leave: Date_____ Time:_____

Whom did resident Return with:		
Resident was returned on time, if not explain below	☐ yes	☐ no
Resident and belongings checked	☐ yes	☐ no

Reason why resident was not returned on time or other information?

_____

_____

Reason why resident/belongings not checked:

_____

Staff checking Resident in:		Date/Time:	
			Date: Time:

Treatment Objectives

Indicate if progress made on objectives listed on front

☐ If unavailable check here and refer to Family Progress note for leave information

Objective #1	☐ yes	☐ no
Objective #2	☐ yes	☐ no
Objective #3	☐ yes	☐ no
Objective #4	☐ yes	☐ no

Detailed information on progress made during this therapeutic leave will be addressed during the next Family Therapy session by the resident's Family Intervention Special therapist

Reviewed by:

_____ **Therapist**

_____ **Physician**

Timed Therapeutic Leave Checklist

Resident:_____ Date of TTV Leave_____
Date of TTV Return_____

Departure:

____ Assigned therapist and case manager have authorized leave.

____ All necessary parties have been notified (parent(s), guardians, referral entity, etc.).

____ Nurse has prepared and communicated medication dispensing to responsible person(s) during the leave.

____ Physician order is written in medical chart regarding the leave "Physician Consent for Patient Leave" is completed to include dates, times and signatures.

____ Unit staff / Nursing staff have prepared for leave (forms, medications, belongings) in advance of scheduled departure

____ Nursing Assessment prior to departure.

_____ _____
Signature of Nursing Staff Date

Return:

____ Belongings thoroughly checked for contraband

____ Nursing Assessment upon return from leave

____ Completed Leave Form placed in designated area for clinical review and process.

_____ _____
Signature of Nursing Staff Date

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL & SOUTHWOOD RTFs

Department: Residential Written by: Barbara Sisarcick, DON

Program/Dept. Director: Program Directors PIRC Approval Date: 1/03

SUBJECT: Program Visiting and Communication

Effective Date: 7/99 Revision Date: 1/03,1/06, 4/09 Page 1 of 2

POLICY

It is the policy of Southwood Residential Programs that visiting and communication with family is an important aspect of treatment. Visiting and communication with family is each resident's right -- subject to the treatment team's determination of therapeutic appropriateness -- and shall never be viewed or used as an incentive, reward, or punishment. For so long as such contact is deemed therapeutically appropriate by the treatment team, and subject to the family's cooperation, each residential program should provide each resident who has a family with weekly contact with his/her family and each resident who does not have a family with weekly contact with his/her guardian.

PROCEDURE

1.0 Each parent/guardian has the right to visit with his/her child at a time and place convenient to the program and to the family,

1.1 Visiting at Southwood's Residential Programs is arranged between the Family Intervention Specialist/Therapist and the family.

1.2 An exception to the visiting requirements is allowed if any of the following conditions exist:

1.2.1 Visiting is clearly not in keeping with the placement goal for the resident, e.g. adoption or independent living;

1.2.2 Visiting is limited or prohibited by the courts;

1.2.3 Visiting is freely refused in writing by the parents;

1.2.4 Parent or guardian is intoxicated, or there is evidence of violent behavior.

2.0 Each child/adolescent has the right to communicate with his/her parents or guardian, clergy, attorney, or placing agency. These communications may not be restricted.

Further:

2.1 Upon admission to a Southwood Residential Program, staff will obtain from the child/adolescent's parent or guardian and involved agency the names and relationships of individuals the child/adolescent is NOT permitted to contact.

2.2 Upon admission to a Southwood Residential Program, staff will request the child/adolescent and his/her family to furnish a list of names and numbers of individuals the child/adolescent is allowed to contact.

2.3 Each Residential Program shall have telephone hours for incoming calls every evening and shall have sufficient phone lines available for such calls.

2.4 Special arrangements will be made for residents whose families live outside the program's calling area and have no long distance service.

3.0 All children and adolescents in the Residential Programs are entitled to receive and send mail. When there is concern about the content of an envelope, the staff will have the child/adolescent open the mail in front of them. Staff will not read the child/adolescent's mail unless permission is given by the child/adolescent.

4.0 Upon admission, children and families will be given a handbook that may indicate specific communication requirements regarding telephone use, etc.

	YFCS Compliance Policy		
	Clinical Reviews and Clinical Data Reporting		
Policy No. 4	Eff. Date: 2/7/05	Rev. Date: 4/25/06; 4/27/07; 5/26/08; 8/12/08; 1/1/09; 4/5/09	Page 1 of 2

Policy

It is the policy of YFCS, Inc. that internal, clinical reviews of YFCS subsidiaries' programs be conducted on a periodic basis and that clinical data be communicated promptly to appropriate parties.

Guidelines and Procedures

1) There are no exceptions to the following requirements:

   a) The dates of any external survey, site visit, and/or audit must be sent to the YFCS Chief Executive Officer (CEO), the YFCS Chief Financial Officer (CFO), YFCS Chief Clinical Officer, the respective Regional Clinical Director, and the Regional Vice President of Operations within twenty-four (24) hours of receipt by the subsidiary of such notification.

   b) The results of each external survey/audit must be forwarded to the YFCS CEO, the YFCS CFO, the YFCS Chief Clinical Officer, the respective Regional Clinical Director, the YFCS Corporate Compliance Director, and, if applicable, the Regional Vice President of Operations within twenty-four (24) hours of receipt by the subsidiary of such results.

   c) All necessary Plans of Correction shall be submitted to the YFCS Chief Clinical Officer, the respective Regional Clinical Director, and the YFCS Corporate Compliance Director according to the following procedures:

      i. For any survey finding that has the potential to impact the facility's licensure status, a draft of the Plan of Correction (POC) must be submitted for approval two weeks prior to submission of the final POC to the accrediting or regulatory body.
      ii. A draft of any POC that does not have the potential to impact the facility's licensure status must be submitted for approval one week prior to submission of the final POC to the accrediting or regulatory body.
      iii. All POCs must be approved by the Chief Clinical Officer and the respective Regional Clinical Director prior to submission to the accrediting or regulatory body.
      iv. A copy of all final POCs must be forwarded to the Chief Clinical Officer, the respective Regional Clinical Director and the YFCS Corporate Compliance Director upon submission to the accrediting or regulatory body.

2) During each facility site visit, the respective Regional Clinical Director will review a random and statistically significant sample of active medical records to validate the quality measures reflected on the subsidiary's Monthly Report Card and Flash Report. Results of these audits will be forwarded to the YFCS CEO, the YFCS CFO, the YFCS Chief Clinical Officer, the facility CEO, the Regional Vice President of Operations, and the YFCS Corporate Compliance Director. These site visits will occur on at least a quarterly basis.

3) A summary of Performance Improvement activities resulting from identified deficiencies will be reviewed and reported, at least quarterly.

4) The YFCS CEO, the YFCS CFO, the YFCS Chief Clinical Officer, the respective Regional Clinical Director, the Regional Vice President of Operations, and the YFCS Corporate Compliance Director must be immediately notified of all reportable Critical Incidents. Critical Incidents are defined as follows:

   a) Death or injury (defined as injury that is reportable to an accrediting or regulatory body) related to the use of restraint(s);
   b) Death or injury related to the use of medication(s);
   c) Suicide;
   d) Death or injury related to abuse or neglect (as defined in the applicable Federal guidelines);
   e) Fire or storm damage (defined as that which results in damage that poses a threat to the health or safety of the residents), flooding, or major equipment failure(s);
   f) A strike or other work action(s);
   g) A manmade disaster that poses a threat to residents (e.g., a toxic waste spill or septic system leak); and
   h) Any other incident that involves or causes actual harm to a resident when such incident prompts a full internal investigation.

5) All clinical audits will be aggregated and reported through the quarterly facility Governing Body Reports by each respective subsidiary's CEO.

6) The requirement of reporting survey information under YFCS, Inc. Fiscal Policy Number 7 does not abrogate any of the above guidelines and procedures.

Youth & Family Centered Services, Inc. _____ (facility)

President/CEO: Signature on File Facility CEO/Administrator: _____

Date: 4/5/09 Date: _____

ORGANIZATION: SOUTHWOOD PSYCHIATRIC HOSPITAL/RTFs

Department: Residential Written by: _____

Program/Dept. Director: _____ PIRC Approval Date: _____

SUBJECT: PRTF Bedtimes

Effective Date: 04/09 Revision Date: Page 1 of

POLICY

It is the policy of the Southwood residential treatment facilities that the bedtime for all residents shall be clinically and age appropriate. As a general matter, the facility bedtimes will be noted on the weekly schedule which same be adhered to except as approved by the shift supervisor for clinically appropriate (including but not limited to recreational outings) exceptions. Bedtime will not be used as a punishment or in a retaliatory manner.

ORGANIZATION: **SOUTHWOOD PSYCHIATRIC HOSPITAL AND SOUTHWOOD RTFs**

Department: Organization-Wide **Written by:** Diane Bickford, MSW, PI Coord.

Program/Dept. Director: Patient Advocate **PIRC Approval Date:** 10/05

SUBJECT: Child/Adolescent/Family Grievance and Appeal / Patient Advocate

Effective Date: 7/99 **Revision Date: 1/03, 10/05, 1/06, 4/09** **Page 1 of 3**

POLICY

To ensure the rights of the children/adolescents/parents and families are safeguarded and that differences concerning their rights and others are resolved promptly and fairly, children/adolescents/parents must have the right to formally document grievances and appeal when informal methods of resolving differences are unsuccessful. Southwood has a grievance and appeal system in effect. Every child/adolescent/parent shall be informed of the grievance and appeal system and shall be encouraged to utilize it when informal methods of resolving complaints are unsuccessful.

PROCEDURES

1.0 Informal Grievances Process: All grievances should be processed through Southwood's informal process for resolving differences between staff and child/adolescents/parents and/or families before reaching the formal process. **The informal process is defined as the individual with a complaint or concern discussing and resolving their issues directly with the people involved. This informal process should be occurring on a regular basis in order for problems to be immediately rectified.**

1.1 Residence Councils exist at each residential program. Residence Council meetings shall be held regularly to elicit ideas from residents on how Southwood can improve its programs. Each month, each Residence Council must meet with the Patient Advocate and discuss topics to enhance resident satisfaction.

2.0 Formal Grievance Process

2.1 When informal methods of resolution of complaints are unsuccessful, child/adolescent/parent grievances may be submitted orally or in writing to the Clinical Program Director **and/or Patient Advocate.** The Patient Advocate shall have significant experience in behavioral healthcare and shall be appointed by the CEO. The Patient Advocate shall not be directly involved in any resident's or

patient's care. The Patient Advocate shall be responsible for investigating any complaints or grievances that are brought to his/her attention. A poster shall be placed prominently in all Southwood locations – and information shall be provided in Admissions paperwork -- notifying residents, patients, and their families/guardians of the Advocate's identity, his/her obligations and ability to assist, and how to contact him/her. Patients and residents shall have daily telephone access to the Patient Advocate.

2.2 The Clinical Program Director **shall immediately inform the Patient Advocate of all Formal Grievances.**

2.3 The **Clinical Program Director/Patient Advocate shall immediately begin an investigation into the compliant, and provide a written response to the person filing the complaint within 48 hours of receiving the complaint. If the investigation is unable to be completed within 48 hours due to extenuating circumstances (employees being off duty, etc.), the person filing the complaint will be contacted with updates and an estimated time for a resolution.**

2.4 The grievance or complaint will be submitted as a Variance Report to the CEO for processing through the Performance Improvement System. **The "Patient/Family/ Other Compliant or Grievance" form will be completed and forwarded to the CEO and Patient Advocate.**

2.5 If there is an appeal to a response by a Clinical Program Director, this appeal may be filed in writing to the Patient Advocate.

2.6 The Patient Advocate will consult with the Clinical Program Director and CEO and **respond to** the child/adolescent/parent within two days of the receipt of the appeal. The Patient Advocate will take necessary investigative steps to resolve the issue **within seven business days**, i.e., review with all and/or specific staff; discuss with family; physician peer review; consult CEO for legal support or interpretation.

2.7 If the process does not resolve the grievance or appeal, the problem will then be submitted to the Medical Director and CEO for their review and response. A final resolution of the grievance or appeal will be submitted by the Medical Director and CEO within **seven business days** of their receipt of the written grievance or appeal.

2.8 The final step of the grievance and appeal, if not resolved, can be forwarded by the patient to the MH/MR Administrator of Allegheny County. The patient may also contact the Office of Mental Health, Bureau of Western Operations.

2.9 If the patient is unable to read or write, assistance will be provided to them by a patient services staff member or an advocate of their choice in order to file a grievance. The grievance will then be processed with verbal and written responses.

2.10 The Patient Advocate is responsible for maintaining a Log of all formal grievances and ensuring that grievances are resolved within the established timeframes. The Patient Advocate is also responsible for analyzing the grievances and reporting quarterly to the PIC committee on trends and plans for improvement.

SOUTHWOOD PSYCHIATRIC

HOSPITAL/SOUTHWOOD RTFs

EDUCATIONAL POLICY

EFFECTIVE, APRIL 2009

Table of Contents

Mission Statement:

To assess, develop, schedule, implement and evaluate staff training and development through professional educational programs.

Philosophy:

The Training Department endeavors to promote the professional growth and development of all personnel.

Educational programs are based upon the identified learning needs of staff, as well as the dynamic nature of the health care industry.

The Training Department supports each employee's responsibility in meeting their learning needs by acquiring and maintaining competence.

Objectives:

- To assess, develop, schedule, implement and evaluate staff training and development through professional educational programs.
- To provide a competency based orientation program that facilitates the new employee's transition to their professional role.
- Promote organizational compliance which meets and exceeds the educational requirements of all regulatory and accrediting agencies.
- To provide educational programs that will assist in the planned care of the patient.
- To provide, track and retain documentation of educational training activities.
- To conduct a Southwood-wide annual assessment of employee educational needs every October with the aid of the supervisory team.
- To develop an Annual Employee Educational Training Plan from the annual assessment each November with the aid of the supervisory and management team.
- To implement and adhere to the Annual Employee Educational Training Plan to best serve our staff and client population.

Scope:

The Training Department is composed of:

- A full-time employee Educator with experience in adult learning principles and behavioral healthcare.
- Southwood employees with trainer certifications in areas such as CPR, TCI or with relevant work experience and a desire to assist with training.

The employee Educator is responsible for overseeing all employee training and development, and will assist in the planning and coordination, as required for all staff education.

The Training Department will maintain all training education records.

The Training Department will track all employee compliance with training and development which will be reported to department heads for dissemination as they see fit.

Responsibility and Accountability:

Program Managers:

- Confirmation of experience, education, and abilities for each employee during department-specific/program-specific orientation.
- Responsible for the implementation, documentation and evaluation of department specific/program-specific orientation, educational activities, competency testing and evaluation, department/program needs assessment, and follow-up monitoring of all educational activities.
- Ensuring continued competency of each employee.
- Ensure completion of a department-specific/program-specific orientation record for each employee.
- Assures attendance of each employee to general facility orientation and other required trainings as communicated.
- Performing follow up with individuals who fail to attend required trainings as necessary.
- Directly informs and reminds individuals of their assigned trainings.
- Delivering all training materials for employee training files to the Training Department for logging and tracking purposes.

Clinical Education Department:

- Responsible for coordinating general facility orientation.
- Plans, coordinates and teaches in-service education for the Southwood facilities.
- Collaborates with Program Managers regarding educational needs.
- Maintains, posts and updates a monthly educational calendar
- Keeps staff informed of upcoming classes, by way of postings and reminder memos
- Ensures classes are scheduled at a variety of times to allow access for all shifts.
- Develops, plans and coordinates periodic in-service trainings on those issues identified by the Performance Improvement Committee or its Teams.
- Prepares the Annual Employee Educational Training Plan based on the annual needs assessment.

General Facility Orientation

- General facility orientation will be conducted on an as-needed basis at Southwood Hospital and at the Southwood RTFs.
  The following topics are included in the general facility orientation:

➢ Professional Expectations

- Employee introductions and background
- Professional standards & expectations
- Training overview and requirements

➢ Welcome / Overview of Facility Operations

- History and organization
- Organization mission, values and goals
- Program overview
- Facility policies and procedures

➢ Human Resources Topics

- Completion of required new employment paperwork
- Benefits overview
- Employment policies and procedures
- Timesheets and payroll
- Worker's compensation
- Harassment Prevention

➢ Back Injury Prevention

- Annual training for all staff during annual mandatory trainings

➢ Environment of Care Management Plan

- Utility systems and back up plans
- Safety programs – weather related emergency plans
- Security plan – hostage taking and bomb threat plans
- Fire safety plan – RACE, PASS, use of key box and fire extinguishers
- Hazardous materials program – disposal of wastes, gloves, PPE disposal, MSDS/Right to know/labeling
- Use of non-Southwood owned equipment
- Slip & Fall Prevention
- Motor Vehicle Safety

➢ Tour of Facilities

- Fire and safety issues pointed out as regards to training on Fire and Safety Program
- Security issues – door locks; walkie talkies – codes

➢ Human Growth and Development

- Normal stages of child and adolescent development
- CASSP principles

➢ Cultural Competency and Literacy

- Organizational culture which delivers culturally competent care
- Understanding cultural awareness & key concepts

➢ Employee Health Requirements

- Hepatitis B program and vaccines
- TB screening

➢ Infection Control

- Exposure control plan
- Standard precautions
- Bloodborne pathogens, TB, HIV, Hepatitis
- Eye wash station
- PPE

➢ HIPAA, Patient Rights and Confidentiality

- HIPAA training
- Release of Information forms / consents
- Court Orders

➢ Admissions, Customer Service, Team Work & Communication Strategies

- Internal and external customer service orientation
- Elements necessary to work successfully as a Team Member
- Admission criteria for program

➢ Corporate Compliance Program

- Network/computer security

➢ Child Abuse Recognition and Reporting

- PA Child Protective Service Law and mandated reporting
- Profiles of child abuse / neglect victims

➢ Risk Management / Performance Improvement

- Incident reporting / tracking
- Sentinel events & Types of Risks
- Patient / Family Complaint / Grievance
- Corporate commitment to performance improvement
- Employee, patient / visitors and security

➢ Social Services

- Patients' Bill of Rights / Patient Advocate
- TDD/TTY, AT&T Language Line

➢ Child Safety and Communication

- Crisis Intervention & Suicide Prevention

➢ Client Population Specific Health Issues

- Cognitive Behavioral Therapy

➢ TCI (Therapeutic Crisis Intervention)

- Training for Direct Care staff in verbal de-escalation techniques, protective interventions, and physical intervention techniques.
- Additional unit specific training to direct care staff working with special populations provided at the specific site.

Re-Orientation:

Employees who have separated from Southwood, and have returned within 180 days, are not required to attend non-program/department-specific orientation again, but must renew all necessary certifications.

Department/Program-Specific Orientation:

- The purpose of Department/Program-Specific Orientation is to orient the new employee with the performance expectations of the job and to provide an overview of the skills, material and network of individuals needed to accomplish the performance expectations. Each department/program will provide the specific training during department/program-specific orientation which addresses:
  - Safety practices for the department/program
  - Individual needs as related to job description
  - Issues relating to patient/resident population served and care to be delivered
  - The safe and effective use of all equipment the employee will utilize on their job.

- Department/program-specific orientation begins immediately upon reporting to the specific site for the first scheduled shift during the initial orientation process. The Department/Program Leader will ensure satisfactory demonstration of competencies at the end of the ninety- (90) day probationary period. A copy of the completed department/program-specific orientation checklist will be completed and filed in the employee training file along with a completed ninety- (90) day employee performance appraisal. Any areas of orientation that have not been completed must be identified and a mechanism for future evaluation of competency will be documented.
- The Department/Program Leader will ensure satisfactory demonstration of competencies annually on all employees and record the date of verification. When an employee's performance falls below the established standard, the Department/Program Leader or his/her designee will provide the necessary education to assist the employee to achieve the desired performance level.
- The annual performance expectations for each employee are:
    - Satisfactory (or above) annual performance review
    - Satisfactory competency identified by Department/Program Leaders which may include but is not limited to:
        - Attendance in General Facility Orientation
        - Completion of mandatory compliance training as identified
        - Completion of other mandatory programs as deemed necessary.
        - Checklists.
        - Tests.
        - Oral interviews demonstrating proficiency in department specific skills.
        - In-service attendance.
        - On the job observations.

The Training Department will assist Department/Program Leaders in monitoring, tracking and evaluating the department/program-specific process. Implementation will be the responsibility of the individual departments/programs.

Hours of Training

In the first year of employment, each employee shall receive at least 80 hours of orientation training, plus at least 20 additional hours of training as well as TCI program training. In the second and each subsequent year of employment, each employee shall receive at least 40 hours of training on the topics discussed below.

Continuing Education:

The Training Department will plan and develop educational activities in response to:

- Results of accident/injury trend information.
- Risk Management studies.
- Practice issues identified through QI monitoring studies.
- Advances in science, technology, and health care management.
- Findings from employee performance appraisals.
- Regulatory/Accrediting agency requirements.
- Employee requests.

Continuing educational opportunities will be offered in a variety of methods, which may include:

- In house course offerings
- Take home study modules/clinical articles
- Viewing of video trainings
- Listening to audio presentations, with corresponding literature
- Teleconferences, with corresponding literature
- Co-operative module development
- External course offerings

External speakers offering continuing education programs can be coordinated through individual departments/programs and with the Training Department for tracking and information housing.

- All programs will be brought to the attention of the Training Department so they can be included on the education calendar.
- External continuing education certificates will be recognized as proof of competency in the given topic of education.
- Employees wishing to attend an external training are required to complete an External Training & Development Request Form to be turned in to the Training Department for tracking purposes.

All educational activities must include the following:

- Topic
- Date and Time of Presentation
- Objective(s)
- Teaching methods
- Mandatory vs. Non-Mandatory education notation
- Name of person/organization presenting the education
- Record of attendance
- Authorized signature

Other requirements as mandated by credentialing agencies.

All education will be documented on the individual's Annual Training Log and submitted to the employee Educator in addition to any support materials, test, evaluations, etc.

Scheduled Educational Programs' Annual Training Requirements

Annual Training Requirements for All Staff:

- Infection Control & Communicable Diseases
- Fire Safety & Hazardous Materials
- Back Injury Prevention
- Human Growth and Development
- Special Clinical Topics
- Child Abuse, Domestic Abuse and Elder Abuse Recognition
- Cultural Competency
- Human Resource Related Topics
- Patient Rights, Confidentiality and HIPAA training
- Customer Service / Team Work & Communication Strategies
- Safety Management

Additional Annual Training Requirements for All Direct Care Staff:

- Driver Safety
- CBT
- TCI
- CPR/FA – if certification is expired
- Any soon to be expired certification

TRAININGS OFFERED MONTHLY

- Therapeutic Crisis Intervention Training (TCI): Recommended 3 month refresher courses for direct care staff (4 hours of refresher training)
- First Aid – American Heart Certification
- CPR – American Heart Certification
- Orientation Program for new employees offered for 10 days of training, on a continuous basis
- Post Orientation and development training competency testing and debriefing
- Clinical journal articles for RN's and LPN's with competency quiz
- Clinical journal articles for Direct Care Staff and Clinicians with competency quiz
- Audio / video training of trainings or special events, with article and competency quiz
- Medication education
- Audio Conference training when appropriate and available
- Department/program-specific trainings; for RTF staff, such training shall include:
  - Appropriate coping skills
  - The impact of staff absenteeism on the RTF programs
  - Respect for colleagues
  - Group facilitation
  - Ways to recognize and avert emotional burnout

- Bullying and hazing
- Working with conduct disorder clients
- Effective communication – micro skills
- Working with sexually maladaptive behaviors
- Ethics and boundaries
- Punishment vs. consequence
- Recognizing when to intervene
- DSM-IV made simple
- Writing effective incident reports
- Improving documentation skills
- Working with personality traits
- Setting milieu expectations
- Working with ADHA

SOUTHWOOD HOSPITAL OVERVIEW OF SCHEDULED MONTHLY TRAININGS

2009 Training Schedule

January			
1/5	NEO Start		
1/9	TCI Refresher	8:00 -12:00	SWH
1/13	CPR/FA	8:00 -12:00	SWH
1/21	JCAHO	8:00 -2:00	Prosperity
1/22	JCAHO	8:00 -2:00	MRDD
1/23	JCAHO	8:00 -2:00	SWH
February			
2/2	NEO Start		
2/3	Relational Aggression	1:00 – 3:00	Prosperity
2/4	Relational Aggression	1:00 – 3:00	MRDD
2/5	Relational Aggression	1:00 – 3:00	Main
2/6	TCI Refresher	8:00 -12:00	SWH
2/10	CPR/FA	8:00 -12:00	SWH
March	**Section 1**		
3/2	Effective Communication – Micro skills	1:00 – 3:00	Prosperity
3/3	Effective Communication – Micro skills	1:00 – 3:00	MRDD
3/4	Effective Communication – Micro skills	1:00 – 3:00	SWH
3/9	NEO Start		
3/13	TCI Refresher	8:00 -12:00	SWH
3/17	CPR/FA	8:00 -12:00	SWH
3/23	TCI Refresher Section 1	8:00 -2:00	Prosperity
3/24	TCI Refresher Section 1	8:00 -2:00	MRDD
3/27	TCI Refresher Section 1	8:00 -2:00	SWH
April			
4/6	NEO Start		
4/10	TCI Refresher	8:00 -12:00	SWH
4/14	CPR/FA	8:00 -12:00	SWH
4/22	Annual Mandatory	8:00 -2:00	Prosperity
4/23	Annual Mandatory	8:00 -2:00	MRDD
4/24	Annual Mandatory	8:00 -2:00	SWH
May			
5/4	NEO Start		
5/6	Group Facilitation	1:00 – 3:00	Prosperity
5/7	Group Facilitation	1:00 – 3:00	MRDD
5/8	Group Facilitation	1:00 – 3:00	SWH
5/8	TCI Refresher	8:00 -12:00	SWH
5/12	CPR/FA	8:00 -12:00	SWH

2009 Training Schedule

June	**Section 2**		
6/1	NEO Start		
6/2	Working w/ Conduct Disorder	1:00 – 3:00	Prosperity
6/3	Working w/ Conduct Disorder	1:00 – 3:00	MRDD
6/4	Working w/ Conduct Disorder	1:00 – 3:00	SWH
6/5	TCI Refresher	8:00 -12:00	SWH
6/9	CPR/FA	8:00 -12:00	SWH
6/25	TCI Refresher Section 2	8:00 -2:00	Prosperity
6/26	TCI Refresher Section 2	8:00 -2:00	MRDD
6/30	TCI Refresher Section 2	8:00 -2:00	SWH
July			
7/6	NEO Start		
7/7	Group Facilitation	1:00 – 3:00	Prosperity
7/8	Group Facilitation	1:00 – 3:00	MRDD
7/9	Group Facilitation	1:00 – 3:00	SWH
7/10	TCI Refresher	8:00 -12:00	SWH
7/14	CPR/FA	8:00 -12:00	SWH
August			
8/10	NEO Start		
8/14	TCI Refresher	8:00 -12:00	SWH
8/18	CPR/FA	8:00 -12:00	SWH
September	**Section 3**		
9/1	TCI Refresher Section 3	8:00 -2:00	Prosperity
9/2	TCI Refresher Section 3	8:00 -2:00	MRDD
9/3	TCI Refresher Section 3	8:00 -2:00	SWH
9/14	NEO Start		
9/18	TCI Refresher	8:00 -12:00	SWH
9/22	CPR/FA	8:00 -12:00	SWH
October			
10/5	SMB	1:00 – 3:00	Prosperity
10/6	SMB	1:00 – 3:00	MRDD
10/7	SMB	1:00 – 3:00	SWH
10/12	NEO Start		
10/16	TCI Refresher	8:00 -12:00	SWH
10/20	CPR/FA	8:00 -12:00	SWH
November			
11/2	Ethics & Boundaries	1:00 – 3:00	Prosperity
11/3	Ethics & Boundaries	1:00 – 3:00	MRDD
11/4	Ethics & Boundaries	1:00 – 3:00	SWH
11/9	NEO Start		
11/13	TCI Refresher	8:00 -12:00	SWH
11/17	CPR/FA	8:00 -12:00	SWH
December			
12/7	NEO Start		
12/11	TCI Refresher	8:00 -12:00	SWH
12/15	CPR/FA	8:00 -12:00	SWH

TRAINING REQUESTS FROM 2008

Most Prevalent Requested Training or Education:

- Working with Conduct Disorder Clients
- Effective Communication – Micro skills
- Group Facilitation
- Working with Sexually Maladaptive Behaviors
- Ethics & Boundaries
- Punishment vs. Consequence
- Recognizing when to Intervene
- DSM – IV made simple
- Writing Effective Incident Reports
- Improving Documentation Skills
- Working with Personality Traits
- Setting Milieu Expectations
- Working with ADHA

TRAINING & DEVELOPMENT FOR ADULT PROFESSIONALS

As adults we take on a new perspective of what we expect from a learning situation, and in fact become rather insistent on certain "Conditions of Learning" before we will truly participate in a good program or session. The following principles and conditions are provided to help guide you in developing and presenting material.

Three Basis Principles of Adult Learning

1. Adults bring a lot of experience with them to any learning encounter, and therefore have something to contribute and something to lose.
2. Adults seek learning experiences that focus on real-life *here* and *now* problems and tasks.
3. Adults are accustomed to being active and self-directed.

The above principles lead to a different approach to teaching that what we all encountered during our years of school. The following are broad outline statements that can help create a positive learning environment.

Conditions of Learning

1. The learners must feel a need to learn. They will only pay attention to material that is relevant to their personal situation.
2. The learning environment must be relaxed, supportive, and non-threatening.
3. The learners need to perceive the goals of the learning experience to be their goals.
4. The learners prefer to participate actively in the learning process. Keep lecture, one-way communication, and single approaches to learning, etc. to minimum.
5. The learning process must be related to and make use of the experience base of the participants.
6. The learners want to have a sense of progress toward goals.

References

Gibbons, S. (1999). Learning Terms: Action Learning for Leaders. Journal for Quality and Participation, 22 (4), p. 26.

Joint Commission on Accreditation of Healthcare Organization (JCAHO)

Knowles, M. & Knowles, H. (1972) Introduction to Group Dynamics. New York: Associated Press.

Lamarche - Bisson, D. (2002). Learning Styles. World & 1, 17 (9), 276.

ORGANIZATION: **SOUTHWOOD PSYCHIATRIC HOSPITAL AND SOUTHWOOD RTFs**

Department: Prosperity RTF **Written by:** Stephen J. Quigley, CEO

Program/Dept. Director: Jeri Jones **PIRC Approval Date:** _____

SUBJECT: Recreation Policy

Effective Date: 04-08-09 **Revision Date:** **Page 1 of 2**

POLICY

It is the policy of Prosperity RTF to encourage the participation of residents in structured recreational activities. These activities are designed to foster and promote a healthy lifestyle for the residents.

PROCEDURES

1.0 Prior to participating in some recreational activities, residents will display safe behaviors and appropriate clinical stability as determined by program staff.

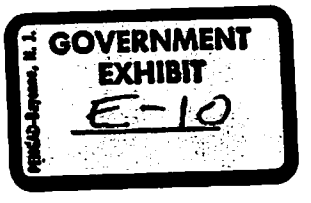
2.0 Residents deemed appropriate for any off campus recreational activity must be free of any homicidal/suicidal ideation and should not have attempted to elope from the facility within the past 24 hours.

3.0 All off campus recreational activities must be pre-approved by the Clinical Program Director or designee prior to the event.

4.0 Outdoor recreational time shall be provided every day to each resident, weather permitting and depending on other therapeutic activities impacting the resident's schedule.

5.0 Large muscle recreational activities will be offered according to the program schedule. These activities will include, but are not limited to the following:

- Basketball
- Flag football
- Volleyball
- Kick ball
- Nature walks
- Cardio-based activity (jump rope, running, walking, use of exercise bikes)



6.0 Small muscle recreational activities will be offered according to the program schedule. These activities will include, but are not limited to the following:

- Board games
- Card games
- Crafts
- Journal writing
- Letter writing
- Video games
- Coloring

6.0 There will be structured activities and social outings to community events that are held off campus and these will include, but are not limited to the following:

- Baseball games
- Hockey games
- Public zoo
- Festivals
- County fairs
- Museums
- Movies
- Skating
- Bowling
- Swimming

ORGANIZATION: **SOUTHWOOD PSYCHIATRIC HOSPITAL AND SOUTHWOOD RTFs**

Department: Dietary **Written by:** David Menovich

Program/Dept. Director: CFO/ Dir of Nursing **PIRC Approval Date:** 2/04

SUBJECT: Consultant Services

Effective Date: 12/99 **Revision Date: 12/99, 1/03, 2/04, 12/05, 10/08, 4/09** **Page 1 of 1**

POLICY

It is the policy of Southwood to utilize a consultant dietician when deemed appropriate.

PROCEDURE

1.0 The consultant will be a dietician registered with the American Dietetic Association.

2.0 The registered dietician will be responsible to remain current on latest research.

3.0 Consulting dietician will be responsible for:

- 3.1 Completing all consults to patients and families when requested by physician.
- 3.2 Completing consultation/service request form (see attached) after each visit. This form is to be reviewed by physician and placed in Medical Record.
- 3.3 Working with Dietary Services Staff on any nutritional or administrative issues deemed appropriate.
- 3.4 Conducting inspections and inservices if requested.
- 3.5 Review and sign off on all menus.
  - 3.5.1 Dietary Manager responsible for maintaining log of all signed menus.

4.0 Dietician is responsible for going to facility on an as-needed basis.

5.0 In the absence of a consulting Dietician (such as staff turnover) the Director of Nursing along with the prescribing physician will ensure that special diets are ordered. Also, in the event that a child would have a rare condition requiring a consult, that child would be referred to an outside provider for assessment and recommendations.

SOUTHWOOD PSYCHIATRIC HOSPITAL

Job Description

POSITION TITLE: **Milieu Manager**

DEPARTMENT/UNIT: **Prosperity Residential Treatment Facility**

RESPONSIBLE TO: **Prosperity Executive Director**

FSLA: **Exempt**

Position Summary:

The Milieu Manager is a specifically trained individual who implements Southwood's mission, philosophies, goals, standards, policies and procedures for the RTF. He or she has twenty-four accountability and oversight of the day-to-day operations. Responsibilities include the management of the direct care staff, as well as ensuring ongoing program operation and development. Administrative responsibilities for the program include ongoing program planning, ensuring efficiency and efficacy of services, practicing fiscal responsibility for program services, ensuring regulatory standards have been met and ongoing performance improvement. The Milieu Manager works in collaboration with the Executive Director.

Minimum Required Education/Experience/Skills:

1. Bachelor's Degree in the human services field from an accredited school.
2. Knowledge of group dynamics preferred.
3. Therapeutic Crisis Intervention (TCI) certification must be maintained to include annual refresher.
4. CPR certification renewed bi-annually or upon expiration of certification.
5. Must be knowledgeable of the developmental stages and age specific behaviors of the individuals served.
6. Maintains competence in identified universal, core and critical competencies.
7. Valid Act 33/34 Clearances.
8. Must meet job competencies within 90 days of hire.
9. The physical demands for this job are as follows:
   Medium Work – Medium Work is defined as lifting **50 lbs.** maximum with frequent lifting and/or carrying objects weighing up to **35 lbs.**
   Reaching, Handling, Fingering and/or Feeling:
   a. Reaching: Extended the hands and arms in any direction.
   b. Handling: Seizing, holding, grasping, turning or otherwise working with the hand or hands fingering not involved).
   c. Fingering: Picking, pinching or otherwise primarily working with the fingers (rather than with the whole hand or arm as handling).
   d. Feeling: Perceiving such attributes of objects and materials as size, shape, temperature and/or texture, by means of receptors in the skin, particularly those of the fingertips.
   Talking and/or hearing are required:

a. Talking: Expressing or exchanging ideas by means of the spoken word.
b. Hearing: Perceiving the nature of sounds by the ear.

Seeing is required:

a. Must be able to read and write.

Mobility is required:

a. Must be able to kneel on the floor (CPR).
b. Must be able to assist in the physical management of the individual (TCI).

10. Must be knowledgeable of the Department of Public Welfare's 3800 Regulations and have ability to implement standards.
11. OSHA Requirements – This position is determined to fall under the following category:
Category II: Those job tasks that involve a low risk of exposure to blood, tissues, body fluids containing visible blood or other body fluids to which Universal Precautions apply.

Specific Performance Components:

1. Safety
   a. Demonstrates understanding of the potential risks and, at all times, performs duties in a manner that ensures the individual, staff and youth safety.
   b. Demonstrates emergency procedures to implement in the event of an emergency (cardiac arrest, tornado, fire, disaster, etc.)
   c. Locates fire fighting equipment, fire exits and evacuation routes on each unit.
2. Professional Development
   a. Assumes basic responsibility for own learning needs.
   b. Demonstrates professional relationships with all team members.
   c. Utilizes established departmental and intra-unit communication lines.
3. Adheres to YFCS/Southwood's mission statement, values and service philosophy.
4. Follows general hospital policies, procedures, as well as the Prosperity RTF specific regulations.
5. Verbalizes an understanding of the job description, competency and performance evaluations.
6. Articulates internal customer service strategy.
7. Fosters and maintains the highest standard of customer service to the internal and external customers.
8. Maintains safety of work environment by participating in worker accidents and injuries investigations; develops safety action plans to decrease future incidents.
9. Completes all necessary forms to report a work-related injury on the same day as the injury, when possible.
10. Completes and submits timely work-related injuries/incidents documentation.

Unit Specific Performance Objectives:

1. Prepares and implements short-term and long-term plans for the program in collaboration with the Executive Director and the Medical Director, in order to ensure ongoing clinical growth of the program to meet changing demands of the healthcare market.
2. Serves as a role model for quality nursing care and program leadership.
3. Develops the program's mission, philosophy, standards, policies and procedures in collaboration with the Executive Director and the Medical Director.
4. Participates in developing, interpreting and implementing hospital and nursing missions, goals and objectives, standards and policies and procedures.
5. Participates in the budget process by meeting the budget goals and assisting the Executive Director in the development of the RTF budget.

6. Develops and implements cost containment efforts for the program.
7. Maintains staffing according to staff management system based on program's acuity level.
8. Interviews and selects the staff for the program.
9. Maintains a performance appraisal process for all program staff that encourages active staff participation.
10. Evaluates in a systematic manner, the effectiveness of care provided; maintains quality improvement monitors for the program and continuously assesses and improves program performance.
11. Investigates and initiates appropriate actions for unusual incidents and grievances from the individual, personnel, other professionals, other departments, families or significant others.
12. Coordinates the efforts of the treatment team, individual, family and community agencies in developing individualized treatment plans.
13. Supports the Director of Nursing in emphasizing to all nursing staff, the importance of maintaining a therapeutic environment, individuals' rights, the nursing process, safety and the participation of the individual, families and significant others in the care of the program.
14. Communicates and coordinates with appropriate professionals, i.e. physicians, family intervention specialists and outside behavioral health professionals to facilitate treatment.
15. Supports an environment conducive to professional growth and learning by providing staff development programs to improve competence.
16. Conducts monthly staff meetings, or more frequently, as indicated.
17. Prepares quarterly and annual reports for the Executive Director and others, as requested.
18. Serves on committees as designated by the Executive Director.
19. Participates in inter-departmental activities to improve communication, coordination and quality patient care.
20. Acts as a liaison to the faculty and students assigned to the program.
21. Acts as a representative and liaison in the community and other service system agency contacts.
22. Participates in staff development designed to meet individual professional needs.
23. Demonstrates knowledge of age specific growth and development.
24. Delegates duties as required.
25. Participates in own performance process.
26. Maintains competence in identified universal, core and critical competencies.
27. Performs other duties as required.

General Performance Components:

1. Appearance
   a. Is clean, neat and observes Southwood Hospital and RTF's dress code at all times.
   b. Wears identification tag at all times.
2. Aptitude
   a. Performs duties in an independent manner with minimal direct supervision.
   b. Manages time efficiently/effectively to complete assignments.
   c. Recognizes and performs duties which need to be performed even though not directly assigned.
   d. Actively assists on special projects.
   e. Improves knowledge/skill as necessary for effective decision-making in performance of duties.
   f. Participates in problem-solving/resolution by offering suggestions.
3. Attendance
   a. Does not abuse or take advantage of sick time or personal days.
   b. Is punctual and provides proper notification for absence or tardiness.

c. Takes corrective action to prevent recurring absences.
d. Completes all of Southwood Hospital's mandatory requirements in a timely manner.

4. Interpersonal Behavior
   a. Is courteous to and considerate of others.
   b. Adapts to change and is flexible.
   c. Works cooperatively with others.
   d. Utilizes effective communication skills in understanding others and expressing self.
   e. Adheres to hospital policies and procedures in a positive manner.
   f. Exhibits mature adult behavior.
   g. Projects a favorable and positive image of Southwood Hospital and the Prosperity RTF at all times.
   h. Is receptive to supervision and constructive criticism.

The physical requirements described herein are representative of those that must be met by an employee to successfully perform the primary functions of this job. Reasonable accommodations may be made to enable individuals with disabilities, who are otherwise qualified, to perform the primary functions.

I can fulfill the job requirements as stated in the job description

1. _____ **without specific accommodations**

2. _____ **with specific accommodations. If so, please explain:**

_____

_____

_____

_____ _____

Employee Signature **Date**

_____ _____

Witness Signature **Date**

The specific statements shown in this description are not intended to be all inclusive. They represent typical elements and criteria considered necessary to successfully perform the job.